BlueCare

For Self-funded Groups

Benefit Booklet

CUSTOMER SERVICE ASSISTANCE:
800-352-2583

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HOW TO USE YOUR BENEFIT BOOKLET

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

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

You should read this Booklet carefully before you need Health Care Services; it contains valuable information about:

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

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

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

When reading your Booklet, please remember:

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

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

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

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

If a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If the word or phrase has a special meaning, it will either be defined in the DEFINITIONS section or within the particular section where it is used.

Where do I find information on…	**…go to:**
What is **covered?**	The **WHAT IS COVERED?** section.
What is **not covered?**	The **WHAT IS NOT COVERED?** section, along with the **WHAT IS COVERED?** section.
How do I know what **Providers** I can use, and how the Providers I use will affect my **Cost Share** amount?	The **HEALTH CARE PROVIDER OPTIONS** section, along with the current **BlueCare Provider Directory**.
How much do I pay for Health Care Services?	The **YOUR SHARE OF HEALTH CARE EXPENSES** section along with the **Schedule of Benefits**.
How do I access Services when I'm **out-of-state?**	The **BLUECARD PROGRAM** section.
How do I **add or remove a Dependent?**	The **ENROLLMENT AND EFFECTIVE DATE OF COVERAGE** section.
What if I am covered under **BlueCare** and **another health plan?**	The **COORDINATION OF BENEFITS** section.
What happens when **my coverage ends?**	The **TERMINATION OF COVERAGE** section, along with the **CONTINUING COVERAGE** section.
What do the **terms used** throughout this Booklet **mean?**	The **DEFINITIONS** section.
Who do I call if I have **questions?**	Call our **customer service** department at **800-352-2583** (this phone number can also be found on your **ID Card)**.

WHAT IS COVERED?

Introduction

This section describes the Health Care Services that are covered under this Booklet. All benefits for Covered Services are subject to: 1) your share of the cost and the benefit maximums listed on your Schedule of Benefits, 2) the applicable Allowed Amount, 3) any limitations and exclusions, as well as any other provisions contained in this Booklet including any Endorsements that are part of your Booklet, and 4) our Medical Necessity guidelines and Coverage Access Rules then in effect (see the MEDICAL NECESSITY and COVERAGE ACCESS RULES sections).

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

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

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

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

Covered Services Categories

Ambulance Services

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

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

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

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

Exclusion

Non-emergency Ambulance or other transportation Services are not covered unless such Services are ordered by an In-Network Provider and authorized in advance.

Ambulatory Surgical Center

Health Care Services provided at an Ambulatory Surgical Center may be covered and include:

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

Anesthesia Administration Services

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

Exclusion

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

Autism Spectrum Disorder

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

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

Payment Guidelines for Autism Spectrum Disorder

The covered therapies provided in the treatment of Autism Spectrum Disorder outlined in paragraph three above will be applied to the Outpatient Therapies Benefit Period maximum set forth in the Schedule of Benefits. Autism Spectrum Disorder Services must be authorized in accordance with criteria established 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 Autism Spectrum Disorder 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.

Behavioral Health Services

Mental Health Services

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

1. Physician office visits;
2. Intensive Outpatient Treatment (rendered in a facility), as defined in this Booklet; and

   Partial Hospitalization, as defined in this Booklet, when provided under the direction of a Physician.

Exclusion

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

Substance Dependency Treatment Services

Detoxification Services for the time necessary for the removal of toxic substances from the blood and outpatient follow-up care are covered. Inpatient and outpatient Detoxification treatment must be authorized in accordance with our criteria then in effect.

Outpatient visits for the care and treatment of Substance Dependency may be covered. Consultations may be provided by a Specialist or Psychologist, who are In-Network Providers, and authorized in accordance with our criteria then in effect.

Referral to, but not payment of, non-medical ancillary Services such as vocational rehabilitation or employment counseling, when we are able to make such referrals. Such Services are to be provided

solely at your expense. You acknowledge that we and/or the Group do not have any contractual or other formal arrangements with the Provider of such Services.

Exclusion

Substance dependency care and treatment Services that are long-term treatment Services for alcoholism and drug addiction, including prolonged treatment in a specialized inpatient or residential facility.

Breast Reconstructive Surgery

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

Casts, Splints and Trusses

Casts, splints and trusses are covered when part of treatment in a facility, office or in a Hospital emergency room. This does not include the replacement of dental splints or trusses.

Child Cleft Lip and Cleft Palate Treatment

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

Clinical Trials

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

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

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

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

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

Exclusion

1. Costs that are generally covered by the clinical trial, including, but not limited to:

a. Research costs related to conducting the clinical trial such as research Physician and nurse time, analysis of results, and clinical tests performed only for research purposes.

b. The investigational item, device or Service itself.

c. Services inconsistent with widely accepted and established standards of care for a particular diagnosis.

2. Services related to an Approved Clinical Trial received outside of the United States.

Dental Services

Dental Services are limited to the following:

1. Care and stabilization treatment rendered within 62 days of an Accidental Dental Injury provided such Services are for the treatment of damage to Sound Natural Teeth.
2. Extraction of teeth required prior to radiation therapy when you have a diagnosis of cancer of the head and/or neck.
3. Anesthesia Services for dental care including general anesthesia and hospitalization Services necessary to assure the safe delivery of necessary dental care provided to you in a Hospital or Ambulatory Surgical Center if:

   a. a Covered Dependent is under eight years of age and it is determined by a dentist and the Covered Dependent's Physician that:

      1) dental treatment is necessary due to a dental Condition that is significantly complex; or

      2) the Covered Dependent has a developmental disability in which patient management in the dental office has proven to be ineffective; or

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

Exclusion

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

Diabetes Treatment Services

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

1. outpatient self-management training and educational Services when provided under the direct supervision of a certified Diabetes Educator or a board-certified Physician specializing in endocrinology;
2. nutrition counseling provided by a licensed dietitian;
3. equipment such as insulin pump and tubing, to treat diabetes; and
4. trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Exclusion

Certain supplies used in the treatment of diabetes are covered under pharmacy benefits, such as blood glucose meters, lancets, test strips. If the Group provides pharmacy coverage under a BlueCare Rx Pharmacy Program, the diabetic supplies covered under that program will not be covered under this category. Refer to the PRESCRIPTION DRUG PROGRAM section for more information.

Diagnostic Services

Diagnostic Services are covered and include the following:

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

Exclusion

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

Dialysis Services

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

Durable Medical Equipment

Durable Medical Equipment is covered when provided by a Durable Medical Equipment Provider and when prescribed by a Physician and is limited to the most cost effective equipment as determined by us.

Payment Guidelines for Durable Medical Equipment

If you own or you are purchasing the equipment, supplies and service to repair medical equipment may be Covered Services. Coverage for Durable Medical Equipment will be based on the lowest of the

following: 1) the purchase price; 2) the lease/purchase price; 3) the rental rate; or 4) our Allowed Amount. Our Allowed Amount for rental equipment will not exceed the total purchase price. Durable Medical Equipment includes, but is not limited to: wheelchairs, crutches, canes, walkers, hospital beds, and oxygen equipment.

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

Exclusion

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

Emergency Services and Urgent Care Services

Emergency Services

Emergency Services in or out of the Service Area for treatment of an Emergency Medical Condition are covered without the need for any prior authorization.

You must notify us as soon as possible, concerning the receipt of Emergency Services and/or any admission which results from an Emergency Medical Condition. If a determination is made that an Emergency Medical Condition does not exist, payment for Services rendered subsequent to that determination will be your responsibility.

Special Payment Rules for Non-Grandfathered Plans

The Patient Protection and Affordable Care Act (PPACA) requires that non-grandfathered health plans apply a specific method for determining the allowed amount for Emergency Services rendered for an Emergency Medical Condition by Providers who do not have a contract with us.

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

1. the amount equal to the median amount negotiated with all HOI In-Network Providers for the same Services;
2. the Allowed Amount as defined in this Booklet;
3. the usual and customary Provider charges for similar Services in the community where the Services were provided; or
4. what Medicare would have paid for the Services rendered.

In no event will Out-of-Network Providers be paid more than their charges for the Services rendered. **If your plan is a grandfathered health plan under PPACA, these payment guidelines do not**

apply to your plan. If you are not sure whether or not your health plan is grandfathered, please contact your Group.

Exclusion

Follow-up care must be rendered by an In-Network PCP or In-Network Specialist. If you are told you need follow-up care after your emergency room visit, be sure to contact your PCP or an In-Network Specialist first. Any follow-up care you receive that is provided by a Provider other than your PCP or an In-Network Specialist may not be covered.

Urgent Care Services

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

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

Enteral Formulas

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

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

Eye Care

Coverage includes the following Services:

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

Exclusion

1. Health Care Services to diagnose or treat vision problems that are not a direct consequence of trauma or prior eye surgery;
2. vision examinations;
3. eye exercises or visual training;
4. eye glasses and contact lenses and their fitting; and
5. any surgical procedure performed primarily to correct or improve myopia or other refractive disorders, such as LASIK.

Family Planning

Family planning Services are covered and include:

1. family planning counseling and Services, including counseling and information on birth control; sex education, including prevention of venereal disease; and fitting of diaphragms;
2. contraceptive medication by injection provided and administered by a Physician; and
3. surgical sterilization (tubal ligations and vasectomies).

Note: Some family planning Services are covered under the Preventative Health Services category, please refer to that category for more information.

Exclusion

Contraceptive medications, devices and appliances, other than as noted above and reversal of surgical sterilization procedures are not covered. Elective abortions are also excluded.

Home Health Care

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

1. you are unable to leave your home without considerable effort and assistance because you are bedridden or chairbound or because you are restricted in ambulation, whether or not you use assistive devices; or you are significantly limited in physical activities due to a Condition;
2. the Home Health Care Services rendered have been prescribed by a Physician by way of a formal written treatment plan to us and we approve the treatment plan;
3. the treatment plan has been reviewed and renewed by the prescribing Physician at least every 30 days until benefits are exhausted. (We reserve the right to request a copy of any written treatment plan in order to determine whether such Services are covered under this Booklet);
4. the Home Health Care Services are provided by or through a Home Health Agency within the Service Area; and
5. you are meeting or achieving the desired treatment goals set forth in the treatment plan as documented in the clinical progress notes.

Home Health Care Services are limited to:

1. part-time or intermittent nursing care, by a Registered Nurse or Licensed Practical Nurse and/or home health aide Services; (part-time is defined as less than eight hours per day and less than 40 hours a week and an intermittent visit will not exceed two hours per day);
2. home health aide Services must be consistent with the plan of treatment, ordered by a Physician, and provided under the supervision of a Registered Nurse;
3. medical social Services;
4. nutritional guidance;
5. respiratory or inhalation therapy, such as oxygen; and
6. Physical Therapy, by a Physical Therapist, Occupational Therapy, by an Occupational Therapist, and Speech Therapy, by a Speech Therapist.

Exclusion

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

Hospice Services

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

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

Recertification is required every six months.

Hospital Services

Covered Hospital Services include:

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

14. Physical, Speech, Occupational and Cardiac Therapies;
15. other Medically Necessary Services; and
16. transplants as set forth in the Transplants Services category.

Exclusion

1. Expenses for the following Hospital Services are excluded when such Services could have been provided without admitting you to the Hospital:
    a. room and board provided during the admission;
    b. Physician visits provided while you were an inpatient;
    c. Occupational, Speech, Physical, and Cardiac Therapies; and
    d. other Services provided while you were an inpatient.
2. gowns and slippers;
3. shampoo, toothpaste, body lotions and hygiene packets;
4. take-home drugs;
5. telephone and television;
6. guest meals or gourmet menus; and
7. admission kits.

Infertility Treatment

Infertility Services for a Covered Person who meets our criteria then in effect, including office visits, diagnosis, and diagnostic procedures to determine the cause of infertility, laboratory work and treatment of infertility limited to testing, Artificial Insemination, and surgical procedures to correct Conditions causing infertility.

Exclusion

Prescription Drugs, In Vitro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT); Zygote Intrafallopian Transfer (ZIFT) and any Services associated with these procedures, or any Services associated with the donation or purchase of sperm.

Inpatient Rehabilitation

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

1. Services must be provided under the direction of a Physician and must be provided by a Medicare certified facility in accordance with a comprehensive rehabilitation program;
2. a plan of care must be developed and managed by a coordinated multi-disciplinary team;
3. coverage is subject to our Medical Necessity coverage criteria then in effect;

4. you must be able to actively participate in at least two Rehabilitative Therapies and be able to tolerate at least three hours per day of skilled Rehabilitation Services for at least five days a week and your Condition must be likely to result in significant improvement; and
5. the Rehabilitation Services must be required at such intensity, frequency and duration that further progress cannot be achieved in a less intensive setting.

Exclusion

All inpatient Rehabilitation Services for Substance Dependency, drug and alcohol related diagnoses (except as otherwise covered in the Behavioral Health Services category), Pain Management, and respiratory ventilator management Services are excluded.

Mammograms

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

Mastectomy Services

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

Maternity Services

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

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

Hospital or Birth Center Services for labor and delivery of the baby including a physical assessment of the mother and any necessary clinical tests in keeping with prevailing medical standards, newborn assessment, room and board and nursery. Your Cost Share for these Services is listed on your Schedule of Benefits under inpatient Hospital or Birth Center, depending on where Services are rendered. You may also choose to deliver your baby at home, in which case, the Hospital or Birth Center Cost Share would not apply.

Exclusion

1. Maternity Services rendered outside the Service Area are not covered except in urgent situations when you did not and could not reasonably expect the need for Services before you left the Service Area.

2. Maternity Services rendered to a Covered Person who becomes pregnant as a Gestational Surrogate under the terms of, and in accordance with, a Gestational Surrogacy Contract or Arrangement. This exclusion applies to all Services related to such pregnancy (prenatal, labor and delivery and postpartum).

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

Medical Pharmacy

Provider-administered Prescription Drugs which are rendered in a Physician's office or in the home in connection with a Home Health nursing visit may be subject to a separate Cost Share amount that is in addition to the office visit or Home Health Cost Share amount. The Medical Pharmacy Cost Share amount applies to the Prescription Drug and does not include the administration of the Prescription Drug. The Medical Pharmacy Cost Share may vary depending on whether the medication is a Preferred Prescription Drug or a Non-Preferred Prescription Drug.

Your plan may also include a maximum monthly amount you will be required to pay out-of-pocket for Medical Pharmacy, this amount may vary for Preferred Prescription Drugs and Non-Preferred prescription Drugs. If your plan includes a Medical Pharmacy out-of-pocket maximum, it will be listed on your Schedule of Benefits and only applies after you have met your Deductible, if applicable.

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

Note: For purposes of this benefit, allergy injections and immunizations are not included in the Medical Pharmacy benefit category.

Newborn Care

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

Newborn Assessment

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

Newborn Ambulance Services

Ambulance Services are covered when necessary to transport the newborn child to and from the nearest appropriate facility which is appropriately 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.

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

Osteoporosis Services

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

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

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 you own 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 one splint in a six-month period unless a more frequent replacement is determined by us to be Medically Necessary. Coverage for Orthotic Devices is based on the most cost-effective Orthotic Device which meets your medical needs as determined by us.

Exclusion

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

Outpatient Therapies and Spinal Manipulation Services

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

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

   Occupational Therapy Services provided by a Physician or Occupational Therapist for the purpose of aiding in the restoration of a previously impaired function lost due to a Condition.

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

   Physical Therapy Services provided by a Physician or Physical Therapist for the purpose of aiding in the restoration of normal physical function lost due to a Condition.

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

   Exclusion

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

   Coverage Access Rules for Massage and Physical Therapy

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

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

Coverage Access Rules for Spinal Manipulation

1. Coverage for spinal manipulation is limited to no more than 26 -30 spinal manipulations per Benefit Period, or the maximum benefit listed in your Schedule of Benefits, whichever occurs first.
2. Payment for covered Physical Therapy Services rendered on the same day as spinal manipulation is limited to one Physical Therapy treatment per day, not to exceed 15 minutes in length.

Your Schedule of Benefits sets forth the maximum number of visits that the Plan will pay for any combination of the outpatient therapies and spinal manipulation Services listed above. For example, even if you may have only been administered two of your spinal manipulations for the Benefit Period, any additional spinal manipulations for that Benefit Period will not be covered if you have already met the combined therapy visit maximum with other Services.

Oxygen

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

Physician Services

Covered Services include medical Services such as office visits and allergy testing and treatment or surgical Health Care Services provided by a Physician, including Services rendered in the Physician's office, in an outpatient facility, or electronically through a computer via the Internet (E-Visits).

Coverage Access Rules for E-Visits

Expenses for E-Visits are covered only if:

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

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

Exclusion

Expenses for Health Care Services rendered by telephone or failure to keep a scheduled appointment are not covered.

Preventive Health Services

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

In order to be covered, Services shall be provided in accordance with prevailing medical standards consistent with:

1. evidence-based items or Services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the U.S. Preventive Services Task Force established under the Public Health Service Act;
2. immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention established under the Public Health Service Act with respect to the individual involved;
3. respect to infants, children, and adolescents, evidence- informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. respect to women, such additional preventive care and screenings not described in paragraph one. as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Women’s preventative coverage under this category includes:
    a. well-woman visits;
    b. screening for gestational diabetes;
    c. human papillomavirus testing;
    d. counseling for sexually transmitted infections;
    e. counseling and screening for human immune-deficiency virus;
    f. contraceptive methods and counseling unless indicated as covered in the PRESCRIPTION DRUGS PROGRAM section;
    g. screening and counseling for interpersonal and domestic violence; and
    h. breastfeeding support, supplies and counseling. Breastfeeding supplies are limited to one manual breast pump per pregnancy.

Exclusion

Routine vision and hearing examinations and screenings are not covered as Preventive Health Services, except as required under paragraph number one and/or number three above. Sterilization procedures covered under this category are limited to tubal ligations only. Contraceptive implants are limited to Intra-uterine devices (IUD) indicated as covered in the Medication Guide only, including insertion and removal.

Prosthetic Devices

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

1. artificial hands, arms, feet, legs and eyes, including permanent implanted lenses following cataract surgery, cardiac pacemakers, and Prosthetic Devices incident to a Mastectomy;
2. appliances needed to effectively use artificial limbs or corrective braces; and
3. penile prosthesis.

Covered Prosthetic Devices (except cardiac pacemakers, and Prosthetic Devices incident to Mastectomy) are limited to the first such permanent prosthesis (including the first temporary prosthesis if it is

determined to be necessary) prescribed for each specific Condition. Coverage for Prosthetic Devices is based on the most cost-effective Prosthetic Device which meets your medical needs as determined by us.

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

Exclusion

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

Second Medical Opinion

You are entitled to a second medical opinion when:

1. you do not agree with the opinion of your treating Physician or us regarding the reasonableness or necessity of a surgical procedure or treatment of a serious injury or illness; or
2. you feel you are not responding to the current treatment plan in a satisfactory manner after a reasonable lapse of time for the Condition being treated.

You may select any licensed Physician who practices medicine within the Service Area to render the second medical opinion, but will need to ask your PCP or an In-Network Specialist to get an authorization from us before you receive the Services. However, you should know that your Cost Share amount for Services rendered by an In-Network Provider (usually a set Copayment) for a second medical opinion will be lower than those rendered by an Out-of-Network Provider. When you use an Out-of-Network Provider for a second medical opinion your Cost Share will be a percentage of the Allowed Amount, which may be less than the Out-of-Network Provider charges for such Services. In this case, in addition to your percentage of the Allowed Amount, you will also have to pay any charges billed by an Out-of-Network Provider in excess of the Allowed Amount.

All tests in connection with rendering the second medical opinion, including tests ordered by an Out-of-Network Physician, must be Medically Necessary and must be performed by In-Network Providers.

Coverage may be denied for a second medical opinion if you seek more than three second medical opinions in any Benefit Period and second medical opinion costs are deemed evidence that you are unreasonably over-utilizing the second medical opinion privileges. The decision, after review of documentation from the second medical opinion you obtained, will be controlling as to the Plan's obligation to pay for such treatment.

Skilled Nursing Facilities

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

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

Exclusion

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

Surgical Procedures

Surgical procedures performed by a Physician including surgical assistant Services rendered by a Physician or a Physician Assistant acting as a surgical assistant when such assistance is Medically Necessary, include the following:

1. surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes;
2. oral surgical procedures for excision of tumors, cysts, abscesses, and lesions of the mouth;
3. surgical procedures involving bones or joints of the jaw such as temporomandibular joint (TMJ) and facial region if, under accepted medical standards, such surgery is necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury; and
4. surgical procedures performed for the treatment of Morbid Obesity (e.g., intestinal bypass, stomach stapling, balloon dilation) and any associated care provided you have not previously undergone the same or a similar procedure while covered under the Group Health Plan.

Note: Must be 18 years of age and is limited to 1 clinical severe obesity surgery per lifetime. Pre/post surgery nutritional and lifestyle counseling required.

Payment Rules for Surgical Procedures

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

Transplant Services

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

1. Bone Marrow Transplant, as defined herein and specifically listed in the applicable chapter of the Florida Administrative Code or covered by Medicare as described in the most recently published Medicare Coverage Issues Manual issued by the Centers for Medicare and Medicaid Services. The Plan will cover the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for you and will be subject to the same limitations and exclusions as would be applicable to you. Coverage for the reasonable expenses of searching for a donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;
2. corneal transplant;
3. heart transplant (including a ventricular assist device, if indicated, when used as a bridge to heart transplant);
4. heart-lung combination transplant;
5. liver transplant;
6. kidney transplant;
7. pancreas transplant;
8. pancreas transplant performed simultaneously with a kidney transplant; or

9. whole single or whole bilateral lung transplant.

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

Exclusion

1. Transplant procedures not included in the list above, or otherwise excluded under this Booklet, such as Experimental or Investigational transplant procedures.
2. Transplant evaluation and procedures rendered **before** we are contacted for authorization.
3. Transplant procedures which are not authorized **before** they are provided.
4. Transplant procedures involving the transplantation of any non-human organ or tissue.
5. Transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered under this Plan.
6. Transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ.
7. Any organ, tissue, marrow, or stem cells which are sold rather than donated.
8. Any Bone Marrow Transplant, as defined herein, which is not specifically listed in the applicable chapter of the Florida Administrative Code or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual.
9. Any Service in connection with the identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant.
10. Any non-medical costs, including but not limited to, temporary lodging or transportation costs for you and/or your family to and from the approved facility.
11. Any artificial heart or mechanical device that replaces either the atrium and/or the ventricle.

PRESCRIPTION DRUG PROGRAM

BlueCare Rx Pharmacy Program

Coverage for Prescription Drugs and Supplies is provided through the BlueCare Rx Pharmacy Program described in this section. We have included this section in this Booklet for ease of reference, however it is important that you understand this BlueCare Rx Pharmacy Program is separate from the medical coverage described in other sections of this Booklet, and provisions which are specific to this Pharmacy Program are described in this section.

Coverage is provided to you for certain Prescription Drugs and Supplies and select Over-the-Counter ("OTC") Drugs purchased at a Pharmacy. In order to obtain benefits under this section, you must pay, at the time of purchase, your Cost Share amounts indicated on the BlueCare Rx Pharmacy Program Schedule of Benefits.

In the Medication Guide you will find lists of Preferred Generic Prescription Drugs, Preferred Brand Name Prescription Drugs, Non-Preferred Prescription Drugs and Covered OTC Drugs. You may be able to reduce your out-of-pocket expenses by: 1) choosing Preferred Prescription Drugs rather than Non-Preferred Prescription Drugs; 2) choosing Generic Prescription Drugs rather than Brand Name Prescription Drugs; and 3) choosing Preferred Generic Prescription Drugs or Covered OTC Drugs.

To verify if a Pharmacy is a Participating Pharmacy, you may access the Pharmacy Program Provider Directory on our website at www.floridablue.com or call the customer service phone number on your ID Card.

Covered Drugs and Supplies

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

1. prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license except for vaccines, which are covered when prescribed and administered by a Pharmacist who is certified in immunization administration;
2. dispensed by a Pharmacist;
3. Medically Necessary;
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, such as Epi-Pen, Epi-Pen Jr., Ana-Kit;
7. authorized for coverage, if prior coverage authorization is required as indicated with a unique identifier in the Medication Guide, then in effect;
8. not specifically or generally limited or excluded herein; and

9. Approved by the FDA and assigned a National Drug Code.

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

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

Coverage and Benefit Guidelines

The benefit guidelines set forth below apply to the benefits under the BlueCare Rx Pharmacy Program, as well as any other applicable payment rules specific to particular Covered Services listed in this Booklet.

Contraceptive Coverage

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

The following are covered at no cost to you when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license and purchased at a Participating Pharmacy:

1. Generic Prescription oral contraceptives indicated as covered in the Medication Guide;

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

   You can obtain an Exception Request Form on our website at www.floridablue.com, or you may call the customer service phone number on your ID Card and one will be mailed to you upon request.
2. Diaphragms indicated as covered in the Medication Guide; and
3. Emergency contraceptives indicated as covered in the Medication Guide.

Exclusion

Contraceptive injectable Prescription Drugs and implants, such as Norplant and IUD are excluded from coverage under this BlueCare Rx Pharmacy Program.

Covered Over-the-Counter (OTC) Drugs

Select OTC Drugs, listed in the Medication Guide, may be covered when you obtain a Prescription for the OTC Drug from your Physician. Only those OTC Drugs listed in the Medication Guide are covered.

A list of Covered OTC Drugs is published in the most current Medication Guide and can be viewed at www.floridablue.com or you may call the customer service phone number on your ID Card and one will be mailed to you upon request.

Diabetic Coverage

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

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

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

Exclusion

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

Mineral Supplements, Fluoride or Vitamins

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

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

Exclusion

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

Specialty Pharmacy: Split Fill Option

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

BlueCare Rx Pharmacy Program Limitations and Exclusions

Limitations

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

1. The Plan will not cover more than the Maximum supply, as set forth in the BlueCare Rx Pharmacy Program Schedule of Benefits, per Prescription for Covered Prescription Drugs and Supplies or Covered OTC Drugs.
2. Prescription refills beyond the time limit specified by state and/or federal law are not covered.
3. Certain Prescription Drugs and Supplies and Covered OTC Drugs require prior coverage authorization in order to be covered.
4. Specialty Drugs (self-administered and Provider-administered), as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.
5. Retinoids (e.g., Retin-A) and their generic or therapeutic equivalents are excluded after age 26.

Exclusions

1. Drugs that are covered and payable under the WHAT IS COVERED? section, such as Prescription Drugs which are dispensed and billed by a Hospital.
2. Except as covered in the Covered Drugs and Supplies subsection, any Prescription Drug obtained from a Pharmacy which is dispensed for administration by intravenous infusion or injection, regardless of the setting in which such Prescription Drug is administered or type of Provider administering such Prescription Drug.
3. Any Drug or Supply which can be purchased over-the-counter without a Prescription even when a written Prescription is provided (Drugs which do not require a Prescription), except for insulin, emergency contraceptives and Covered OTC Drugs listed in the Medication Guide.
4. All Supplies other than Covered Prescription Supplies.
5. Any Drugs or Supplies dispensed prior to the Effective Date or after the termination date of coverage of this BlueCare Rx Pharmacy Program.
6. Therapeutic devices, appliances, medical or other Supplies and equipment, such as air and water purifiers, support garments, creams, gels, oils and waxes, regardless of the intended use (except for Covered Prescription Supplies).
7. Drugs and Supplies that are:
    a. in excess of the limitations specified in this section or on the BlueCare Rx Pharmacy Program Schedule of Benefits;
    b. furnished to you without cost;
    c. Experimental or Investigational;
    d. indicated or used for the treatment of infertility;

e. used for cosmetic purposes including but not limited to Minoxidil, Rogaine or Renova;

f. prescribed by a Pharmacist except for vaccines;

g. used for smoking cessation, such as Chantix, Nicorette and Zyban;

h. listed in the Homeopathic Pharmacopoeia;

i. not Medically Necessary;

j. indicated or used for sexual dysfunction, such as Cialis, Levitra, Viagra and Caverject;

k. purchased from any source (including a Pharmacy) outside of the United States;

l. prescribed by any health care professional not licensed in any state or territory of the United States of America, such as Puerto Rico, U.S. Virgin Islands or Guam;

m. OTC Drugs not listed in the Medication Guide;

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

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

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

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

10. Immunization agents, biological sera, blood and blood plasma, except as listed in the Covered Drugs and Supplies subsection.

11. Drugs prescribed for uses other than the FDA-approved label indications. This exclusion does not apply to any Drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the Drug is recognized for treatment of your particular cancer in a Standard Reference Compendium or recommended for such treatment of your particular cancer in Medical Literature. Drugs prescribed for the treatment of your particular cancer that have not been approved for any indication are also excluded.

12. Drugs that have not been approved by the FDA, as required by federal law, for distribution or delivery into interstate commerce.

13. Drugs that are compounded except when all active ingredients are FDA-approved Prescription Drugs with valid National Drug Codes.
14. Drugs and Supplies purchased from a Non-Participating Pharmacy, except as a result of an Emergency Medical Condition or when authorized in advance by us.
15. Any Drug prescribed in excess of the manufacturer's recommended specifications for dosages, frequency of use, or duration of administration as set forth in the manufacturer's insert for such Drug. This exclusion does not apply if:
    a. the dosages, frequency of use, or duration of administration of a Drug has been shown to be safe and effective as evidenced in published peer-reviewed medical or pharmacy literature;
    b. the dosages, frequency of use, or duration of administration of a Drug is part of an established nationally recognized therapeutic clinical guideline such as those published in the United States by the American Medical Association, National Heart Lung and Blood Institute, American Cancer Society, American Heart Association, National Institutes of Health, American Gastroenterological Association, Agency for Health Care Policy and Research; or
    c. HOI and/or the Group, in our sole discretion, waive this exclusion with respect to a particular Drug or therapeutic class of Drugs.
16. Any Drug prescribed in excess of the dosages, frequency of use, or duration of administration shown to be safe and effective for such Drug as evidenced in published peer-reviewed medical or pharmacy literature or nationally recognized therapeutic clinical guidelines such as those published in the United States by the:
    a. American Medical Association;
    b. National Heart Lung and Blood Institute;
    c. American Cancer Society;
    d. American Heart Association;
    e. National Institutes of Health;
    f. American Gastroenterological Association; or
    g. Agency for Health Care Policy and Research;

    unless HOI and/or the Group, in our sole discretion, decide to waive this exclusion with respect to a particular Drug or therapeutic class of Drugs.
17. Any amount you are required to pay under the BlueCare Rx Pharmacy Program as indicated on the BlueCare Rx Pharmacy Program Schedule of Benefits.
18. Any benefit penalty reductions.
19. Drugs or Supplies you prescribe to yourself or prescribed by any person related to you by blood or marriage.
20. Food or medical food products, whether prescribed or not.

21. Prescription Drugs designated in the Medication Guide as not covered based on (but not limited to) the following criteria:

    a. the Drug is a Repackaged Drug;

    b. the Drug is no longer marketed;

    c. the Drug has been shown to have excessive adverse effects and/or safer alternatives;

    d. the Drug is available Over-the-Counter (OTC);

    e. the Drug has a preferred formulary alternative;

    f. the Drug has a widely available/distributed AB rated generic equivalent formulation;

    g. the Drug has shown limited effectiveness in relation to alternative Drugs on the formulary; or

    h. the number of members affected by the change.

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

Pharmacy Alternatives

For purposes of the section, there are two types of Pharmacies: Participating Pharmacies and Non-Participating Pharmacies.

Participating Pharmacies

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

With BlueCare Rx, there are four types of Participating Pharmacies:

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

To verify if a Pharmacy is a Participating Pharmacy, you may refer to the Pharmacy Program Provider Directory then in effect at www.floridablue.com or call the customer service phone number on your ID Card.

Prior to purchase, you must present your ID Card to the Participating Pharmacy and the Pharmacy must be able to verify that you are, in fact, covered under the BlueCare Rx Pharmacy Program.

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, and will be one of the following:

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

Specialty Pharmacy

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

Using a Specialty Pharmacy to provide these Specialty Drugs should lower the amount you have to pay for these medications.

The Specialty Pharmacies designated, solely by us, are the only Participating suppliers for Specialty Drugs. Any Pharmacy not designated by us as a Specialty Pharmacy is considered Non-Participating for payment purposes, even if such Pharmacy is a Participating Pharmacy for other Covered Prescription Drugs under this BlueCare Rx Pharmacy Program.

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

Mail Order Pharmacy

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

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

Non-Participating Pharmacies

A Prescription Drug, OTC Drug or Self-Administered Injectable Prescription Drug purchased from a Non-Participating Pharmacy is covered under this BlueCare Rx Pharmacy Program **only** if it is prescribed as a result of an Emergency Medical Condition or authorized in accordance with our criteria then in effect.

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

When Covered Prescription Drugs and Supplies or Covered OTC Drugs are purchased from a Non-Participating Pharmacy, as a result of an Emergency Medical Condition, or when authorized, you may be required to pay the full cost of the Drug at the time of purchase.

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

Pharmacy Utilization Review Programs

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

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

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

Our pharmacy utilization review programs include the following:

Responsible Steps

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

Prior to filling a Prescription, your Physician may contact us to request coverage for a Prescription Drug or OTC Drug subject to the Responsible Steps program by following the procedures for prior coverage authorization outlined in the Medication Guide.

Dose Optimization Program

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

Prior Coverage Authorization Program

You are required to obtain prior coverage authorization in accordance with our criteria then in effect, in order for certain Prescription Drugs and Supplies and OTC Drugs to be covered. **If you do not obtain an authorization when one is required coverage and payment will be denied.** Prescription Drugs and Supplies and OTC Drugs that require prior coverage authorization are designated in the Medication Guide.

For additional details on how to obtain prior coverage authorization, refer to the Medication Guide.

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

Ultimate Responsibility for Medical Decisions

The pharmacy utilization review programs have been established solely to determine whether coverage or benefits for Prescription Drugs, Supplies and OTC Drugs will be provided under the terms of this

Booklet. Ultimately the final decision as to whether the Prescription Drug, Supply or OTC Drug should be prescribed must be made by you and the prescribing Physician. Decisions made by us or the Group in authorizing coverage are made only to determine whether coverage or benefits are available under this BlueCare Rx Pharmacy Program and not for the purpose of providing or recommending care or treatment. We reserve the right to modify or terminate these programs at any time.

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

BlueCare Rx Pharmacy Program Definitions

Certain important terms applicable to the BlueCare Rx Pharmacy Program are set forth below. For additional applicable definitions, please refer to the DEFINITIONS section of this Booklet.

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

Coinsurance means, when applicable, the sharing of health care expenses for each Covered Prescription Drug and Supply and/or Covered OTC Drug between you and the Plan. After any applicable Pharmacy Deductible requirement is met, the Plan will pay a percentage of the Participating Pharmacy Allowance for each Covered Prescription Drug and Supply and/or Covered OTC Drug, as set forth in the BlueCare Rx Pharmacy Program Schedule of Benefits. The percentage you are responsible for is your Coinsurance.

Copayment means, when applicable, the amount you must pay to a Participating Pharmacy for each Covered Prescription Drug and Supply and/or Covered OTC Drug, at the time of purchase, as set forth in the BlueCare Rx Pharmacy Program Schedule of Benefits.

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

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

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

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

1. Prescription diaphragms;
2. syringes and needles prescribed with insulin, or a Self-Administered Injectable Prescription Drug which is authorized for coverage;

3. syringes and needles prescribed with a Prescription Drug authorized for coverage;
4. syringes and needles contained in anaphylactic kits (e.g., Epi-Pen, Epi-Pen, Jr., Ana Kit); and
5. Prescription Supplies used in the treatment of diabetes, limited to only blood glucose testing strips and tablets, lancets, blood glucose meters, and acetone test tablets.

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

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

FDA means the United States Food and Drug Administration.

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

Mail Order Copayment means, when applicable, the amount payable to the Mail Order Pharmacy for each Covered Prescription Drug, Covered Prescription Supply and/or Covered OTC Drug as set forth in the BlueCare Rx Pharmacy Program Schedule of Benefits

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

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

Medication Guide means the guide then in effect issued by us that may designate the following categories of Prescription Drugs: Preferred Generic Prescription Drugs; Covered OTC Drugs, Preferred Brand Name Prescription Drugs; and Non-Preferred Prescription Drugs. The Medication Guide does not list all Non-Preferred Prescription Drugs due to space limitations, but some Non-Preferred Prescription Drugs and potential alternatives are provided for your information.

Note: The Medication Guide is subject to change at any time. You may access the most current guide at www.floridablue.com or call the customer service phone number on your ID Card for current information.

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

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

Non-Participating Pharmacy means a Pharmacy that has not agreed to participate in our BlueCare Rx Pharmacy Program and is not a National Network Pharmacy, Specialty Pharmacy or the Mail Order Pharmacy.

Non-Preferred Prescription Drug means a Generic Prescription Drug, Brand Name Prescription Drug or compound Drug that is not included on the Preferred Medication List then in effect.

One-Month Supply means a Maximum quantity per Prescription up to a 30-Day Supply as defined by the Drug manufacturer's daily dosing recommendations. Certain Drugs (such as Specialty Drugs) may be dispensed in lesser quantities due to manufacturer package size or course of therapy.

Over-the-Counter (OTC) Drug means a Drug that is safe and effective for use by the general public, as determined by the FDA, and can be obtained without a Prescription.

Participating Pharmacy means a Pharmacy that has signed an agreement with us to participate in the BlueCare Rx Pharmacy Program. National Network Pharmacies, Specialty Pharmacies and the Mail Order Pharmacy are also Participating Pharmacies.

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

Pharmacist means a person properly licensed to practice the profession of Pharmacy per Chapter 465 of the Florida Statutes, or a similar law of another state that regulates the profession of Pharmacy.

Pharmacy means an establishment licensed as a Pharmacy per Chapter 465 of the Florida Statutes, or a similar law of another state, where a Pharmacist dispenses Prescription Drugs.

Pharmacy Benefit Manager means an organization that has established, and manages, a Pharmacy network and other Pharmacy management programs for third party payers and employers, which has entered into an arrangement with us to make such network and/or programs available to you.

Pharmacy Deductible means, when applicable, the amount of charges up to the Participating Pharmacy Allowance, for Covered Prescription Drugs and Supplies and Covered OTC Drugs that you must actually pay per Benefit Period, in addition to any applicable Copayment or percentage of the Participating Pharmacy Allowance, to a Pharmacy who is recognized for payment under this BlueCare Rx Pharmacy Program, before the Plan's payment for Covered Prescription Drugs and Supplies and Covered OTC Drugs begins.

Preferred Brand Name Prescription Drug means a Brand Name Prescription Drug that is included on the Preferred Medication List then in effect. The Preferred Medication List is contained within the Medication Guide. A Preferred Brand Name Prescription Drug on the Preferred Medication List then in effect will be reclassified as a Non-Preferred Prescription Drug on the date the FDA approves a bioequivalent Generic Prescription Drug.

Preferred Generic Prescription Drug means a Generic Prescription Drug on the Preferred Medication List then in effect. The Preferred Medication List is contained within the Medication Guide.

Preferred Medication List means a list of Preferred Prescription Drugs then in effect, which have been designated by us as preferred and for which coverage and benefits are provided, subject to the exclusions in this section. The Preferred Medication List is contained within the Medication Guide.

Preferred Prescription Drug means a Prescription Drug that appears on the Preferred Medication List then in effect. A Preferred Prescription Drug may be a Brand Name Prescription Drug or a Generic Prescription Drug. The Preferred Medication List is contained within the Medication Guide.

Prescription means an order for medications or Supplies by a Physician or other health care professional authorized by law to prescribe such Drugs or Supplies.

Prescription Drug means any medicinal substance, remedy, vaccine, biological product, Drug, pharmaceutical or chemical compound which can only be dispensed pursuant to a Prescription and/or which is required by state law to bear the following statement or similar statement on the label: "Caution: Federal law prohibits dispensing without a Prescription". For purposes of the BlueCare Rx Pharmacy Program, emergency contraceptives and insulin is considered a Prescription Drug because, in order to be covered hereunder, we require that it be prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license.

Repackaged Drug(s) means a pharmaceutical product that is removed from the original manufacturer container (Brand Originator) and repackaged by another manufacturer with a different NDC.

Self-Administered Injectable Prescription Drug means an FDA-approved injectable Prescription Drug that you may administer to yourself, as recommended by a Physician, by means of injection, (except insulin). Covered Self-Administered Injectable Prescription Drugs are denoted with a special symbol in the Medication Guide.

Specialty Drug means an FDA-approved Prescription Drug that has been designated by us as a Specialty Drug due to requirements such as special handling, storage, training, distribution, and management of therapy. Specialty Drugs may be Provider administered or self-administered and are identified with a special symbol in the Medication Guide.

Specialty Pharmacy means a Pharmacy that has signed a Participating Pharmacy Provider Agreement with us to participate in the BlueCare Rx Pharmacy Program, to provide specific Prescription Drug products, as determined by us. The fact that a Pharmacy is a Participating Pharmacy does not mean that it is a Specialty Pharmacy.

Supply(ies) means any Prescription or non-Prescription device, appliance or equipment including, but not limited to, syringes, needles, test strips, lancets, monitors, bandages, cotton swabs, and similar items and any birth control device.

Three-Month Supply means a Maximum quantity per Prescription up to a 90-Day Supply as defined by the Drug manufacturer’s dosing recommendations.

WHAT IS NOT COVERED?

Introduction

The following exclusions are in addition to any that are specified in the WHAT IS COVERED? and PRESCRIPTION DRUG PROGRAM sections, including any Endorsement that is a part of this Booklet. **If you do not follow the Coverage Access Rules, any Services you receive will not be covered.** For further information, please refer to the COVERAGE ACCESS RULES section.

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

Exclusions

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

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

Completion of any form and /or medical information.

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

Cost Share amounts you are required to pay even when the cost share amount is waived by a Provider.

Cosmetic Services, including any Service to improve the appearance or self-perception of an individual, including and without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling such as Minoxidil, Rogaine, Retin-A and hair implants/transplants.

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

Drugs

1. Drugs prescribed for uses other than the United States Food and Drug Administration (FDA) approved label indications. This exclusion does not apply to any drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the drug is recognized for treatment of your particular cancer in a Standard Reference Compendium or recommended for treatment of your particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.

2. dispensed to, or purchased by you from a pharmacy, except as covered under the PRESCRIPTION DRUG PROGRAM section. This exclusion does not apply to drugs dispensed to you when:

    a. you are an inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility or a Hospice facility;

    b. you are in the outpatient department of a Hospital;

    c. dispensed to your Physician for administration to you in the Physician's office and prior coverage authorization has been obtained (if required);

    d. you are receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills for such drugs, including Self-Administered Prescription Drugs that are rendered in connection with a nursing visit;

    e. defined by, and covered under the PRESCRIPTION DRUG PROGRAM section .

3. Any non-Prescription medicines, remedies, vaccines, biological products (except insulin), pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, over-the-counter drugs, products, or health foods.

4. Any drug which is indicated or used for sexual dysfunction, such as Cialis, Levitra, Viagra and Caverject.

5. Any drug which requires prior coverage authorization when prior coverage authorization is not obtained.

6. Blood or blood products used to treat hemophilia, except when provided to you for:

    a. emergency stabilization;

    b. during a covered inpatient stay, or

    c. when proximately related to a surgical procedure.

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

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

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

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

General Exclusions include, but are not limited to:

1. Any Health Care Service received prior to your Effective Date or after the date your coverage terminates under the Plan, unless coverage is extended in accordance with the Extension of Benefits subsection in the CONTINUING COVERAGE section.

2. Any Health Care Service not within the Covered Services Categories described in the WHAT IS COVERED? or PRESCRIPTION DRUG PROGRAM sections or any Endorsement that is part of this Booklet, unless such Services are specifically required to be covered by applicable law.
3. Any Health Care Service you render to yourself or those rendered by a Physician or other health care Provider related to you by blood or marriage.
4. Any Health Care Service that is not Medically Necessary as defined in this Booklet and determined by us in accordance with our criteria then in effect. The ordering of a Service by a health care Provider does not, in itself, make such Service Medically Necessary or a Covered Service.
5. Any Health Care Service rendered at no charge.
6. Expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage.
7. any Health Care Service to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with:
    a. war or an act of war, whether declared or not;
    b. your participation in, or commission of, any act punishable by law as a misdemeanor or felony whether or not you are charged or convicted, or which constitutes riot, or rebellion;
    c. your engaging in an illegal occupation;
    d. Services received at military or government facilities; or
    e. Services received to treat a Condition arising out of your service in the armed forces, reserves and/or National Guard.
8. Services that are not patient-specific, as determined solely by us.
9. Health Care Services rendered because they were ordered by a court, unless such Services are otherwise Covered Services under this Booklet.
10. Any Health Care Service rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group.
11. Any Health Care Service rendered outside the Service Area, except Emergency Services for treatment of an Emergency Medical Condition, unless such Services are approved by us in advance.

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

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

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

Orthomolecular Therapy including nutrients, vitamins, and food supplements.

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

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

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

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

Private Duty Nursing Care rendered at any location.

Sexual Reassignment, or Modification Services, including but not limited to any Service or supply related to such treatment, such as psychiatric Services.

Smoking Cessation Programs, including any Service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products, such as gum, transdermal patches, etc.

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

Training and Educational Programs or materials, including, but not limited to programs or materials for Pain Management and vocational rehabilitation, except as provided under the Diabetes Treatment Services 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.

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

Wigs and/or cranial prosthesis.

Work Related Health Care Services to treat a work related Condition to the extent you are covered or required to be covered by Workers' Compensation law. Any Service or supply to diagnose or treat any Condition resulting from or in connection with your job or employment are excluded, except for Medically Necessary Services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual.

MEDICAL NECESSITY

In order for Health Care Services to be covered under this Booklet, the Services must meet all of the requirements to be a Covered Service, including being Medically Necessary, as determined by us and/or the Group and defined in this Booklet. **As a self-funded plan, FCSRMC is ultimately responsible for determining whether expenses incurred for medical care are covered under this Booklet. However, it is important to note that under our ASO Agreement; FCSRMC has asked us to use our Medical Necessity criteria and guidelines currently in effect.**

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

All decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical Services, are solely your responsibility and that of your treating Providers. You and your Providers are responsible for deciding what medical care you should have and when that care should be provided. HOI and the Group are solely responsible for determining whether expenses incurred for that medical care are covered under this Booklet. In making coverage decisions, neither HOI nor the Group will be deemed to participate in or override your decisions concerning your health or the medical decisions of your health care Providers.

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

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

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

YOUR SHARE OF HEALTH CARE EXPENSES

This section explains what your share of the health care expenses may be for Covered Services you receive. Since not all plans include all the different types of Cost Shares explained in this section, it is important that you refer to your Schedule of Benefits to determine your share of the cost with regard to Covered Services.

Deductible

Individual Deductible

This amount, when applicable, must be satisfied by you and each of your Covered Dependents each Benefit Period, before any payment will be made by the Plan. Only those charges indicated on claims received for Covered Services will be credited toward the individual Deductible and only up to the applicable Allowed Amount.

Family Deductible

If your plan includes a family Deductible, after the family Deductible has been met by your family, neither you nor your Covered Dependents will have any additional Deductible responsibility for the remainder of that Benefit Period. The maximum amount that any one Covered Person in your family can contribute toward the family Deductible is the amount applied toward the individual Deductible, if applicable.

Hospital Per Admission Deductible

The Hospital per admission Deductible, when applicable, must be satisfied by you for each Hospital admission before any payment will be made by the Plan for any claim for inpatient Services. The Hospital per admission Deductible applies regardless of the reason for the admission.

Copayments

Covered Services rendered by certain Providers or at certain locations or settings may be subject to a Copayment. This is the dollar amount you have to pay when you receive these Services. Please refer to your Schedule of Benefits for the specific Covered Services that are subject to a Copayment. Listed below is a brief description of some of the Copayment requirements that may apply to your plan. In some cases, when the Allowed Amount or the Provider's actual charge for a Covered Service rendered is less than the Copayment amount, you may be responsible for the lesser of the Allowed Amount or the Provider's actual charge for the Covered Service.

Office Services Copayment

If your plan is a Copayment plan, the Copayment for Covered Services rendered in the office must be paid by you, for each office visit before any payment will be made by the Plan. The office Services Copayment applies regardless of the reason for the office visit and applies to all Covered Services rendered during that visit, with the exception of Durable Medical Equipment, Medical Pharmacy, Orthotics and Prosthetics, which may require Cost Share amounts in addition to the Office Services Copayment, as set forth on your Schedule of Benefits.

Inpatient Facility Services Copayment

The Copayment for inpatient facility Services, if applicable to your plan, must be satisfied by you, for each inpatient admission to a Hospital, Psychiatric Facility, or Substance Abuse Facility, before any payment will be made by the Plan for any claim for inpatient Covered Services. The Copayment for inpatient facility Services, if applicable to your plan, applies regardless of the reason for the admission, and applies to all inpatient admissions unless your Schedule of Benefits states otherwise. Additionally, you may be responsible for out-of-pocket expenses for Covered Services provided by Physicians and other health care professionals while you are an inpatient.

Outpatient Facility Services Copayment

The Copayment for outpatient facility Services, if applicable to your plan, must be satisfied by you, for each outpatient visit to a Hospital, Ambulatory Surgical Center, Independent Diagnostic Testing Center, Psychiatric Facility or Substance Abuse Facility, before any payment will be made for any claim for outpatient Covered Services. The Copayment for outpatient facility Services, if applicable to your plan, applies regardless of the reason for the visit. Additionally, you may be responsible for out-of-pocket expenses for Covered Services provided by Physicians and other healthcare professionals while using these facilities.

Note: Copayments for outpatient facility Services may vary depending on the type of facility chosen and the Services received. Please see your Schedule of Benefits for more information.

Emergency Room Facility Services Copayment

The Copayment for emergency room facility Services, if applicable to your plan, applies regardless of the reason for the visit, is in addition to any applicable Deductible or Coinsurance amount, and applies to emergency room facility Services in or outside the Service Area. The Copayment for emergency room facility Services, if applicable to your plan, must be satisfied by you for each visit. If you are admitted to the Hospital as an inpatient at the time of the emergency room visit, the Copayment for emergency room facility Services, if applicable to your plan, will be waived, but you will still be responsible for your share of the expenses for inpatient facility Services as listed in your Schedule of Benefits.

Coinsurance

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

Special Calculation Rule for Capitated Providers

Except as described below, only the amounts actually paid by the Plan for Covered Services will be credited toward applicable Deductibles. Furthermore, the amount that you will pay for your Coinsurance will be based on the Allowed Amount actually paid for the Covered Services provided.

Under certain agreements with Providers, the payment to the Provider may be a set monthly amount per individual to cover the cost of providing Covered Services to you, whether or not care is actually provided during that month. This form of payment is called “capitation”. In these instances, when you receive Covered Services from such a Provider, the amounts credited toward any Deductible, will be the amount the Plan would have paid (based on the Allowed Amount then in effect) had the Provider not been paid on

a capitated basis. Similarly, in these instances, the amount you will owe for Coinsurance will be the amount you would have owed (based on the Allowed Amount then in effect) had the Provider not been paid on a capitated basis.

Out-of-Pocket Maximums

Individual Out-of-Pocket Maximum

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

Family Out-of-Pocket Maximum

If your plan includes a family out-of-pocket maximum, once your family has reached the family out-of-pocket maximum amount listed in your Schedule of Benefits, neither you nor your covered family members will have any additional out-of-pocket responsibility for Covered Services for the remainder of that Benefit Period and the Plan will pay 100 percent of the Allowed Amount for Covered Services rendered during the remainder of that Benefit Period. The maximum amount any one Covered Person in your family can contribute toward the family out-of-pocket maximum, if applicable, is the amount applied toward the individual out-of-pocket maximum. Please see your Schedule of Benefits for more information.

Note: The Deductible, any applicable Copayments and Coinsurance will accumulate toward the out-of-pocket maximums. .

Prior Coverage Credit

You will be given credit for the satisfaction or partial satisfaction of any deductible and coinsurance maximums met by you under a prior group, blanket, or franchise insurance or group Health Maintenance Organization (HMO) policy maintained by FCSRMC if this Plan replaces such a policy. This provision only applies if the prior group, blanket, or franchise insurance or HMO coverage was in effect immediately preceding the Effective Date of this Group Health Plan. This provision is only applicable for you during the initial Benefit Period of coverage under the Plan and the following rules apply:

Prior Coverage Credit for Deductible

For the initial Benefit Period of coverage only under this Group Health Plan, charges credited by the Group's prior policy, toward your deductible requirement, for Services rendered during the 90-day period immediately preceding the Effective Date of this Group Health Plan, will be credited to the Deductible requirement under this Booklet.

Prior Coverage Credit for Coinsurance

For the initial Benefit Period of coverage only under this Group Health Plan, charges credited toward your coinsurance maximum under the Group's prior policy, for Services rendered during the 90-day period immediately preceding the Effective Date of this Group Health Plan, will be credited to your out-of-pocket maximum under this Booklet.

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

Prior coverage credit under this Booklet only applies at the initial enrollment of the entire Group under this Booklet. You and/or the Group are responsible for providing us with any information necessary for us to apply this prior coverage credit.

Additional Expenses You Must Pay

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

1. charges in excess of any maximum benefit limitation listed in your Schedule of Benefits;
2. expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage;
3. charges for Health Care Services which are non-Covered Services or excluded; and
4. any contribution amount required by FCSRMC.

How Benefit Maximums are Credited

Except as described below, only the amounts actually paid by the Plan for Covered Services will be credited toward applicable benefit maximums. The amounts the Plan pays that are credited toward your Benefit Period maximums will be based on the Allowed Amount for the Covered Services provided. Also see the Special Calculation Rule for Capitated Providers subsection above for more information.

HEALTH CARE PROVIDER OPTIONS

Introduction

It is important that you understand how the Providers you choose to use for medical care will affect how much you have to pay for medical Services. Under this HMO plan, most Services must be rendered by In-Network Providers in order to be Covered Services. This is true even when the Services you receive are Medically Necessary (except in the case of an Emergency Services for an Emergency Medical Condition). This section explains some special rules for getting Covered Services with certain types of Providers under this Booklet.

For information on Pharmacy Provider options, please refer to the PRESCRIPTION DRUG PROGRAM section.

Provider Participation Status

You are responsible for making sure a Provider is In-Network prior to receiving Services. To find out if a Provider is in our network you can:

1. access the current BlueCare Provider directory on our website at www.floridablue.com; or
2. call the customer service phone number on your ID Card.

In-Network Providers

Primary Care Physician (PCP)

The first and most important decision you must make when joining a health maintenance organization is the selection of a PCP for each covered family member. This decision is important since it is through this Provider that all other Covered Services, particularly those of Specialists, are coordinated. You do not need a referral to see your PCP.

Specialist Care

If you need to visit a Specialist, you and/or your PCP may choose any In-Network Specialist.

Your PCP may consult with us regarding coverage or benefits and with the Specialist in order to coordinate your care. This provides you with continuity of treatment by the Physician who is most familiar with your medical history and who understands your total health profile.

You do not need a referral from your PCP to see an In-Network Specialist; however, some Services require an authorization from us before Services are rendered in order to be covered. In-Network Providers are responsible for obtaining authorization.

Below are some special rules for certain types of Providers:

Chiropractors and Podiatrists: Upon your request, a Doctor of Chiropractic or a Doctor of Podiatry who is an In-Network Provider may be assigned to you for the purpose of providing chiropractic Services and podiatric Services, respectively. You shall have access to the assigned Doctor of Chiropractic or Doctor of Podiatry without the need for referrals from your PCP.

Certified Registered Nurse Anesthetist: You have access to anesthesia Services within the scope of a duly licensed Certified Registered Nurse Anesthetist's license if you request such Services, provided such Services are available, as determined by us and are Covered Services under the Plan.

Dermatologists: You may access an In-Network dermatologist for up to five visits each Benefit Period without an authorization. Some Services, such as surgical procedures will require an authorization before the Services are rendered and if you do not have an authorization; the Services will not be covered.

Obstetric and Gynecological Providers: You may access In-Network Providers who specialize in obstetrics or gynecology for obstetric or gynecological care without the need for authorization.

Osteopathic Hospitals: Inpatient and outpatient Services, similar to inpatient and outpatient Services by allopathic Hospitals may be covered at a Hospital accredited by the American Osteopathic Association when such Services are available in the Service Area even when such Hospital has not entered into a written agreement with us for such Services. The Hospital providing these Services may not charge more than their usual and customary rates less the average discount that we have with allopathic Hospitals within the Service Area. You must contact us to get the documents necessary to comply with this provision.

Physician Assistant: You have access to surgical assistant Services rendered by a Physician Assistant only when acting as a surgical assistant. Certain types of medical procedures and other Covered Services may be rendered by licensed Physician Assistants, nurse practitioners or other individuals who are not Physicians.

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

You must use a Specialty Pharmacy to provide these Specialty Drugs. Please refer to the Medication Guide for a list of Specialty Pharmacies.

Provider Financial Incentive Disclosure

Health care decisions are the shared responsibility of you, your family, and your health care Providers. A Provider's decisions regarding Health Care Services may have a financial impact on you and/or the Provider. For example a Provider in his or her contract with us may agree to accept financial responsibility for your Health Care Services. We encourage you to talk to your Providers about how, and to what extent, the acceptance of financial risk by the Provider may affect his or her Health Care Service decisions.

Continuity of Coverage and Care Upon Termination of a Provider Contract

When a contract between us and an In-Network Provider (including a PCP) is terminated by us or the Provider without cause and, at the time of the In-network Provider’s termination, you are actively receiving Services for a Condition, Services for that Condition shall continue even after the date of the In-Network

Physician's contract termination. Services for that Condition will be covered with that Provider only until the earlier of:

1. treatment for that specific Condition is completed;
2. you select another In-Network Physician; or
3. the next open enrollment period.

This extension period will not exceed the maximum time period allowed under Florida law, and in no case will it be longer than six months after termination of the Provider's contract with us.

Maternity benefits will continue under this Plan, regardless of the trimester in which Services were initiated, until completion of your postpartum care, if you initiated your prenatal care prior to the termination of the In-Network Provider's contract.

The Group Health Plan is not required to cover or pay for any Services under this subsection for an individual whose coverage under the Plan is not in effect at the time Services are rendered. Further, this subsection does not apply if the In-Network Provider is terminated "for cause".

Services Not Available from In-Network Providers

Except as provided in the WHAT IS COVERED? section, if a Covered Service is not available through In-Network Providers, we may authorize coverage for such Services to be rendered by an Out-of-Network Provider. Covered Services provided by an Out-of-Network Provider must be authorized by us **before** the Services are rendered.

Assignment of Benefits to Providers

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

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

The Group Health Plan specifically reserves the right to honor an assignment of benefits or payment by you to a Provider who: 1) is an In-Network Provider under your Plan; 2) is a licensed Hospital or Physician and the benefits which have been assigned are for care provided per Florida Statutes; or 3) is an Ambulance Provider that provides transportation for care from a location where an Emergency Medical Condition, as defined per Florida Statutes, first occurred to a Hospital, and the benefits which have been assigned are for transportation to care per Florida Statutes. A written attestation of the assignment of benefits may be required.

BLUECARD® PROGRAM

Out-of-Area Services

We have a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs". Whenever you obtain Health Care Services outside of our Service Area, the claims for these Services may be processed through one of these Inter-Plan Programs.

Typically, when accessing care outside our Service Area and the service area of Blue Cross and Blue Shield of Florida, Inc. ("BCBSF"), you will obtain care from health care Providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating health care Providers. Our payment practices in both instances are described below.

Your plan covers only limited Health Care Services received outside of our service area. As used in this section, "Out-of-Area Covered Health Care Services" include Emergency Services for treatment of an Emergency Medical Condition obtained outside the geographic area we serve. Any other Services will not be covered when processed through any Inter-Plan Programs arrangements. These "other Services" must be provided or authorized by your Primary Care Physician ("PCP").

BlueCard Program

Under the BlueCard Program, when you obtain Out-of-Area Covered Health Care Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care Providers.

The BlueCard Program enables you to obtain Out-of-Area Covered Health Care Services, as defined above, from a health care Provider participating with a Host Blue, where available. The participating health care Provider will automatically file a claim for the Out-of-Area Covered Health Care Services provided to you, so there are no claim forms for you to fill out. You will be responsible for your Cost Share amount, as stated in your Schedule of Benefits.

Emergency Services: If you experience a medical emergency while traveling outside the Service Area, go to the nearest emergency or urgent care facility.

Whenever you access Covered Services outside our Service Area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar Copayment, is calculated based on the lower of:

- The billed covered charges for your 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 health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on

a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

Out-of-Network Providers Outside Our Service Area

Your Liability Calculation

When Covered Services are received from Out-of-Network Providers, our payment will be based on the Allowed Amount, as defined in the DEFINITIONS section.

COVERAGE ACCESS RULES

It is important that you become familiar with the rules for accessing health care coverage through this HMO plan. The following section explains our role and the Primary Care Physician's (PCP) role, how to access specialty care coverage, and what to do if Emergency Services are needed. It is also important for you to review all Service Area-specific Coverage Access Rules for particular types of Services and In-Network Providers within the Service Area. These Service Area-specific Coverage Access Rules, if any, are set forth in the provider directory and may vary based on negotiated Provider contracts and other network factors specific to the Service Area.

Choosing a Primary Care Physician

The first and most important decision you must make when joining a health maintenance organization is the selection of a PCP. This decision is important since it is through this Provider that all other Covered Services, particularly those of Specialists, are coordinated. You are free to choose any PCP listed in our published list of PCPs whose practice is open to additional HMO patients. This choice should be made when you enroll. You are responsible for choosing a PCP for all minor Covered Dependents including a newborn child or an adopted newborn child. If you do not choose a PCP when enrolling, we will assign one to you and notify you of that assignment. The following important rules apply to your PCP relationship:

- Primary Care Physicians are trained to provide a broad range of medical care and can be a valuable resource to coordinate your overall health care needs. Developing and continuing a relationship with a PCP allows the Physician to become knowledgeable about your health history.
- A PCP can help you determine the need to visit a Specialist and also help you find one based on his or her knowledge of you and your specific health care needs.
- A PCP may specialize in internal medicine, family practice, general practice, or pediatrics. Also, a gynecologist or obstetrician/gynecologist may elect to contract with us as a Primary Care Physician.
- Care rendered by your PCP usually results in lower Cost Share for you.

The PCP you select maintains a Physician-patient relationship with you, and will be, except as specified by the Coverage Access Rules set forth in the provider directory, if any, responsible for helping to coordinate medical Services for you.

Both you and your PCP may request a change in the PCP assignment as discussed below:

1. You may request a transfer to another PCP whose practice is open to new HMO patients. The transfer to the newly selected PCP will start on the first day of the following calendar month if we receive your request before the 15th of the month.
2. There are also times when a PCP, for good cause, may request that we assist you in choosing another PCP.
3. If your PCP terminates his or her contract with us or is unable to perform his or her duties or is on a leave of absence, we may help you choose another PCP or assign a new one for you.

Authorization Requirements

Many Services have to be authorized **before** the Services are rendered in order to be covered under this Booklet. **Since this is a self-funded plan, FCSRMC is ultimately responsible for determining whether expenses incurred for medical care are covered under this Booklet. However, it is important to note that under our ASO Agreement; FCSRMC has asked us to use our authorization criteria and guidelines currently in effect.**

There may be times when Services are authorized, but only if received in a specific setting, such as an Ambulatory Surgical Center or Independent Diagnostic Testing Center. If the authorization includes a specific setting and you receive the Services in a different setting, such Services may be denied. For example, a procedure may be authorized only when performed in an Ambulatory Surgical Center. In this case, if you have the procedure done in a Hospital, the claim may be denied because the procedure was only authorized when performed in an Ambulatory Surgical Center.

In-Network Providers have agreed to obtain these authorizations for you; however, you should ask your Provider if an authorization has been obtained if one is required. Services that must be authorized by us in advance include, but are not limited to:

1. hospitalization, both inpatient and observation stays;
2. certain radiology Services, including advanced diagnostic imaging Services, such as CT scans, MRIs, MRAs and nuclear imaging;
3. Home Health Care;
4. certain Durable Medical Equipment;
5. Pain Management Services;
6. Surgery (at all locations);
7. Services provided by Out-of-Network Providers;
8. all Services provided in a Skilled Nursing Facility;
9. certain injections and infusion therapy;
10. certain Provider-administered drugs (denoted with a special symbol in the Medication Guide);
11. Hospice Services; and
12. certain diagnostic Services.

Personal Case Management Program

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

Under the personal case management program, alternative benefits or payment for cost-effective Health Care Services may be offered to you. These alternative benefits or payments may be made available on a case-by-case basis when you meet the case management criteria then in effect. Such alternative

benefits or payments, if any, will be made available in accordance with a treatment plan with which you, or your representative, and your Physician agree to in writing. Because your Group Health Plan is self-funded, FCSRMC will be required to specifically agree to such treatment plan and the alternative benefits or payment.

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

ELIGIBILITY FOR COVERAGE

Each employee or other individual who is eligible to participate in this Group Health Plan, and who meets and continues to meet the Group's eligibility rules described in this Booklet, shall be entitled to apply for coverage under this Booklet. These eligibility rules are binding upon you and /or your eligible family members. No changes in the eligibility rules will be permitted except as approved by the Group. Acceptable documentation that an individual meets and continues to meet the eligibility requirements, such as a court order naming the Covered Plan Participant as the legal guardian or appropriate Adoption documentation may be required as described in the ENROLLMENT AND EFFECTIVE DATE OF COVERAGE section.

Covered Plan Participant Eligibility

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

1. the employee must maintain his or her primary residence in the Service Area or be regularly employed in the Service Area;
2. be a bona fide employee;
3. the employee's job must fall within the job classifications designated by the Group;
4. complete any applicable Waiting Period established by the Group; and
5. meet any additional eligibility requirements required by the Group.

The Group's Covered Plan Participant eligibility classification may be expanded to include:

1. retired employees;
2. additional job classifications;
3. employees of affiliated or subsidiary companies of the Group; and
4. other individuals as determined by the Group.

The Group shall have sole discretion concerning the expansion of eligibility classifications.

Dependent Eligibility

An individual who maintains his or her primary residence in the Service Area and 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 Domestic Partner when the Covered Plan Participant has completed and submitted any required forms to the Group and the Group has determined the Domestic Partnership eligibility requirements have been met.

3. The Covered Plan Participant's or Covered Domestic Partner's natural, newborn, Adopted, Foster or step child (or a child for whom the Covered Plan Participant has been court-appointed as legal guardian or legal custodian) who has not reached the end of the Calendar Year in which he or she reaches age 26 regardless of the dependent child's student or marital status, financial dependency on the covered parent, whether the dependent child resides with the covered parent, or whether the dependent child is eligible for or enrolled in any other health plan.
4. The newborn child of a Covered Dependent child who has not reached the end of the Calendar Year in which he or she becomes 26. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Note: If a Covered Dependent child who has reached the end of the Calendar Year in which he or she becomes 26 obtains a dependent of their own (e.g., through birth or adoption) such newborn child will not be eligible for this coverage and the Covered Dependent child will also lose his or her eligibility for this coverage. It is your sole responsibility as the Covered Plan Participant to establish that a child meets the eligibility rules. Eligibility will terminate at the end of the Calendar Year in which the child no longer meets the eligibility rules required to be an Eligible Dependent.

Extension of Eligibility for Dependent Children

A Covered Dependent child who maintains his or her primary residence in the Service Area may continue coverage beyond the age of 26, provided he or she is:

1. unmarried and does not have a dependent;
2. A Florida resident or a full-time or part-time student;
3. Not enrolled in any other health coverage policy or plan;
4. Not entitled to benefits under Title XVIII of the Social Security Act unless the child is a handicapped dependent child.

This eligibility shall terminate on the last day of the Calendar Year in which the dependent child reaches age 30.

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 26, 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 26th birthday.

This eligibility will 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.

Exception for Students on Medical Leave of Absence from School

A Covered Dependent child who is a full-time or part-time student at an accredited post-secondary institution, who takes a physician certified medically necessary leave of absence from school, will still be

considered a student for eligibility purposes under this Booklet for the earlier of 12 months from the first day of the leave of absence or the date the Covered Dependent would otherwise no longer be eligible for coverage under this Booklet.

Other Rules Regarding Eligibility

1. No individual whose coverage has been terminated for cause (see the TERMINATION OF COVERAGE section) shall be eligible to re-enroll in the Group Health Plan.
2. No person shall be refused enrollment or re-enrollment because of race, color, creed, marital status, gender, or age (except as provided in the Dependent Eligibility subsection).
3. The Covered Plan Participant must notify the Group as soon as possible when a Covered Dependent is no longer eligible for coverage. If a Covered Dependent fails to continue to meet each of the eligibility requirements, and proper notification is not provided timely by the Covered Plan Participant, the Group shall have the right to retroactively terminate the coverage of such dependent to the date any such eligibility requirement was not met. Upon request, the Covered Plan Participant shall provide proof, which is acceptable to the Group, of a Covered Dependent's continuing eligibility for coverage.
4. If the Group offers an alternative health benefits plan for Medicare eligibles or retirees, and an individual elects to be covered under such plan, then such individual shall not be eligible for coverage under this Booklet.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Eligible Employees and Eligible Dependents may enroll for coverage as described in this section. Any Eligible Employee or Eligible Dependent who is not properly enrolled with us will not be covered under this Booklet. Neither HOI nor the Group shall have no obligation whatsoever to any individual who is not properly enrolled.

General Rules for Enrollment

1. You may apply for coverage by completing an Enrollment Form and submitting it to the Group.
2. All factual representations on the Enrollment Forms must be accurate and complete. Any false, incomplete or misleading information provided during enrollment, or at any time, may cause you to be disqualified for coverage and, in addition to any other legal right the Group may have, the Group may terminate or Rescind your coverage.
3. The Group will not provide coverage or benefits to any person who would not have been eligible to enroll, had accurate and complete information been provided on a timely basis. In such cases, the Group may require you or a person legally responsible for you, to repay any payments made on your behalf.

How to Apply for Coverage

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

1. complete the Enrollment Form and submit it to the Group;
2. provide any other information the Group may need to determine eligibility, upon request;
3. agree to pay any contribution amounts required by the Group; and
4. to add Eligible Dependents or delete Covered Dependents, complete the Enrollment Form and submit it to the Group.

When applying for coverage, you must elect one of the types of coverage available under the Group Plan. Such types may include:

Coverage Type	Provides Coverage for:
Employee Only	the Eligible Employee only
Employee / Spouse	the Eligible Employee and his or her spouse
Employee / Child(ren)	the Eligible Employee and children only
Employee / Family	the Eligible Employee, spouse and children

There may be an additional contribution amounts for each Covered Dependent based on the coverage provided by the Group.

Enrollment Periods

There are only certain times during the year that you can enroll for coverage, these enrollment periods are as follows:

Initial Enrollment Period: this is the period of time when you are first eligible to enroll. It starts on the date you are first eligible and ends no less than 30 days later. This time can be when the Group first starts its Plan under this Booklet, or when an employee first becomes eligible for coverage under this Plan.

Annual Open Enrollment Period: this is the period of time (usually 30 days) when you have an opportunity to select coverage from the alternatives your Group offers in its health benefit program. This period usually takes place every year prior to the Anniversary Date. FCSRMC will establish the dates and length of this period.

Special Enrollment Period: this is the 30-day period of time immediately following a special event such as getting a new dependent or losing other coverage. During this time you may apply for coverage because of the special event. Special events are described in the Special Enrollment Period subsection of this section.

Initial Enrollment Period

1. If you are an Eligible Employee when FCSRMC first starts its plan under this Booklet; you must enroll (yourself and any Eligible Dependents) during the Initial Enrollment Period in order to become covered as of the Effective Date of the Group. In this case, the Effective Date of coverage for you and the dependents you enroll will be the same as the Group.
2. If you become an Eligible Employee after FCSRMC has this plan (for example, newly-hired employees) you must enroll (yourself and any Eligible Dependents) before or within the Initial Enrollment Period and your Effective Date of coverage will begin on the date specified, in writing, by the Group.

Annual Open Enrollment Period

If you did not apply for coverage during the Initial Enrollment Period or a Special Enrollment Period you may apply for coverage by completing an Enrollment Form during an Annual Open Enrollment Period. Your Effective Date of coverage will be the date specified by the Group.

If you do not enroll or change your coverage selection during the Annual Open Enrollment Period, you must wait until the next Annual Open Enrollment Period to make any changes, unless a special event, as outlined in the Special Enrollment Period subsection of this section, occurs.

Special Enrollment Period

You may apply for coverage outside of the Initial Enrollment Period and Annual Enrollment Period as a result of a special enrollment event. To apply for coverage, you must complete an Enrollment Form and submit it to the Group within the time periods noted below for each special enrollment event.

If you declined coverage when it was first offered under this Plan and you stated in writing, that coverage under another group health plan or health insurance coverage was the reason for declining enrollment,

you may apply for coverage if one of the following special enrollment events occurs and you complete an Enrollment Form and submit it to the Group within time periods indicated in the chart that follows.

Special Enrollment Events

Loss of Coverage under…	**Caused by…**	**Enrollment Form due to Group within…**
a group health plan or COBRA	• Exhaustion of COBRA • termination of employment • reduction in the number of hours you work • reaching or exceeding the lifetime maximum of all benefits under other health coverage • the employer stopped offering group health coverage • death of your spouse • divorce or legal separation • employer contributions toward such coverage are terminated	30 days of the date coverage was terminated
a Children's Health Insurance Program or Medicaid	• loss of eligibility for such coverage • becoming eligible for the optional state premium assistance program	60 days of the date coverage was terminated
***Adding Coverage…**	• your marriage • your getting a new dependent through birth, Adoption or placement in anticipation of Adoption	30 days of the date of the event

* The statement in the paragraph above this chart about declining coverage when it was first offered does not apply to these special enrollment events.

Your Effective Date of coverage will be the date of the special enrollment event. If you do not enroll or change your coverage during the Special Enrollment Period you must wait until the next Annual Open Enrollment Period.

Note: Loss of coverage for failure to pay your required contribution on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the prior health coverage) is not a qualifying event for special enrollment.

Dependent Enrollment

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

Newborn Children – To enroll a newborn child who is an Eligible Dependent, the Covered Plan Participant must complete an Enrollment Form and submit it to the Group. The Effective Date of coverage for a newborn child is usually the date of birth as long as you have enrolled the newborn child in time (as indicated below). The Group must be notified, in writing, when you are adding a newborn and

the rules for Effective Date and contribution amounts charged for the newborn vary depending on when this written notification is received. The chart that follows indicates these differences:

Newborn Enrollment

If written notice is received within…	**the Effective Date of the newborn will be…**	**Contribution amounts for the newborn child…**
30 days after the date of birth	the date of birth	will **not** be charged for the **first 30 days**
31 to 60 days after the date of birth	the date of birth	will be charged from the date of birth
61 or more days***** after the date of birth	the date of birth	will be charged from the date of birth

*****This applies only if the Group **has not had** an Annual Open Enrollment Period since the baby was born. If the written notice is received more than 60 days after the birth of the newborn child, and your Group **has had** an Annual Open Enrollment Period since the birth of the newborn, the child may not be added until the Group's next Annual Open Enrollment Period.

Additional Rules for Adopted Newborn Children

If an Adopted newborn's Effective Date of coverage is determined to be the date of birth (based on the above chart), a written agreement to Adopt such child must have been entered into by the Covered Plan Participant prior to the birth of such child, whether or not such an agreement is enforceable. The Covered Plan Participant may be required to provide any information and/or documents deemed necessary by us or the Group in order to administer this provision. If the Adopted newborn child is not ultimately placed in your residence, there shall be no coverage for the Adopted newborn child. It is your responsibility as the Covered Plan Participant to notify the Group within ten calendar days of the date that placement was to occur if the Adopted newborn child is not placed in your residence.

The guidelines above only apply to newborns born after the Effective Date of the Covered Plan Participant. If a child is born before the Effective Date of the Covered Plan Participant the newborn should be added during the Initial Enrollment Period.

Adopted/Foster Children: To enroll an Adopted child (other than a newborn child) or Foster Child, the Covered Plan Participant must complete an Enrollment Form and submit it to the Group within 30 days after the date of placement and the Effective Date will be the date the Adopted or Foster Child is placed in the residence of the Covered Plan Participant pursuant to Florida law. If timely notice is given, no additional contribution amount will be charged for coverage of the Adopted or Foster Child for the duration of the notice period (the 30-day period before the child was placed in your home). You may need to provide additional information and/or documents deemed necessary in order to properly administer this provision.

If timely notice is not given, the child will be added as of the date of placement so long as we receive the Enrollment Form within 60 days of the placement, and any applicable contribution amount is paid back to the date of placement. If notification is not received within 60 days of the date of placement, the Covered Plan Participant must make application during an Annual Open Enrollment Period or Special Enrollment Period in order for the Adopted or Foster Child to be covered.

Adopted Children

For all children covered as Adopted children, if the final decree of Adoption is not issued, coverage shall not be continued for such Adopted Child. It is your responsibility as the Covered Plan Participant to notify the Group if the Adoption does not take place. Upon receipt of this notification, such child's coverage will be terminated as of the Effective Date of the Adopted child.

Foster Children

If the Covered Plan Participant 's status as a foster parent is terminated, coverage will end for any Foster Child. It is your responsibility as the Covered Plan Participant to notify the Group in writing that the Foster Child is no longer in your care. Upon receipt of this notification, such child's coverage will be terminated on the date provided by the Group.

Marital Status: If the Covered Plan Participant marries after his or her Effective Date, he or she may add the spouse who is an Eligible Dependent due to a legally valid marriage. The Covered Plan Participant must complete an Enrollment Form and submit it to the Group within 30 days of the marriage and the Effective Date of coverage for the new spouse will be the date of the marriage.

Court Order: You, as the Covered Plan Participant may add an Eligible Dependent outside of the Initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided by you for a minor child under your plan. The Covered Plan Participant must complete an Enrollment Form and submit it to the Group within 30 days of the court order and the Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order will be the date required by the court order.

Other Provisions

Rehired Employees

If you are rehired as an employee of the Group; you are considered a newly-hired employee for purposes of this section. The provisions of the Group Health Plan, applicable to newly-hired employees and their Eligible Dependents, such as Effective Dates of coverage and Waiting Periods will apply to you.

TERMINATION OF COVERAGE

Covered Plan Participant

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

1. on the date the ASA between HOI and FCSRMC terminates;
2. on the date the Covered Plan Participant becomes covered under an alternative health benefits plan which is offered through or in connection with the Group;
3. on the date the Covered Plan Participant no longer meets any of the applicable eligibility requirements;
4. on the date the Covered Plan Participant's coverage is terminated for cause; or
5. on the date specified by the Group.

Covered Dependent

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

1. on the date the Covered Plan Participant's coverage terminates for any reason;
2. on the date the Covered Dependent becomes covered under an alternative health benefits plan which is offered through or in connection with the Group;
3. on the last day of the Calendar Year that the Covered Dependent no longer meets the eligibility requirements;
4. on the date the Covered Dependent's coverage is terminated for cause;
5. on the date specified by the Group.

If you, as the Covered Plan Participant, wish to delete a Covered Dependent from coverage, you must complete an Enrollment Form and submit it to the Group. If you wish to delete your spouse from coverage, in the case of divorce for example, the Enrollment Form must be submitted before the termination date you are requesting, or within 10 days of the date the divorce is final, whichever is applicable.

Domestic Partner and Domestic Parter's Dependent Children

In addition to the provisions stated in the Covered Dependent subsection, coverage under this Booklet for a Covered Domestic Partner and his or her Covered Dependent children will terminate at 12:01 a.m. on the date that the Domestic Partnership terminates or the date of death of the Covered Domestic Partner. The Covered Plan Participant must notify the Group within 10 days of when the Domestic Partnership eligibility requirements are no longer met or within 10 days of the death of the Covered Domestic Partner.

Termination for Cause

If any of the following events occur, the Group may terminate an individual's coverage for cause:

1. disruptive, unruly, abusive, unlawful, fraudulent or uncooperative behavior to the extent that your continued coverage with the Group impairs their ability to provide coverage and/or benefits or impairs our ability to arrange for the delivery of Health Care Services to you or any other Covered Person. Prior to terminating your coverage for any of the above reasons, we, if requested by the Group, will:
    a. make a reasonable effort to resolve the problem presented by you, including the use or attempted use of the Complaint and Grievance Process;
    b. ascertain, to the extent possible, that your behavior is not related to the use of medical Services or mental illness; and
    c. document the problems encountered, efforts made to resolve the problems, and any of your medical conditions involved.
2. fraud, material misrepresentation or omission in applying for coverage or benefits;
3. you intentionally misrepresent, omit, or give false information on Enrollment Forms or other forms completed, by you or on your behalf;
4. misuse of the ID Card;
5. you no longer live or work in the Service Area; or
6. a Covered Dependent reaches the limiting age.

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

Note: Only fraudulent misstatements on the Enrollment Form may be used by the Group to void coverage or deny any claim for loss incurred or disability, if discovered after two years from your Effective Date.

Rescission of Coverage

The Group and HOI reserve the right to Rescind coverage under this Booklet for any individual covered under this Booklet as permitted by law.

The Group and/or HOI may only Rescind your coverage if you or another person on your behalf commits fraud or intentional misrepresentation of material fact in applying for coverage or benefits.

The Group and/or HOI will provide at least 45 days advance written notice to the Covered Plan Participant of the intent to Rescind coverage.

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

Notice of Termination

It is FCSRMC's responsibility to immediately notify you of termination of the Group Health Plan for any reason.

Group Health Plan Responsibilities Upon Termination of Your Coverage

Upon termination of your coverage for any reason, HOI and the Group will have no further liability to you under the Group Health Plan, except as otherwise specifically described in this Booklet.

Certification of Creditable Coverage

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

The certification of Creditable Coverage will indicate the period of time you were enrolled under the Group Health Plan. Creditable Coverage may reduce the length of any Pre-existing Condition exclusion period by the length of time you had prior Creditable Coverage.

Upon request, another certification of Creditable Coverage will be sent to you within a 24-month period after termination of coverage. You may call the customer service phone number indicated in this Booklet or on your ID Card to request the certification.

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

CONTINUING COVERAGE

Introduction

This section describes the ways coverage can be continued after your termination date. We have divided this section into three subsections: Federal Continuation Provisions, Conversion Privilege and Extension of Benefits.

Federal Continuation of Coverage Law

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

You must contact your Group to determine if you are entitled to COBRA continuation of coverage. Your Group is solely responsible for meeting all of the obligations under COBRA, including the obligation to notify you of your rights under COBRA. If you do not meet your obligations under COBRA and this Plan, the Group shall not be liable for any claims incurred by you after your coverage terminates.

A summary of your COBRA rights and the general conditions for qualification for COBRA continuation coverage is provided below. This summary is not meant as a representation that any of the COBRA obligations of the Group are met by the Group Health Plan; the duty to meet such obligations remains with FCSRMC.

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

1. You may elect to continue your coverage for a period not to exceed 18 months* in the case of:
    a. termination of employment of the Covered Plan Participant other than for gross misconduct; or
    b. reduced hours of employment of the Covered Plan Participant.

    ***Note:** You are eligible for an 11 month extension of the 18 month COBRA continuation option above (up to a total of 29 months) if you are totally disabled, as defined by the Social Security Administration (SSA), at the time of your termination, reduction in hours or within the first 60 days of COBRA continuation coverage. You must supply notice of the disability determination to the Group within 18 months of becoming eligible for continuation coverage and no later than 60 days after the SSA's determination date.
2. Your Covered Dependents may elect to continue their coverage for a period not to exceed 36 months in the case of:
    a. the Covered Plan Participant's entitlement to Medicare;
    b. divorce or legal separation from the Covered Plan Participant;
    c. death of the Covered Plan Participant;
    d. the employer files bankruptcy (subject to bankruptcy court approval); or

e. a Covered Dependent child who ceases to be an Eligible Dependent under the terms of the Policy.

Important Note: Covered Domestic Partners and their Covered Dependents are not entitled to continuing coverage but, may be entitled to apply for one of our conversion policies as set forth in the Conversion Privilege subsection later in this section.

Children born to or placed for Adoption with the Covered Plan Participant during the continuation coverage periods noted above are also eligible for the remainder of the continuation period.

If you are eligible to continue group health insurance coverage pursuant to COBRA, the following conditions must be met:

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

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

Note: This section shall not be interpreted to grant any continuation rights in excess of those required by COBRA and/or Section 4980B of the Internal Revenue Code. Additionally, this Booklet shall be deemed to have been modified, and shall be interpreted, so as to comply with COBRA and changes to COBRA that are mandatory with respect to the Group.

Conversion Privilege

If your Group Health Plan has terminated you may apply for conversion to a non-group plan. HOI and the Group have no obligation to notify you of the conversion privilege. It is your sole responsibility to exercise this conversion privilege subject to the provisions set forth below.

Eligibility Criteria for Conversion

You are entitled to apply for a conversion contract for a non-group plan if:

1. you have been continuously covered under this Group Health Plan for at least three consecutive months; **or**
2. you were covered for at least three consecutive months under any other group policy providing similar benefits that this Group Health Plan immediately replaced; **and**
3. your coverage has been terminated for any reason, including discontinuance of this Group Health Plan in its entirety and termination of continued coverage under COBRA; **and**
4. you maintain your primary residence in the Service Area.

The conversion contract shall be issued without regard to health status or requirements for Health Care Services. **We must receive the completed conversion application and the applicable premium payment within the 63-day period beginning on the date this Group Health Plan terminated.**

In the event we do not receive the conversion application and the initial premium payment within such 63-day period, your conversion application will be denied, and you will not be entitled to a conversion policy.

Conversion is not available if termination occurred for any of the following reasons:

1. you had not been continuously covered under the Group Health Plan for at least three months prior to termination;
2. failure by you to pay on a timely basis, any required contribution amounts required for coverage under the Group Health Plan;
3. replacement of coverage by similar group coverage occurs within 31 days of termination;
4. you commit fraud or intentional misrepresentation in applying for the Group Health Plan or for any Covered Services;
5. termination for cause as set forth in the TERMINATION OF COVERAGE subsection;
6. you have left the Service Area with the intent to relocate or to establish a new residence outside the Service Area; or
7. you are eligible for, or covered under, Medicare.

Additionally, conversion is not available:

1. if you are eligible for similar benefits, whether or not you are actually covered under any arrangement of coverage for individuals in a group;
2. if you are covered by similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical Service insured contract or medical practice or other prepayment plan, or by any other plan or program;

3. if similar benefits are provided for or are available to you pursuant to or in accordance with the requirements of any state or federal law (e.g., COBRA); or

4. if the benefits provided or available to you, together with the benefits provided by us, would result in excess of coverage, as determined by us.

Conversion Coverage

The conversion contract issued to each individual who converts to non-group coverage shall include a level of benefits for "minimum Services" which is similar to the level of benefits for the Services included in this Booklet. For purposes of this section, the term "minimum Services" shall mean Services which include any of the following: emergency care, inpatient Hospital Services, Physician care, ambulatory diagnostic treatment, and preventive Health Care Services. Conversion coverage is not a continuation of the Group Health Plan. Benefits under such conversion coverage may differ from benefits under the Group Health Plan and any Endorsements attached thereto. Conversion coverage may continue in effect as long as you: (a) continue to meet all applicable eligibility requirements; (b) pay all applicable fees and charges; and (c) otherwise comply with all requirements under the conversion contract.

Effective Date of Conversion

The effective date of conversion coverage shall be the day following the termination under the Group Health Plan. However, until such time as coverage under the conversion contract becomes effective, you shall pay the Allowed Amount for any Covered Services rendered during the 63-day period immediately following termination of the Group Health Plan. In the event such conversion coverage becomes effective, you may request reimbursement from us for any payment for Covered Services. You must submit proof of payment to us in order to obtain reimbursement.

Extension of Benefits

If the Group Health Plan is terminated, coverage will end on the termination date. There will be no coverage or benefits for any Covered Service received on or after the termination date, except as listed below. The extension of benefits described below only applies when the Group Health Plan is terminated, and the benefits provided under an extension of benefits are subject to all other terms included in this Booklet.

Note: You must provide proof that you are entitled to an extension of benefits.

Extension of Benefits

1. If you are pregnant on the termination date of the Group Health Plan, a limited extension of the maternity benefits will be provided, as long as the pregnancy started while you were covered by the Group Health Plan. This extension of benefits is only for Covered Services necessary to treat the pregnancy and will automatically terminate on the date the child is born.

2. If you are totally disabled on the termination date of the Group Health Plan because of a specific accident or illness that happened while you were covered under the Group Health Plan, a limited extension of benefits will be provided for you only. This extension of benefits is only for Covered Services necessary to treat the disabling Condition. This extension of benefits will only continue as long as the disability is continuous and uninterrupted; however, in any event, this extension of

benefits will automatically terminate at the end of the 12-month period beginning on the termination date of the Group Health Plan.

Note: For purposes of this subsection, you will be considered totally disabled only if, in our opinion, you are unable to work at a job for which you have the education, training, or experience, and you continue to require regular care from a Physician for the disability. This applies, even if you are not working (e.g., a student, non-working spouse, or children), if you are unable to perform the normal day-to-day activities which you would otherwise be able to perform.

Neither the Group nor HOI is required to provide an extension of benefits if you leave the Service Area with the intent to relocate or establish a new residence outside the Service Area; if you intentionally left out or provided false information on any Enrollment Form in order to obtain coverage or Covered Services; or if you were terminated for disruptive, unruly, abusive, unlawful, fraudulent or uncooperative behavior to the extent that your continued coverage with us impairs our ability to provide coverage and/or benefits or to arrange for the delivery of Health Care Services to you or any other Covered Person.

COORDINATION OF BENEFITS

Coordination of Benefits

Coordination of Benefits is a limitation of coverage and/or benefits to be provided under this Booklet. It is designed to avoid duplication of payment for Covered Services and/or supplies. It is your responsibility to provide us information concerning any duplication of coverage under any other health plan, program, or policy you or your Covered Dependents may have. This means you must notify us in writing if you have other applicable coverage or if there is no other coverage. You may be requested to provide this information at initial enrollment, by written correspondence annually thereafter, or in connection with a specific Health Care Service you receive. If the information is not received, claims may be denied and you will be responsible for payment of any expenses related to denied claims.

Payment for Covered Services will be coordinated to the maximum extent allowed by law provided you follow the Coverage Access Rules set forth in the COVERAGE ACCESS RULES section. Plans which may be subject to Coordination of Benefits include, but are not limited to, the following which will be referred to as "plan(s)" for purposes of this section:

1. any group insurance, group-type self-insurance, or HMO plan;
2. any group contract issued by any Blue Cross and/or Blue Shield Plan(s);
3. any plan, program or insurance policy, including an automobile insurance policy, provided that any such non-group policy contains a coordination of benefits provision;
4. Medicare, as described in the Medicare Secondary Payer Provisions subsection.

The amount of payment, if any, is based on whether or not the Group Health Plan is the primary payer. When the Group Health Plan is primary, payment for Covered Services will be made without regard to your coverage under other plans. When the Group Health Plan is not primary, payment may be reduced so that total benefits under all plans will not exceed 100 percent of the total reasonable expenses actually incurred for the Covered Services. **In the event that the primary payer's payment exceeds the maximum amount established by us, no payment will be made for such Services.** In the event the Covered Services were rendered by an In-Network Provider, total reasonable expenses, for purposes of this section, shall be equal to the amount obligated to the In-Network Provider based on the Provider's contract.

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

1. When the Group Health Plan covers you as a dependent and the other plan covers you as other than a dependent, the Group Health Plan will be secondary.
2. When the Group Health Plan covers 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, the Group Health Plan will be secondary.

3. When the Group Health Plan covers you as a dependent child whose parents are not married, or are separated or divorced:
    a. if the parent with custody is not remarried, the plan of the parent with custody is primary;
    b. if the parent with custody has remarried, the plan of the parent with custody is primary; the step-parent's plan is secondary; and the plan of the parent without custody pays last;
    c. regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is always primary.
4. When the Group Health Plan covers you as a dependent child and the other plan covers you as a dependent child:
    a. the plan of the parent who is neither laid off nor retired will be primary;
    b. if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.
5. When rules 1, 2, 3, and 4 above do not establish an order of benefits, the plan which has covered the individual the longest shall be primary.

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

Medicare Secondary Payer Provision

When you become covered under Medicare and are still eligible and covered under this Booklet, the Group Health Plan will be primary and Medicare benefits will be secondary, but only to the extent required by law. In all other instances, the Group Health Plan will be secondary to any Medicare benefits. When the Group Health Plan is the primary payer, claims for Covered Services should be filed with HOI first.

If you become covered under Medicare and are still eligible and covered under the Group Health Plan, FCSRMC MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you. Also, the Group MAY NOT persuade you to decline or terminate your group health coverage and elect Medicare as the primary payer.

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

Individuals With End Stage Renal Disease

If you become entitled to Medicare coverage because of ESRD, your Group Health Plan is primary for 30 months beginning with the earlier of:

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

If Medicare was already primary before ESRD, Medicare will remain primary. Also, if your Group Health Plan coverage was primary before ESRD entitlement, the Group Health Plan will remain primary for the

ESRD coordination period. If you are eligible for Medicare due to ESRD, your Group Health Plan coverage is primary for 30 months.

Disabled Active Individuals

The Group Health Plan coverage is primary, if:

1. your Group is a part of a health plan that has covered employees of at least one employer of 100 or more full-time or part-time employees on 50% or more of its regular business days during the previous Calendar Year; and
2. you are entitled to Medicare coverage because of disability (unless you have ESRD).

Primary coverage under the Group Health Plan is pursuant to the following terms:

1. your Group Health Plan coverage is primary during any month in which you are entitled to Medicare coverage because of disability;
2. your entitlement to primary coverage under this subsection will terminate automatically when:
   a. you turn 65 years of age; or
   b. you no longer qualify for Medicare coverage because of disability; or
   c. you elect Medicare as the primary payer. Coverage will terminate as of the date of your election.

   Under Medicare, FCSRMC MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you or induce you to decline or terminate your group health coverage and elect Medicare as the primary payer.
3. Your entitlement to primary coverage under this subsection will terminate automatically if you no longer qualify under applicable Medicare regulations and instructions. The Group shall notify us, without delay, of any such change in status.

Miscellaneous

This section shall be changed, if necessary, to comply with federal statutory and regulatory Medicare Secondary Payer rules as they relate to Medicare beneficiaries who are covered under a Group Health Plan.

We will not be liable to FCSRMC or anyone covered under the Group Health Plan due to any nonpayment of primary benefits that result from any failure of the Group's performance or obligations set forth in this section.

If primary payment is made for Covered Services rendered to you as described in this section in a period prior to receipt of the information required by the terms of this section, you may be required to reimburse the Group Health Plan for such payments.

Subrogation

If you are injured or become ill as a result of another party's intentional act, negligence or fault you must notify us and the Group concerning the circumstances under which you were injured or became ill. You or your lawyer must provide notification by certified or registered mail, if you intend to claim damages from someone for injuries or illness. If you recover money to compensate for the cost/expense of Health Care

Services to treat your illness or injury, the Group Health Plan is legally entitled to be repaid for payments made on your behalf to the doctors, Hospitals, or other Providers who treated you. This legal right to be repaid in such cases is called "subrogation". HOI, on behalf of FCSRMC or the Group Health Plan may recover the amount of any payments made on your behalf minus their pro rata share for any costs and attorney fees incurred by you in pursuing and recovering damages. HOI, on behalf of FCSRMC or the Group Health Plan may "subrogate" against all money recovered regardless of the source of the money including but not limited to uninsured motorist coverage and workers' compensation.

Although FCSRMC may, but is not required to, take into consideration any special factors relating to your specific case in resolving the subrogation claim, they will have the first right of recovery out of any recovery or settlement amount you are able to obtain even if you or your attorney believes that you have not been made whole for your losses or damages by the amount of the recovery or settlement.

You must do nothing to prejudice the FCSRMC's right of subrogation hereunder and no waiver, release of liability, or other documents executed by you, without notice to HOI and the Group and FCSRMC's written consent, will be binding.

Non-Duplication of Government Programs

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

CLAIMS PROCESSING

Introduction

This section is intended to:

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

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

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

Types of Claims

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

Post-Service Claims

How to File a Post-Service Claim

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

In-Network Providers have agreed to file Post-Service Claims for Covered Services they render to you. If you receive a bill from an In-Network Provider, you should forward it to us. If you require Emergency Services from an Out-of-Network Provider while inside or outside the Service Area or, if we refer you to an Out-of-Network Provider, the Group Health Plan will pay for Covered Services provided to you. If you receive a bill from an Out-of-Network Provider for Covered Services, you should forward it to us. We rely on the information you provide when processing a claim.

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

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

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

Note*:* Please refer to the PRESCRIPTION DRUG PROGRAM section for any applicable information on the processing of prescription drug claims. Further, special claims processing rules may apply for Health Care Services you receive outside the state of Florida under the BlueCard Program. (See the BLUECARD PROGRAM or AWAY FROM HOME CARE section.)

Processing Post-Service Claims

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

Payment for Post-Service Claims

When payment is due under the terms of this Booklet, we will use our best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, we will use our best efforts to pay (in whole or in part) for paper Post-Service Claims within 40 days of receipt. You may receive notice of payment for paper claims within 30 days of receipt. If we are unable to determine whether the claim or a portion of the claim is payable because we need more information, we may contest or deny the claim within the timeframes set forth below.

Contested Post-Service Claims

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

denied. Upon receipt of the requested information, we will use our best efforts to complete the processing of the Post-Service Claim within 15 days of receipt of the information.

Denial of Post-Service Claims

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

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

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

Pre-Service Claims

How to file a Pre-Service Claim

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

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

Benefit Determinations on Pre-Service Claims Involving Urgent Care

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

(1) receipt of the requested information; or (2) the end of the period you were afforded to provide the specified additional information as described above.

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

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

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

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

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Covered Services

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

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

We will use our best efforts to notify you of such reduction or termination in advance so you will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the COMPLAINT AND GRIEVANCE PROCESS described in this Booklet. In no event shall we be required to provide more than a reasonable period of time within which you may develop your appeal before we actually terminate or reduce coverage for the Covered Services.

Requests for Extension of Covered Services

Your Provider may request an extension of coverage or benefits for a Covered Service beyond the approved period of time or number of approved Covered Services. If the request for an extension is for a Claim Involving Urgent Care, we will use our best efforts to notify you of the approval or denial of such requested extension within 24 hours after receipt of the request, provided it is received at least 24 hours

prior to the expiration of the previously approved number or length of coverage for such Covered Services. We will use our best efforts to notify you within 24 hours if: (1) we need additional information; or (2) you or your representative did not follow proper procedures in the request for an extension. If we request additional information, you will have 48 hours to provide the requested information. We may notify you orally or in writing, unless you or your representative specifically request that it be in writing. A denial of a request for an extension of Covered Services is considered an Adverse Benefit Determination and is subject to the Complaint and Grievance process described in this Booklet.

Adverse Benefit Determinations

Manner and Content of a Notification of an Adverse Benefit Determination

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

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

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

Additional Claims Processing Provisions

Release of Information/Cooperation

In order to process claims, we may need certain information, including information regarding other health care coverage you may have. You must cooperate with us in our effort to obtain this information, including signing any release of information form at our request. If you do not fully cooperate with us we may deny the claim and we nor FCSRMC will have no liability for such claim.

Physical Examination

In order to make coverage and benefit decisions, we may, at our expense, require you to be examined by a Provider of our choice as often as is reasonably necessary while a claim is pending. If you do not fully cooperate with such examination we may deny the claim and we will have no liability for such claim.

Legal Actions

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

Fraud, Misrepresentation or Omission in Applying for Benefits

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

Communication of Claims Decisions

All claims decisions, including denial and review decisions, will be communicated to you in writing. This written correspondence may indicate:

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

Circumstances Beyond Our Control

To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within our control, results in facilities, personnel or our financial resources being unable to process claims for Covered Services, we will have no liability or obligation for any delay in the payment of

claims for Covered Services, except that we will make a good faith effort to make payment for such Covered Services, taking into account the impact of the event. For purposes of this paragraph, an event is not within our control if we cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

GENERAL PROVISIONS

Access to Information

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

Care Profile Program – A Payer-Based Health Record Program

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

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

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

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

Compliance with State and Federal Laws and Regulations

The terms of coverage and benefits to be provided under this Booklet shall be deemed to have been modified by the parties, and shall be interpreted, so as to comply with applicable state or federal laws and

regulations dealing with rates, benefits, eligibility, enrollment, termination, conversion, or other rights and duties of you, the Group, or us.

Confidentiality

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

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

Cooperation Required of Covered Persons

You must cooperate with HOI and FCSRMC, and must execute and submit such consents, releases, assignments, and other documents as may be requested in order to administer, and exercise any rights hereunder. Failure to do so may result in the denial of claims and will constitute grounds for termination for cause as described in the TERMINATION OF COVERAGE section.

Customer Rewards Program

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

Employer as Plan Administrator

Your employer, as the plan administrator, retains full, final, discretionary authority with respect to the administration of the coverage and benefits described in this Benefit Booklet, including, but not limited to, the authority to establish the benefits and scope of coverage to be provided hereunder; authority to make ultimate coverage and claims payment decisions; authority to determine the eligibility of individuals for coverage; and authority to construe and interpret the terms of coverage under this Benefit Booklet.

Evidence of Coverage

You have been provided with this Booklet and an Identification Card as evidence of coverage under FCSRMC's Group Health Plan.

Florida Agency for Health Care Administration (AHCA) Performance Data

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

Identification Cards

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

Modification of Provider Network

Our Provider network is subject to change at any time without prior notice to, or approval of, you or the Group. Additionally, we may, at any time, terminate or modify the terms of any Provider contract and may enter into additional Provider contracts without prior notice to, or approval of, you or the Group. It is your responsibility to determine whether a health care Provider is an In-Network Provider at the time Services are rendered.

Non-Waiver of Defaults

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

Notices

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

If to us:

To the address printed on the Identification Card.

If to you:

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

If to the Group:

To the address indicated by the Group.

Our Obligations Upon Termination

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

Promissory Estoppel

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

Relationships Between the Parties

HOI and Health Care Providers

Neither HOI nor any of its officers, directors or employees provides health care Services to you. By accepting coverage and benefits, you agree that health care Providers rendering Health Care Services are not our employees or agents. **In this regard, we hereby expressly disclaim any agency relationship, actual or implied, with any health care Provider.** We do not, by virtue of making coverage, benefit, and payment decisions, exercise any control or direction over the medical judgment or clinical decisions of any health care Provider. Any decisions made by us concerning appropriateness of setting, or whether any Service is Medically Necessary, shall be deemed to be made solely for the purpose of determining whether such Services are covered, and not for the purpose of recommending any treatment or non-treatment. Neither HOI nor the Group will assume liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

HOI and the Group

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

You and In-Network Providers

The relationship between you and In-Network Providers shall be that of a health care Provider-patient relationship, in accordance with any applicable professional and ethical standards.

Right of Recovery

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

Right of Reimbursement

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

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

Right to Receive and Release Necessary Information

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

Third Party Beneficiary

The terms and provisions of the Group Health Plan shall be binding solely upon, and inure solely to the benefit of FCSRMC and individuals covered under the terms of this Benefit Booklet, and no other person shall have any rights, interest or claims thereunder, or under this Booklet, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. FCSRMC hereby specifically expresses its intent that Providers that have not entered into contracts with HOI to participate in our Provider networks shall not be third-party beneficiaries under the terms of the FCSRMC's Group Health Plan or this Booklet.

COMPLAINT AND GRIEVANCE PROCESS

Introduction

We have established a process for reviewing your Complaints and Grievances. The purpose of this process is to facilitate review of, among other things, your dissatisfaction with us, our administrative practices, coverage, benefit or payment decisions, or with the administrative practices and/or the quality of care provided by any independent In-Network Provider. The Complaint and Grievance Process also permits you or your Physician, or a person acting on your behalf, to expedite our review of certain types of Grievances. The process described in this section must be followed if you have a Complaint or Grievance.

Informal Review

We encourage you to first attempt the informal resolution of any dissatisfaction by calling us. To advise us of a Complaint, you should first contact our customer service department, either by phone or in person. The phone number is listed on your ID Card, and our office address is listed at the end of this section. A service associate, working with appropriate personnel, will review the Complaint within a reasonable time after its submission and attempt to resolve it to your satisfaction. You must provide all of the facts relevant to the Complaint to the service associate. If you do not provide all requested or relevant information it may delay our review of the Complaint. Consequently, you must cooperate with us in our review of the matter.

If you remain dissatisfied with our resolution of the Complaint, you may submit a Grievance in accordance with the Formal Review subsection below.

Formal Review

You, a Provider who has been directly involved in your treatment or diagnosis acting on your behalf, a state agency, or another person designated in writing by you, may submit a Grievance.

In order to begin the formal review process, you may fill out a pre-printed form, write a letter or meet with us in person to explain the facts and circumstances relating to the Grievance. You should provide as much detail as possible and attach copies of any relevant documentation. You are not required to use our form, however, we strongly urge you to use this form, as it was designed to help facilitate logging, identification, processing, and tracking of the Grievance through the review process.

If you need assistance in preparing your Grievance, you may contact us for assistance. If you are hearing impaired you may contact us via TTY/TDD.

Review of Grievances Involving Adverse Benefit Determination

A Grievance involving an Adverse Benefit Determination will be reviewed using the process described below. The Grievance must be submitted to us in writing for an internal Grievance within 365 days of the original Adverse Benefit Determination, except in the case of Concurrent Care Decisions which may, depending upon the circumstances, require you to file within a shorter period of time from notice of the denial. The following guidelines are applicable to reviews of Adverse Benefit Determinations:

1. You must cooperate fully with us in our effort to promptly review and resolve a Complaint or Grievance. In the event you do not fully cooperate with us, you will be deemed to have waived your right to have the Complaint or Grievance processed within the time frames set forth in this section.
2. We will offer to meet with you if you believe that such a meeting will help us resolve the Complaint or Grievance to your satisfaction, you may also initiate a request for such meeting by notifying us. You may elect to meet with us in person, by telephone conference call, or by video-conferencing (if facilities are available). We will not pay for your travel or lodging in connection with any such meeting. Appropriate arrangements will be made to allow telephone conferencing or video conferencing to be held at our administrative offices within the Service Area. We will make these telephone or video arrangements with no additional charge to you.
3. You, or a Provider or a person acting on your behalf, must specifically request an expedited review. The Expedited Review process only applies to Pre-Service Claims or requests for extension of Concurrent Care Services made within 24 hours before the authorization for such Services expires. An expedited review will not be accepted for an Adverse Benefit Determination on a Post-Service Claim.
4. You may review pertinent documents upon request and free of charge, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing.
5. If the Adverse Benefit Determination is based on the lack of Medical Necessity of a particular Service or the Experimental or Investigational exclusion, you may request an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of this Booklet to your medical circumstances. This information is provided free of charge.
6. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination.
7. We may consult with appropriate Physicians in the same or similar specialty as typically manages the Condition, procedure, or treatment under review, as necessary.
8. Any independent medical consultant who reviews the Adverse Benefit Determination on our behalf will be identified upon request.
9. If the claim is a Claim Involving Urgent Care, you may request an expedited review orally or in writing in which case all necessary information on review may be transmitted between you and us by telephone, facsimile or other available expeditious method. You may call our expedited phone line at the number listed at the end of this section.
10. If your request for expedited review arises out of a concurrent review determination by us that a continued hospitalization is not Medically Necessary, coverage for the hospitalization will continue until you have been notified of the determination.
11. If you wish to give someone else permission to file a Grievance for an Adverse Benefit Determination on your behalf, we must receive a completed Appointment of Representative form signed by you indicating the name of the person who will represent you with respect to the Grievance. An Appointment of Representative form is not required if the Physician is requesting review of an Adverse Benefit Determination relating to a Claim Involving Urgent Care. Appointment of

Representative forms are available at www.floridablue.com or by calling the customer service phone number on your ID Card.

12. The Internal Review Panel will review the Grievance and may make a decision based on medical records, additional information, and input from health care professionals in the same or similar specialty as typically manages the Condition, procedure or treatment under review.
13. We will advise you of all Grievance decisions in writing, as outlined in the Timing of Our Grievance Review on Adverse Benefit Determinations subsection.
14. We will provide written confirmation of our decision concerning a Claim Involving Urgent Care within two working days or three calendar days, whichever is less, after providing notification of that decision.
15. The Panel that reviews appeals is composed of individuals who did not participate in the previous decision, nor are they subordinates of such individual(s).
16. You have the right to an independent external review through an external review organization for certain Grievances, as provided in the Patient Protection and Affordable Care Act of 2010.

Timing of Our Grievance Review on Adverse Benefit Determinations

We will use our best efforts to review Grievances of Adverse Benefit Determinations and communicate the decision in accordance with the following time frames:

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

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

How to Request External Review

If you are not satisfied with our internal review of your Grievance involving an Adverse Benefit Determination, please refer to the Adverse Benefit Determination notice or call the customer service phone number on your ID Card for information on how to request an external review.

ERISA Civil Action Provision

A federal law known as the Employee Retirement Security Act of 1974 (ERISA), as amended, may apply to the Group Health Plan. If ERISA applies to the Group Health Plan, you are entitled, after exhaustion of the procedures described in this section, to pursue civil action under Section 502(a) of ERISA in connection with an Adverse Benefit Determination or any other legal or equitable remedy otherwise available.

Telephone Numbers and Addresses

You may contact a Grievance Coordinator at the phone number listed on your ID Card or at the phone numbers listed below.

Department of Financial Services
Division of Consumer Services
200 East Gaines Street
Tallahassee, Florida 32399-0322
800-342-2762

Health Options, Inc.
Attention: Grievance Department
8400 NW 33rd Street, Suite 100
Miami, Florida 33122-1932
877-352-2583

877-842-9118 **-** Expedited Review for a Claim Involving Urgent Care

Dial 7-1-1 for Florida Relay Service assistance with TTY/TDD calls

IMPORTANT INFORMATION FOR YOU

What is an HMO?

A health maintenance organization (HMO) is an alternative health care financing and/or delivery organization that either provides directly, or through arrangements made with other persons or entities, comprehensive health care coverage and benefits or services, or both, in exchange for a prepaid per capita or prepaid aggregate fixed sum.

While some HMOs are similar, not all HMOs operate or are organized in the same way. For example, an HMO can be organized and operate as a staff model, a group model, an IPA model or a network model.

Types of HMOs

Staff and Group Model HMOs

In a staff model HMO, the doctors and other Providers rendering care are usually salaried employees of the HMO and generally provide care in a clinic setting rather than in their own personal offices. Group model HMOs, on the other hand, contract with large medical group practices to provide or arrange for most Health Care Services. Typically, the doctors in the medical groups own the HMO. In both these models, the HMO's doctors and other providers typically do not see patients covered by other third party payers or managed care organizations.

IPA Model HMOs

In an IPA model HMO, the HMO typically contracts with individual, independent doctors and/or a Physician organization, which may, in turn, contract services with additional doctors and Providers. Unlike the staff or group model HMOs, the IPA model HMO does not provide Health Care Services itself. Instead, it pays independent, qualified Providers to render health care to its members. The doctors in an IPA model HMO are not the agents or employees of the HMO; they typically practice in their own personal offices, and continue to see patients covered by other third party payers or managed care organizations.

Note: This description is not intended to be an exhaustive listing of all HMO organization models in use in the United States.

Health Options is an IPA Model HMO. **It is not a staff or group model HMO.** This means that the doctors and other Providers with whom we contract are independent contractors and not the employees or agents, actual or ostensible, of Health Options. Rather these independent doctors and Providers typically continue to see their own patients in their own personal offices or facilities and continue to see patients covered by other third party payers or managed care organizations.

Your Rights and Responsibilities

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

Rights

- To be provided with information about our services and the associated Providers of Health Care Services.
- To receive medical care and treatment from In-Network Providers who have met our credentialing standards.
- To expect health care Providers who participate in our network to permit you to participate in the major decisions about your health care, consistent with legal, ethical, and relevant patient-Provider relationship requirements.
- To expect to receive treatment and relevant information about your treatment from our In-Network Providers with courtesy, respect, and concern for your dignity and privacy.
- To appeal unfavorable medical or administrative decisions by following the established appeal or grievance procedures found in this Booklet.
- To inform In-Network Providers that you refuse treatment, and to expect them to honor your decision, if you choose to accept the responsibility and the consequences of your decision.
- To have access to your medical records, and to be assured that the confidentiality of your records is maintained, in accordance with applicable law and HOI's rules.

Responsibilities

- To seek all non-emergency care through your assigned PCP or another In-Network Provider and to cooperate with anyone providing your care and treatment.
- To be respectful of the rights, property, comfort, environment and privacy of other patients and not be disruptive.
- To be responsible for understanding and following instructions about your treatment and to ask questions if you do not understand or need an explanation.
- To provide accurate and complete information concerning your health problems and medical history and to answer all questions truthfully and completely.
- To pay your Cost Share amounts set forth on the Schedule of Benefits and to provide current information concerning your coverage status to any In-Network Provider.
- To follow the process for filing a grievance about medical or administrative decisions that you feel were made in error.
- To request your medical records in accordance with our rules and procedures and in accordance with applicable law.
- To follow Coverage Access Rules established by us.

Disclosure of Continuing Care Facility Resident/Retirement Facility Resident Rights

If, at the time of enrollment you are a resident of a continuing care facility certified under Chapter 651, Florida Statutes, or a retirement facility consisting of a nursing home or assisted living facility and

residential apartments, your PCP must refer you to that facility's skilled nursing unit or assisted living facility if:

1. you request it and the facility agrees;
2. your PCP finds that such care is Medically Necessary;
3. the facility agrees to be reimbursed at the same contracted rate as similar Providers for the same Covered Services and supplies; and
4. the facility meets all guidelines established by us related to quality of care, utilization, referral authorization, risk assumption, use of our Provider network, and other criteria applicable to Providers under contract with us for the same Services.

If your request to be referred to the skilled nursing unit or assisted living facility that is part of your place of residence is not honored, you have the right to initiate a Complaint or Grievance under the process described in this Booklet.

Statement on Advance Directives

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

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

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

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

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

Another common form of advance directive is the Health Care Surrogate Designation. When properly executed, a Health Care Surrogate Designation grants authority for the surrogate to make health care

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

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

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

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

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

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

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

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

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

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

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

AWAY FROM HOME CARE®

Away From Home Care (AFHC) Guest Membership is an out-of-area program sponsored by the Blue Cross Blue Shield Association (BCBSA). AFHC is available to you under the Group Health Plan through HOI, a participating Blue-sponsored HMO when the program's requirements are met. Guest Membership is defined as a courtesy membership for individuals who are temporarily residing outside of their Home HMO service area. Health Options, Inc. (HOI) is your Home HMO. For purposes of the Group Health Plan, you will be a guest member of the Host HMO and will be entitled to coverage and benefits under the terms of the Host HMO's benefit booklet.

Under AFHC, you receive a courtesy enrollment in a participating Host HMO and have access to a comprehensive range of benefits, including routine and preventive Services. You will receive the benefits of the Host HMO plan while in that HMO Plan's service area. You remain a Covered Plan Participant under your Home HMO under the Group Health Plan and are entitled to payment for Covered Services not payable under your AFHC Guest Membership under the terms of this Booklet. Should your coverage with your Home HMO terminate, you will no longer be eligible for AFHC coverage, and if you are then in this program your AFHC coverage will also be terminated.

The Host HMO pays the Provider the lowest available rate on a fee-for-service basis and then bills the Home HMO for reimbursement. You pay any applicable Cost Share amounts to the Provider in the Host Plan's service area at the time of Service.

Guest Application

You must complete an AFHC Guest Application with the Home HMO, and then work with the Host HMO to locate a PCP in the Host Plan's service area. The AFHC Guest Application form is used to verify your eligibility and to provide the appropriate information for billing and reimbursement.

Guest Membership Types

The types of Guest Memberships are based on your eligibility and the length of time that you will be out of the Home HMO service area. The three types of Guest Memberships are as follows:

Long-Term Traveler

This Guest Membership is available to Covered Persons that are away from home for at least 90 consecutive days (three months) but not more than 180 days (six months).

This Guest Membership is typically used for long-term work assignments or for a retiree with a dual residence. Home HMOs may limit the number of Long-Term Traveler Guest Memberships to two per year.

Families Apart

The Families Apart Guest Membership is available to Covered Dependents that do not reside in the Home HMO service area for 90 or more consecutive days. A Covered Plan Participant is not eligible for this type of Guest Membership.

To qualify for a Families Apart Guest Membership, the Covered Dependent must not be living with the Covered Plan Participant and must live in the service area of a Blue-Sponsored HMO.

There is no administrative time limit on the length of a Families Apart Guest Membership.

Student

The Student Guest Membership is available to Covered Dependents that are out of the Home HMO Service Area for 90 or more consecutive days attending school.

To qualify for a Student Guest Membership, the Covered Dependent must not be living with the Covered Plan Participant and must live in the service area of a Blue-Sponsored HMO.

The Student Guest Membership is typically used for students while they are away at school. The student membership should terminate when the student returns to the Home HMO Service Area for the summer. There is no administrative time limit on the length of a Student Guest Membership.

Covered Dependents under a Student Guest Membership that seek care in a third HMO service area (out of the Home HMO area and out of the Host HMO area) should be referred back to HOI, the Home HMO.

Guest Membership Policies

Host HMOs need enough time to process and set up Guest Memberships before the desired effective date. A 15-day notification period is provided for Host HMOs to complete the processing and setup of the Guest Membership. Covered Persons can be under only one Guest Membership at a time.

Guest Membership Renewals

When your Guest Membership expires, you may apply for a separate, consecutive Guest Membership period to begin after your current one expires. The 15-day notification period applies to Guest Membership renewals, so it is important that you apply for renewal far enough in advance to avoid a lapse in Guest Membership.

Guest Membership renewals have the same requirements as initial Guest Memberships, including the 90-day out-of-area requirement. Renewals must be for a minimum of 90 or more consecutive days in length. A renewal requires that the Home HMO Guest Membership Coordinator re-verify eligibility, submit a new Guest Application form, obtain a new signature sticker and pay a new setup and renewal fee.

Renewals typically apply to Families Apart and Student Guest Memberships which commonly renew on an annual basis. A Long Term Traveler Guest Membership can also renew but you would need to re-qualify by being out of area for a minimum of 90 consecutive days from the date of the requested renewal, as well as meeting all other Home HMO eligibility requirements. You are not required to return to the Home HMO Service Area to qualify for a renewal.

DEFINITIONS

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

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

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

Administrative Services Agreement or **ASA** means an agreement between FCSRMC and HOI. Under the Administrative Services Agreement, HOI provides claims processing and payment services, customer service, utilization review services, and access to HOI's network of independent contracting providers.

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

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

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

Allergy Treatment means testing and desensitization therapy (e.g., injections), including cost of hyposensitization serum.

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

1. In the case of an In-Network Provider located in the Service Area, this amount will be established in accordance with the applicable agreement between that Provider and HOI.
2. In the case of Out-of-Network Providers located outside of the Service Area who participate in the BlueCard Program, this amount will generally be established in accordance with the negotiated price that the Host Blue passes on to us, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the BLUECARD PROGRAM section in the Benefit Booklet for more details.
3. In the case of an Out-of-Network Provider that has not entered into an agreement with HOI to provide access to a discount from the billed amount of that Provider for the specific Covered Services

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

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

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

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

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

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

Anniversary Date means the date one year after the Effective Date stated in the ASA, and subsequent annual anniversaries or such other date as mutually agreed to in writing by the parties.

Applied Behavior Analysis means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

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

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

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

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

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

Autism Spectrum Disorder means any of the following disorders as defined in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders:

1. Autistic disorder;
2. Asperger's syndrome;

3. Pervasive developmental disorder not otherwise specified; and

4. Childhood Disintegrative Disorder.

Benefit Booklet or **Booklet** means the certificate of coverage, which is evidence of coverage under the Group Health Plan.

Benefit Period means a consecutive period of time, specified by the Group, in which benefits accumulate toward the satisfaction of Deductibles, out-of-pocket maximums and any applicable benefit maximums. Your benefit period is listed on your Schedule of Benefits, and will not be less than 12 months.

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

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

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

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

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

Certified Nurse Midwife means a person who is licensed pursuant to Chapter 467 of the Florida Statutes, or similar applicable laws of another state, as an advanced registered nurse practitioner and who is certified to practice midwifery by the American College of Nurse Midwives.

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

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

Coinsurance means the sharing of health care expenses for Covered Services between you and the Plan. After your Deductible is met, the Plan will pay a percentage of the Allowed Amount for Covered Services, as listed in the Schedule of Benefits. The percentage you are responsible for is your Coinsurance. Not all plans include coinsurance.

Complaint means an oral (non-written) expression of dissatisfaction, whether or not such dissatisfaction is made in person, by telephone, or by another person acting on your behalf.

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

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

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

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

Copayment means a fixed dollar amount which must be paid to a health care Provider by you at the time certain Covered Services are rendered by that Provider.

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

Coverage Access Rules means the rules or procedures in this Benefit Booklet, your provider directory, or established by HOI, that you must follow in order for Health Care Services you receive to be covered. Failure to follow applicable Coverage Access Rules may result in the denial of coverage or benefits under this Booklet.

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

Covered Person means a Covered Plan Participant or Covered Dependent.

Covered Plan Participant means an Eligible Employee or other individual who continues to meet all applicable eligibility requirements described in the ELIGIBILITY FOR COVERAGE section and who is enrolled, and actually covered, under the Group Health Plan other than as a Covered Dependent.

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

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

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

Crisis Intervention means acute inpatient psychiatric care which is required for evaluation of an acute psychosis or crisis situation in which the patient presents as a danger to self or others. The acute or crisis situation may be an exacerbation of a history of mental illness or the sudden onset of a psychiatric disorder. The crisis or acute period normally extends 48 to 72 hours, but may be of greater duration depending upon the response to therapy.

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

Deductible means the amount of charges, up to the Allowed Amount, for Covered Services which you must actually pay to an appropriate licensed health care Provider who is recognized for payment under this Booklet, before payment for Covered Services under the Group Health Plan begins. Not all plans include a deductible.

Detoxification means a process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted through the period of time necessary to eliminate, by metabolic or other means, the

intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a Physician, while keeping the physiological risk to the person at a minimum.

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

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

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

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

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

1. both individuals are each other's sole Domestic Partner and intend to remain so indefinitely;
2. individuals are not related by blood to a degree of closeness (e.g., siblings) that would prohibit legal marriage in the state in which they legally reside;
3. both individuals are unmarried, at least 18 years of age, and are mentally competent to consent to the Domestic Partnership;
4. both individuals are financially interdependent and have resided together continuously in the same residence for at least 12 months prior to applying for coverage under the Group Health Plan and intend to continue to reside together indefinitely;
5. the Covered Plan Participant has submitted acceptable proof of evidence of common residence and joint financial responsibility to the Group; and
6. the Covered Plan Participant has completed and submitted any required forms to the Group and the Group has determined the Domestic Partnership eligibility requirements have been met.

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

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

Effective Date for the Group means 12:01 a.m. on the date specified in the ASA; and for you means 12:01 a.m. on the date coverage will begin as specified in the ENROLLMENT AND EFFECTIVE DATE OF COVERAGE section.

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

Eligible Employee means an employee who meets and continues to meet all of the eligibility requirements set forth in the ELIGIBILITY FOR COVERAGE section and is eligible to enroll as a Covered Plan Participant. An eligible employee is not a Covered Plan Participant until actually enrolled and accepted for coverage as a Covered Plan Participant by the Group.

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

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

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

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

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

Enrollment Forms means those forms, electronic or paper, which are used to maintain accurate enrollment files under the Group Health Plan.

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

1. such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the Florida Department of Health and approval for marketing has not, in fact, been given at the time such is furnished to you;
2. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device;
3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations;
4. reliable evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
5. reliable evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine maximum tolerated dosage(s), toxicity,

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

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

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

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

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

FDA means the United States Food and Drug Administration.

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

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

Gene Therapy means treating disease by replacing, manipulating, or supplementing nonfunctioning or malfunctioning genes.

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

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

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

Grievance means a written expression of dissatisfaction.

Group means FCSRMC, the employer, labor union, trust, association, partnership, or corporation, department or other organization or entity through which coverage and benefits described in this Booklet are made available to you, and through which you become entitled to coverage and benefits for the Covered Services described herein.

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

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

HOI means Health Options, Inc., a Florida Corporation (and any successor corporation) operating as a Health Maintenance Organization under applicable provisions of federal and/or state law.

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

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

Hospice means a public agency or private organization duly licensed pursuant to Florida Statutes, or a similar applicable law of another state to provide Hospice Services. In addition, such licensed entity must be principally engaged in providing pain relief, symptom management, and supportive Services to terminally ill persons and their families.

Hospital means a facility properly licensed pursuant to Chapter 395 of the Florida Statutes, or a similar applicable law of another state, that offers Services which are more intensive than those required for room, board, personal Services and general nursing care; offers facilities and beds for use beyond 24 hours; and regularly makes available at least clinical laboratory Services, diagnostic x-ray Services and treatment facilities for surgery or obstetrical care or other definitive medical treatment of similar extent.

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

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

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

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

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

In-Network Provider means any health care Provider who, at the time Covered Services are rendered to you, is under contract with us to provide Covered Services described in this Booklet.

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

Internal Review Panel means a panel established by us to review Grievances related to Adverse Benefit Determinations that an admission, availability of care, continued stay, or other Health Care Service has been reviewed and, based upon the information provided, does not meet our requirements for Medical Necessity, appropriateness, health care setting, level of care, or efficacy. This panel consists of Physicians who have appropriate expertise, and who were not previously involved in the initial Adverse Benefit Determination nor do these Physicians report to anyone who was involved in making the initial determination.

In Vitro Fertilization (IVF) means a process in which an egg and sperm are combined in a laboratory dish to facilitate fertilization. If fertilized, the resulting embryo is transferred to a woman's uterus.

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

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

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

Medical Literature means peer reviewed literature included in the PubMed/Medline database of the National Library of Medicine.

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

1. in accordance with Generally Accepted Standards of Medical Practice;
2. clinically appropriate, in terms of type, frequency, extent, site of Service, duration, and considered effective for your illness, injury, or disease or symptoms;
3. not primarily for your convenience, your family's convenience, your caregiver's convenience or that of your Physician or other health care Provider, and
4. not more costly than the same or similar Service provided by a different Provider, by way of a different method of administration, an alternative location (e.g., office vs. inpatient), and/or an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury, disease or symptoms.

   When determining whether a Service is not more costly than the same or similar Service as referenced above, we may, but are not required to, take into consideration various factors including, but not limited to, the following:

   a) the Allowed Amount for Service at the location for the delivery of the Service versus an alternate setting;

   b) the amount we have to pay to the proposed particular Provider versus the Allowed Amount for a Service by another Provider including Providers of the same and/or different licensure and/or specialty; and/or

   c) an analysis of the therapeutic and/or diagnostic outcomes of an alternate treatment versus the recommended or performed procedure including a comparison to no treatment. Any such analysis may include the short and/or long-term health outcomes of the recommended or performed treatment versus alternate treatments including an analysis of such outcomes as the ability of the proposed procedure to treat comorbidities, time to disease recurrence, the likelihood of additional Services in the future, etc.

Note: The distance you have to travel to receive a Health Care Service, time off from work, overall recovery time, etc. are not factors that we are required to consider when evaluating whether or not a Health Care Service is not more costly than an alternative Service or sequence of Services.

Reviews we perform of Medical Necessity may be based on comparative effectiveness research, where available, or on evidence showing lack of superiority of a particular Service or lack of difference in outcomes with respect to a particular Service. In performing Medical Necessity reviews, we may take into consideration and use cost data which may be proprietary.

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

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

Medication Guide for purposes of this Booklet, means the guide then in effect issued by us where you may find information about Preferred Prescription Drugs and Non-Preferred Prescription Drugs, Specialty Drugs, Prescription Drugs that require prior coverage authorization and Self-Administered Prescription Drugs that may be covered under this plan.

Note: The Medication Guide is subject to change at any time. Please refer to our website at www.floridablue.com for the most current guide or you may call the customer service phone number on your Identification Card.

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

Mental and Nervous Disorder means any disorder listed in the diagnostic categories of the International Classification of Disease, Ninth Edition, Clinical Modification (ICD-9 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

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

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

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

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

Out-of-Network Provider means a Provider who, at the time Health Care Services are rendered to you does not have a contract with us to provide Covered Services described in this Booklet.

Outpatient Rehabilitation Facility means an entity which renders, through Providers properly licensed pursuant to Florida law or a similar applicable law of another state: outpatient Physical Therapy; Speech Therapy; Occupational Therapy; Cardiac Therapy; and Massage for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition. Further, such an entity must meet our criteria for eligibility as an outpatient rehabilitation facility. The term outpatient rehabilitation facility, as used herein, shall not include any Hospital including a general acute care Hospital, or any separately organized unit of a Hospital, which provides comprehensive medical rehabilitation inpatient Services, or rehabilitation outpatient Services, including, but not limited to, a Class III "specialty rehabilitation hospital" described Chapter 59-A, of the Florida Administrative Code or a similar applicable law of another state.

Pain Management includes, but is not limited to, Services for pain assessment, medication, Physical Therapy, biofeedback, and/or counseling. Pain management programs feature multidisciplinary Services directed toward helping those with chronic pain to reduce or limit their pain.

Partial Hospitalization means treatment in which an individual receives at least 6 clinical hours of institutional care per day (24-hour period) for at least 5 days per week and returns home or is not treated as an inpatient during the remainder of that 24-hour period. A Hospital shall not be considered a "home" for purposes of this definition.

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

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

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

Physician Assistant means a person properly licensed to perform surgical first assisting Services pursuant to Chapter 458 of the Florida Statutes, or a similar applicable law of another state.

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

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

Prescription means an order for drugs, Services or supplies by a Physician or other health care professional authorized by law to prescribe such drugs, Services or supplies.

Prescription Drug means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound which can only be dispensed with a Prescription and/or which is required by state law to bear the following statement or similar statement on the label: "Caution: Federal law prohibits dispensing without a Prescription".

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

Primary Care Physician (PCP) means the Physician who, at the time Covered Services are rendered, was under a primary care physician Provider contract with us. A primary care physician may specialize in internal medicine, family practice, general practice, or pediatrics. Also, a gynecologist or obstetrician/ gynecologist may elect to contract with us as a primary care physician.

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

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

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

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

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

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

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

Rehabilitation Plan means a written plan, describing the type, length, duration, and intensity of Rehabilitation Services to be provided to a person with rehabilitation potential. Such plan must have realistic goals which are attainable by the individual within a reasonable length of time and must be likely to result in significant improvement within 62 days from the first date such Services are to be rendered. The rehabilitation plan must be renewed every 30 days.

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

Rehabilitative Therapies means therapies with the primary purpose of restoring or improving a bodily or mental function impaired or eliminated by a Condition, and include, but are not limited to, Physical Therapy, Speech Therapy, Pain Management, pulmonary therapy or Cardiac Therapy.

Rescission or **Rescind** refers to HOI's or FCSRMC's action to retroactively cancel or discontinue coverage under the Group Health Plan. Rescission does not include a cancellation or discontinuance of coverage with only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively due to non-payment of premium.

Self-Administered Prescription Drug means an FDA-approved Prescription Drug that you may administer to yourself, as recommended by a Physician.

Service Area means the geographic area in which Florida Blue HMO has been authorized by the Agency for Health Care Administrations (AHCA) to arrange for the provision of Health Care Services to members.

A list of Florida counties in the Service Area is available at: http://consumerdirect.bcbsfl.com/cws/plancounties or you may call the customer service phone number on your ID Card.

Skilled Nursing Facility means an institution or part thereof which meets our criteria for eligibility as a skilled nursing facility and which: 1) is licensed as a skilled nursing facility by the state of Florida, or a similar applicable law of another state; 2) is accredited as a skilled nursing facility by The Joint Commission or recognized as a skilled nursing facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by us.

Sound Natural Teeth means teeth that are whole or properly restored (restoration with amalgams, resin or composite only); are without impairment, periodontal, or other conditions; and are not in need of Services provided for any reason other than an Accidental Dental Injury. Teeth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated with endodontics, are not sound natural teeth.

Specialist means a Physician who limits practice to specific Services or procedures such as surgery, radiology, pathology, certain age categories of patients such as pediatrics, geriatrics, certain body systems such as dermatology, orthopedics, cardiology, internal medicine or types of diseases such as allergy, psychiatry, infectious diseases, oncology. Specialists may have special education and training related to their respective practice and may or may not be certified by a related specialty board.

Specialty Drug means an FDA-approved Prescription Drug that has been designated solely by us, as a specialty drug due to special handling, storage, training, distribution requirements and/or management of therapy. Specialty drugs may be Provider administered or self-administered and are identified with a special symbol in the Medication Guide.

Specialty Pharmacy means a Pharmacy that has signed a Participating Pharmacy Provider Agreement with us to provide specific Prescription Drug products, as determined by us. In-network specialty pharmacies are listed in the Medication Guide. The fact that a pharmacy is a participating pharmacy does not mean that it is a specialty pharmacy.

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

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

Stabilize shall have the same meaning with regard to Emergency Services as the term is defined in Section 1867 of the Social Security Act.

Standard Reference Compendium means (a) the United States Pharmacopoeia Drug Information; (b) the American Medical Association Drug Evaluation; and/or (c) the American Hospital Formulary Service Hospital Drug Information.

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

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

Urgent Care Center means a properly licensed facility that: 1) is available to provide Services to patients at least 60 hours per week with at least 25 of those available hours after 5:00 p.m. on weekdays or on Saturday or Sunday; 2) posts instructions for individuals seeking Health Care Services, in a conspicuous public place, as to where to obtain such Services when the urgent care center is closed; 3) employs or contracts with at least one or more board certified or board eligible Physician and Registered Nurse (RN) who are physically present during all hours of operation. (Physicians, RNs, and other medical professional staff must have appropriate training and skills for the care of adults and children); and 4) maintains and operates basic diagnostic radiology and laboratory equipment in compliance with applicable state and/or federal laws and regulations. For purposes of this Booklet, an urgent care center is not a Hospital, Psychiatric Facility, Substance Abuse Facility, Skilled Nursing Facility or Outpatient Rehabilitation Facility.

Waiting Period means the period of time specified by the Group, if any, which must be met by an individual before that individual is eligible to enroll for coverage under the Group Health Plan.

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