



BlueOptions

Student Medical Insurance
Plan

Benefit Booklet

BlueOptions
Student Medical Insurance Plan
University of South Florida
21909 R0408 BCA
54145-08-2008



**BlueCross BlueShield
of Florida**

An Independent Licensee of the
Blue Cross and Blue Shield Association

BlueOptions

Student Medical Insurance
Plan

Benefit Booklet



Robert I. Lufrano, M.D.

Chairman of the Board and Chief
Executive Officer

This Benefit Booklet Contains
Deductible Provisions

For Customer Service Assistance:
800-664-5295

Servicing Agent:

Student Insurance Group (SIG)
110 Athens Street
Tarpon Springs, FL 34689

Phone: 1-866-931-9560
Fax: 1-727-939-8323

www.studentinsurancegroups.us



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of Florida**

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BlueOptions

Schedule of Benefits

Student Plan

You should carefully review this Schedule of Benefits, which is part of your Benefit Booklet, to be aware of important information concerning your share of the expenses for Covered Services you receive. This is a **limited** benefit plan. This plan contains a “per person” Annual Benefit Maximum and all Services received will apply to that maximum. Once the “per person” Annual Benefit Maximum has been met, no additional payment for Covered Services will be made under this plan for the remainder of that Benefit Period. Your share of the expenses, including any applicable Copayments, Deductibles, and Coinsurance responsibilities, **will vary** depending upon the Provider you choose and the setting in which the Services are rendered. References to Deductible are abbreviated as “DED”.

Your Benefit Period August 18-August 17

A. Deductible and Coinsurance Amounts

Benefit Description	In-Network	Out-of-Network
Individual Deductible (DED)	\$300	\$500
Family Deductible (DED)	Not Applicable	
Coinsurance percentage Payable By BCBSF	80% of the Allowed Amount	70% of the Allowed Amount
Individual Out-of-Pocket Maximum	Not Applicable	
Family Out-of-Pocket Maximum	Not Applicable	

The In-Network Deductibles and Out-of-Network Deductibles are separate, and as such, accumulate separately. Therefore, amounts incurred for In-Network shall be applied only to the In-Network Deductibles and Out-of-Network amounts incurred shall be applied only to Out-of-Network Deductibles.

B. Office Services

Benefit Description	In-Network	Out-of-Network
A Family Physician is a Physician whose primary specialty is, according to BCBSF's records, one of the following: Family Practice, General Practice, Internal Medicine, and Pediatrics.		
Office Services Rendered by: 1. Student Health Center 2. Family Physicians 3. Physicians other than Family Physicians; and other health care professionals licensed to perform such Services.	\$0 Copayment per visit* \$20 Copayment per visit and 80% of the Allowed Amount after DED \$20 Copayment per visit and 80% of the Allowed Amount after DED	\$20 Copayment per visit and 70% of the Allowed Amount after DED \$20 Copayment per visit and 70% of the Allowed Amount after DED
Allergy Injections rendered by: 1. Student Health Center 2. Family Physicians 3. Physicians other than Family Physicians; and other health care professionals licensed to perform such Services.	\$0 Copayment per visit* \$10 Copayment per visit* \$10 Copayment per visit*	70% of the Allowed Amount
E-Visits	\$10 Copayment per visit*	70% of the Allowed Amount after DED
Durable Medical Equipment, Prosthetics, and Orthotics	80% of the Allowed Amount after DED	70% of the Allowed Amount after DED

*These Services are subject to the Copayment only.

Note: You should verify a Provider's participation status whenever possible prior to receiving Health Care Services. To verify a Provider's specialty or participation status, you may contact

the local BCBSF office, review the most recent Provider directory or access the BlueOptions Provider directory at our website at www.bcbsfl.com.

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

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center Services	\$100 Copayment per visit*	70% of the Allowed Amount after DED
Physician and other health care professional Services rendered at an Ambulatory Surgical Center	80% of the Allowed Amount after DED	70% of the Allowed Amount after DED
Independent Diagnostic Testing Facility Services	80% of the Allowed Amount after DED	70% of the Allowed Amount after DED
Urgent Care Center	\$35 Copayment per visit	\$35 Copayment per visit
Independent Clinical Lab Services	100% of the Allowed Amount	70% of the Allowed Amount after DED

*These Services are subject to the Copayment only.

D. Inpatient/Outpatient Services (Rendered at a Hospital, Psychiatric Facility, or Substance Abuse Facility)

Benefit Description	In-Network		Out-of-Network
	Option 1	Option 2	
Inpatient Facility Services (Applies per admission)	80% of the Allowed Amount after DED		70% of the Allowed Amount after DED
Outpatient Facility Services (Applies per visit)	80% of the Allowed Amount after DED		70% of the Allowed Amount after DED
Inpatient/outpatient Physician and other health care professional Services	80% of the Allowed Amount after DED		70% of the Allowed Amount after DED
Emergency Room Facility Services (Applies per visit) Copayment waived if admitted	\$100 Copayment		\$100 Copayment

*These Services are subject to the Copayment only.

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

E. Preventive Health Services

Benefit Description	In-Network	Out-of-Network
<p>Preventive Adult Wellness Services rendered by:</p> <ol style="list-style-type: none"> 1. Student Health Center 2. Family Physicians 3. Physicians other than Family Physicians; and other health care professionals licensed to perform such Services. 	<p style="text-align: center;">\$10 Copayment per visit*</p> <p style="text-align: center;">\$20 Copayment per visit and 80% of the Allowed Amount</p> <p style="text-align: center;">\$20 Copayment per visit and 80% of the Allowed Amount</p>	<p style="text-align: center;">\$20 Copayment per visit and 70% of the Allowed Amount</p> <p style="text-align: center;">\$20 Copayment per visit and 70% of the Allowed Amount</p>
<p>Preventive Adult Well Woman Services rendered by:</p> <ol style="list-style-type: none"> 1. Student Health Center 2. Family Physicians 3. Physicians other than Family Physicians; and other health care professionals licensed to perform such Services. 	<p style="text-align: center;">\$10 Copayment per visit*</p> <p style="text-align: center;">\$20 Copayment per visit and 80% of the Allowed Amount</p> <p style="text-align: center;">\$20 Copayment per visit and 80% of the Allowed Amount</p>	<p style="text-align: center;">\$20 Copayment per visit and 70% of the Allowed Amount</p> <p style="text-align: center;">\$20 Copayment per visit and 70% of the Allowed Amount</p>

*These Services are subject to the Copayment only.

Supplies obtained through the Pharmacy Program Endorsement are not subject to the Benefit Period Maximum.

Durable Medical Equipment Per Benefit Period	\$1,000
Enteral Formulas Per Benefit Period	\$2,500
Home Health Care Per Benefit Period	\$2,500
Hospice (Combined Inpatient, Outpatient and Home) Per Person Per Lifetime	\$5,200
Mental Health Services (Inpatient) – Inpatient days/visits or combination of inpatient and Partial Hospitalization days, Per Benefit Period	30
Mental Health Services (Outpatient) – Outpatient Visits Per Benefit Period	30
Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations Per Benefit Period	\$1,500
Note: Refer to the Benefit Booklet for reimbursement guidelines. Spinal manipulations rendered by Osteopathic Physicians are not subject to the Outpatient Therapies maximum benefit listed above.	
Preventive Adult Wellness Per Benefit Period	\$150
Covered Services as described below for an adult. For purposes of this benefit an adult is 17 years or older.	
Preventive Adult Wellness Services include:	
1. annual physical or gynecological exam , including family planning/contraceptive Services; and	
2. related wellness Services including, but not limited to, pap smears, Prostate Specific Antigen (PSA), x-rays, laboratory Services, and immunizations. Routine vision and hearing examinations and screenings are <u>not</u> covered.	
Note: The wellness Services above are not subject to the Deductible. Your share of the expenses may vary based on the location of service and whether the Provider is In-Network or Out-of-Network.	
Skilled Nursing Facility Days Per Benefit Period	60
Substance Dependency Care and Treatment – Inpatient, outpatient or any combination Per Benefit Period	\$2,000
Total Lifetime Maximum Benefit Per Person	Unlimited

G. Additional Benefits/Features

Benefit Maximum Carryover

If, immediately before the Effective Date of the School, you or your Covered Dependent were covered under a prior School policy form issued by BCBSF to the School, amounts applied to your Benefit Period maximums, and lifetime maximums under the prior BCBSF policy, will be applied toward your Benefit Period maximums, and lifetime maximums under the Benefit Booklet.

Note: This Benefit Maximum Carryover provision does not apply to the Annual Benefit Maximum Per Person provision included in this Schedule.

Prescription Drug Program

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

In-Network Providers

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

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

***Value Added Services - Medical Evacuation and Repatriation**

Medical Evacuation and Medical Repatriation

Per Lifetime combined maximum \$25,000

Repatriation of Remains \$25,000

***These are value added services that may be offered through BCBSF or through a third party under contract with BCBSF to provide these value added services. See the Benefit Booklet for further information including limitations and exclusions.**

BlueScript[®] Pharmacy Program

Schedule of Benefits

You should carefully review this Pharmacy Program Schedule of Benefits. If you did not receive, or cannot find, the BlueScript Pharmacy Program Endorsement, which this Pharmacy Program Schedule of Benefits is a part of, contact us to obtain one. To verify if a Pharmacy is a Participating Pharmacy, you may access the Pharmacy Program Provider Directory at our website at www.bcbsfl.com or call the customer service number on your Identification Card.

Amount You are Required to Pay

- **Your Pharmacy Deductible Per Benefit Period**\$0
- **Copayment and/or Coinsurance Amount you must pay that applies to each Covered Prescription Drug or Covered Prescription Supply obtained from a Participating Pharmacy for up to a One-Month Supply:**
 - Preferred Generic Prescription Drugs\$20
 - Preferred Brand Name Prescription Drugs.....\$35
 - Preferred Covered Prescription Supplies\$35
 - Non-Preferred Prescription Drugs \$35
- **Benefit Period Maximum**

The maximum amount we will pay for Covered Prescription Drugs and Supplies under this BlueScript Pharmacy Program Endorsement per Benefit Period.....\$1,000

Note: The Benefit Period Maximum does not apply to Diabetic Medications and/or Supplies

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Section 1: How to Use Your Benefit Booklet

This is your Benefit Booklet (“Booklet”). You should read it carefully before you need Health Care Services. It contains valuable information about:

- your BlueOptions benefits
- what is covered
- what is excluded or not covered
- our coverage and payment rules
- our Blueprint for Health Programs
- how and when to file a claim
- how much, and under what circumstances, we will pay
- what you will have to pay as your share
- and other important information including when benefits may change; how and when coverage stops; our subrogation rights; and our right of reimbursement.

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

When reading your Booklet, please remember that:

- you should read this Booklet in its entirety in order to determine if a particular Health Care Service is covered.
- the headings of sections contained in this Benefit Booklet are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.
- references to “you” or “your” throughout refer to you as the Covered Student 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 Student or solely to your Covered Dependent(s) will be noted as such.

- references to “we”, “us”, and “our” throughout refer to Blue Cross and Blue Shield of Florida, Inc. We may also refer to ourselves as “BCBSF”.
- if a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If the word or phrase has a special meaning, it will either be defined in the “Definitions” section or defined within the particular section where it is used.

Where do you find information on...

- **what particular types of Health Care Services are covered?**
Read the “What Is Covered?” and “What Is Not Covered?” sections.
- **how much does BCBSF pay and how much do you have to pay?**
Read the “Understanding Your Share of Health Care Expenses” section along with your Schedule of Benefits.
- **how to take advantage of the BlueCard® (Out-of-State) Program when you receive Services out of state?**
Read the “BlueCard® (Out-of-State) Program” section.
- **how to add or remove a Dependent?**
Read the “When Coverage Begins and Ends” section.
- **what happens if you are covered under BlueOptions and another health plan?**
Read the “General Provisions” section.

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

Read the “When Coverage Begins and Ends” section.

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

Read the “Definitions” section.

Overview of How BlueOptions Works

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

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

Section 2: What Is Covered?

Introduction

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

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

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

1. within the Health Care Services categories in this "What Is Covered?" section;
2. actually rendered (not just proposed or recommended) by an appropriately licensed health care Provider who is recognized for payment by us 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;
3. Medically Necessary, as defined in this Booklet and determined by us in accordance with our Medical Necessity coverage criteria

then in effect, except as specified in this section;

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

We will determine whether Services are Covered Services under this Booklet after you have obtained the Services and we have received a claim for the Services. In some circumstances we may determine whether Services might be Covered Services under this Booklet before you are provided the Service. For example, we may determine whether a proposed transplant is a Covered Service under this Booklet before the transplant is provided. We are not obligated to determine, in advance, whether any Service not yet provided to you would be a Covered Service.

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

Our Benefit Guidelines

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

1. Our payment for certain Health Care Services is included within the Allowed

Amount for the primary procedure, and therefore no additional amount is payable by us for any such Services.

2. Our payment is based on the Allowed Amount for the actual Service rendered (i.e., payment is not based on the Allowed Amount for a Service which is more complex than that actually rendered), and is not based on the method utilized to perform the Service nor the day of the week nor the time of day the procedure is performed.
3. Our payment for a Service includes all components of the Health Care Service when the Service can be described by a single procedure code, or when the Service is an essential or integral part of the associated therapeutic/diagnostic Service rendered.

Covered Services Categories

Accident Care

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

Exclusion:

Health Care Services to treat an injury or illness resulting from an Accident related to your job or employment are excluded except for Services (not otherwise excluded) when you are not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by you.

Allergy Testing and Treatments

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

Ambulance Services

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

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

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

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

Please refer to your Schedule of Benefits for the benefit maximums for ground transportation and air/water transportation.

Ambulatory Surgical Centers

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

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

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

Anesthesia Administration Services

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

Exclusion:

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

Breast Reconstructive Surgery

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

Child Cleft Lip and Cleft Palate Treatment

Treatment and Services for Child Cleft Lip and Cleft Palate, including medical, dental, Speech Therapy, audiology, and nutrition Services for treatment of a child under the age of 18 who has cleft lip or cleft palate are covered. In order for such Services to be covered, your Covered Dependent’s Physician must specifically prescribe such Services and such Services must

be consequent to treatment of the cleft lip or cleft palate.

Concurrent Physician Care

Concurrent Physician care Services are covered, provided: 1) the additional Physician actively participates in your treatment; 2) the Condition involves more than one body system or is so severe or complex that one Physician cannot provide the care unassisted; and 3) the Physicians have different specialties or have the same specialty with different sub-specialties.

Consultations

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

Dental Services

Dental Services are limited to the following:

1. Care and stabilization treatment rendered within 62 days of an Accidental Dental Injury to Sound Natural Teeth.
2. Extraction of teeth required prior to radiation therapy when you have a diagnosis of cancer of the head and/or neck.
3. Anesthesia Services for dental Services including general anesthesia and hospitalization Services necessary to assure the safe delivery of necessary dental Services provided to you or your Covered Dependent in a Hospital or Ambulatory Surgical Center if:
 - a. 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; or
 - b. the Covered Dependent is under 8 years of age and it is determined by a

dentist and the Covered Dependent's Physician that:

- i. dental treatment is necessary due to a dental Condition that is significantly complex; or
- ii. the Covered Dependent has a developmental disability in which patient management in the dental office has proven to be ineffective.

Exclusion:

1. Dental Services provided more than 62 days after the date of an Accidental Dental Injury regardless of whether or not such services could have been rendered within 62 days; and
2. Dental Implants.

Diabetes Outpatient Self-Management

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

Notwithstanding the above, if your Benefit Booklet was amended by a BCBSF Pharmacy Program Endorsement which covers diabetes equipment and supplies, then diabetes equipment and supplies will be covered in

accordance with the terms and conditions of such Pharmacy Program Endorsement.

Diagnostic Services

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

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

Dialysis Services

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

Durable Medical Equipment

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

Payment Guidelines for Durable Medical Equipment

Supplies and Service to repair medical equipment may be Covered Services only if you own the equipment or you are purchasing the equipment. Our payment for Durable Medical

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

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

Exclusion:

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

Enteral Formulas

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

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

Eye Care

Coverage includes the following Services:

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

Exclusion:

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

Home Health Care

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

1. you are unable to leave your home without considerable effort and the assistance of another person because you are: bedridden or chairbound or because you are restricted in ambulation, whether or not you use assistive devices; or you are significantly limited in physical activities due to a Condition; and
2. the Home Health Care Services rendered have been prescribed by a Physician by way of a formal written treatment plan which has been reviewed and renewed by the prescribing Physician every 30 days. 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.

3. the Home Health Care Services are provided directly by (or indirectly through) a Home Health Agency; and
4. you are meeting or achieving the desired treatment goals set forth in the treatment plan as documented in the clinical progress notes.

Home Health Care Services are limited to:

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

Exclusions:

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

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

Hospice Services

Health Care Services provided in connection with a Hospice treatment program may be Covered Services, provided the Hospice treatment program is approved by your Physician. We reserve the right to request that your Physician certify, in writing, your life expectancy.

Hospital Services

Covered Hospital Services include:

1. room and board in a semi-private room when confined as an inpatient, unless the patient must be isolated from others for documented clinical reasons;
2. intensive care units, including neonatal, cardiac and progressive care;
3. use of operating and recovery rooms;
4. use of emergency rooms;
5. respiratory, pulmonary, or inhalation therapy (e.g., oxygen);
6. drugs and medicines administered (except for take-home drugs) by the Hospital;
7. intravenous solutions;
8. administration of, including the cost of, whole blood or blood products;
9. dressings, including ordinary casts;
10. anesthetics and their administration;
11. transfusion supplies and equipment;
12. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
13. Physical, Speech, Occupational, and Cardiac Therapies; and
14. transplants as described in the Transplant Services subsection.

Exclusion:

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

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

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

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

Inpatient Rehabilitation

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

1. Services must be provided under the direction of a Physician and must be provided by a Medicare certified facility in accordance with a comprehensive rehabilitation program;
2. a plan of care must be developed and managed by a coordinated multi-disciplinary team;
3. coverage is limited to the specific acute, catastrophic target diagnoses of severe stroke, multiple trauma, brain/spinal injury, severe neurological motor disorders, and/or severe burns;
4. the individual must be able to actively participate in at least 2 rehabilitative therapies and be able to tolerate at least 3 hours per day of skilled Rehabilitation Services for at least 5 days a week and their

Condition must be likely to result in significant improvement; and

5. the Rehabilitation Services must be required at such intensity, frequency and duration as to make it impractical for the individual to receive Services in a less intensive setting.

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

Exclusion:

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

Mammograms

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

Benefits for mammograms may not be subject to the Deductible, Coinsurance, or Copayment (if applicable). Please refer to your Schedule of Benefits for more information.

Mastectomy Services

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

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

after consultation with you, may choose the appropriate setting.

Maternity Services

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

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

Exclusion:

Maternity Services rendered to a Covered Person who becomes pregnant as a Gestational Surrogate under the terms of, and in accordance with, a Gestational Surrogacy Contract or Arrangement are excluded. This exclusion applies to all expenses for prenatal, intra-partal, and post-partal maternity/obstetrical care, and Health Care Services rendered to the Covered Person acting as a Gestational Surrogate.

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

Mental Health Services

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

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

Exclusion:

1. Services rendered in connection with a Condition not classified in either the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM) or the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder;
2. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or for mental retardation;
3. Services extended beyond the period necessary for evaluation and diagnosis of learning disabilities or for mental retardation;
4. Services for marriage counseling, when not rendered in connection with a Condition classified in either the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) or 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;
5. Services for pre-marital counseling;
6. Services for court-ordered care or testing, or required as a condition of parole or probation;
7. Services for testing of aptitude, ability, intelligence or interest;

8. Services for testing and evaluation for the purpose of maintaining employment;
9. Services for cognitive remediation;
10. inpatient confinements that are primarily intended as a change of environment; and
11. inpatient (overnight) mental health Services received in a residential treatment facility.

Newborn Care

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

Newborn Assessment:

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

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

Orthotic Devices

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

Benefits may be provided for necessary replacement of an Orthotic Device which is

owned by you when due to irreparable damage, wear, or a change in your Condition, or when necessitated due to growth of a child.

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

Exclusion:

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

Osteoporosis Screening, Diagnosis, and Treatment

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

1. estrogen-deficient individuals who are at clinical risk for osteoporosis;
2. individuals who have vertebral abnormalities;

3. individuals who are receiving long-term glucocorticoid (steroid) therapy; or
4. individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis.

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

1. Outpatient therapies listed below may be Covered Services when ordered by a Physician or other health care professional licensed to perform such Services. The outpatient therapies listed in this category are in addition to the Cardiac, Occupational, Physical and Speech Therapy benefits listed in the Home Health Care, Hospital, and Skilled Nursing Facility categories herein.
 - a) **Cardiac Therapy** Services provided under the supervision of a Physician, or an appropriate Provider trained for Cardiac Therapy, for the purpose of aiding in the restoration of normal heart function in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery are covered.
 - b) **Occupational Therapy** Services provided by a Physician or Occupational Therapist for the purpose of aiding in the restoration of a previously impaired function lost due to a Condition are covered.
 - c) **Speech Therapy** Services of a Physician, Speech Therapist, or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from a Condition are covered.
 - d) **Physical Therapy** Services provided by a Physician or Physical Therapist for the purpose of aiding in the restoration of normal physical function lost due to a Condition are covered.

- e) **Massage Therapy** Massage provided by a Physician, Massage Therapist, or Physical Therapist when the Massage is prescribed as being Medically Necessary by a Physician licensed pursuant to *Florida Statutes* Chapter 458 (Medical Practice), Chapter 459 (Osteopathy), Chapter 460 (Chiropractic) or Chapter 461 (Podiatry) is covered. The Physician's prescription must specify the number of treatments.

Payment Guidelines for Physical and Massage Therapy

Massage or a combination of Massage and Physical Therapy Services are limited to four (4) modalities per day not to exceed the Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations benefit maximum listed on your Schedule of Benefits.

Exclusion:

Application or use of the following or similar techniques or items for the purpose of aiding in the provision of a Massage: hot or cold packs; hydrotherapy; colonic irrigation; thermal therapy; chemical or herbal preparations; paraffin baths; infrared light; ultraviolet light; Hubbard tank; and contrast baths are excluded.

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

Payment Guidelines for Spinal Manipulations

We will cover up to 26 spinal manipulations per Benefit Period, or the maximum benefit listed in your Schedule of Benefits, whichever occurs first.

Your Schedule of Benefits sets forth the maximum amount that we will pay for any combination of the outpatient therapies and

spinal manipulation Services listed above. For example, you may have only utilized two (2) of your spinal manipulations for the Benefit Period, but if you have already met the combined therapy benefit maximum with other Services, this Benefit Booklet will not cover any additional spinal manipulations for that Benefit Period.

Oxygen

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

Physician Services

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

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

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

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

The term "established patient," as used herein, shall mean that the covered individual has received professional services from the Physician who provided the online medical

Services, or another Physician of the same specialty who belongs to the same group practice as that Physician, within the past three years.

Exclusion:

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

Expenses for online medical Services provided by a health care Provider that is not a Physician and expenses for Health Care Services rendered by telephone are also excluded.

Preventive Adult Wellness Services

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

Preventive Child Health Supervision Services

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

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

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

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

Prosthetic Devices

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

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

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

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

Exclusion:

1. Expenses for microprocessor controlled or myoelectric artificial limbs (e.g. C-legs); and
2. Expenses for cosmetic enhancements to artificial limbs.

Self-Administered Injectable Prescription Drugs

Unless otherwise covered under a BCBSF Pharmacy Program Endorsement to this Benefit Booklet, only Self-Administered Injectable Prescription Drugs used in the treatment of diabetes, cancer, Conditions requiring immediate stabilization (e.g. anaphylaxis), or in the administration of dialysis are covered.

Skilled Nursing Facilities

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

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

We reserve the right to request a treatment plan for determining coverage and payment.

Exclusion:

Expenses for an inpatient admission to a Skilled Nursing Facility for purposes of Custodial Care, convalescent care, or any other Service primarily for the convenience of you and/or your family members or the Provider are excluded. Expenses for any inpatient days beyond the per person per Benefit Period maximum number of days listed on your Schedule of Benefits are also excluded.

Substance Dependency Care and Treatment

Care and treatment for Substance Dependency includes the following:

1. Health Care Services (inpatient and outpatient or any combination thereof) provided by a Physician, Psychologist or

Mental Health Professional in a program accredited by the Joint Commission on the Accreditation of Healthcare Organizations or approved by the state of Florida for Detoxification or Substance Dependency.

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

Exclusion:

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

Surgical Assistant Services

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

Payment Guidelines for Surgical Assistant Services

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

Surgical Procedures

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

1. 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 (e.g., temporomandibular joint [TMJ]) and facial region if, under accepted medical standards, such surgery is necessary to treat Conditions caused by

congenital or developmental deformity, disease, or injury; and

4. Services of a Physician for the purpose of rendering a second surgical opinion and related diagnostic Services to help determine the need for surgery; and
5. sterilization (tubal ligations and vasectomies), regardless of Medical Necessity.

Payment Guidelines for Surgical Procedures

1. Payment for multiple surgical procedures performed in addition to the primary surgical procedure, on the same or different areas of the body, during the same operative session will be based on 50 percent of the Allowed Amount for any secondary surgical procedure(s) performed and the Coinsurance or Copayment (if any) indicated in your Schedule of Benefits. This guideline is applicable to all bilateral procedures and all surgical procedures performed on the same date of service.
2. Payment for incidental surgical procedures is limited to the Allowed Amount for the primary procedure, and there is no additional payment for any incidental procedure. An "incidental surgical procedure" includes surgery where one, or more than one, surgical procedure is performed through the same incision or operative approach as the primary surgical procedure which, in 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 (i.e., there is no payment for the removal of the normal appendix in the example).
3. Payment for surgical procedures for fracture care, dislocation treatment, debridement, wound repair, unna boot, and other related

Health Care Services, is included in the Allowed Amount of the surgical procedure.

Transplant Services

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

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

1. Bone Marrow Transplant, as defined herein, which is specifically listed in the rule 59B-127.001 of the *Florida Administrative Code* or any successor or similar rule or covered by Medicare as described in the most recently published Medicare Coverage Issues Manual issued by the Centers for Medicare and Medicaid Services. We will cover the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for you and will be subject to the same limitations and exclusions as would be applicable to you. Coverage for the reasonable expenses of searching for the donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;
2. corneal transplant;
3. heart transplant (including a ventricular assist device, if indicated, when used as a bridge to heart transplantation);
4. heart-lung combination transplant;
5. liver transplant;
6. kidney transplant;
7. pancreas transplant;
8. pancreas transplant performed simultaneously with a kidney transplant; or
9. lung-whole single or whole bilateral transplant.

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

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

Exclusion:

Expenses for the following are excluded:

1. transplant procedures not included in the list above, or otherwise excluded under this Booklet (e.g., Experimental or Investigational transplant procedures);
2. transplant procedures involving the transplantation or implantation of any non-human organ or tissue;
3. transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered by us;
4. transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ;
5. any organ, tissue, marrow, or stem cells which is/are sold rather than donated;
6. any Bone Marrow Transplant, as defined herein, which is not specifically listed in rule 59B-127.001 of the *Florida Administrative Code* or any successor or similar rule or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual;
7. any Service in connection with the identification of a donor from a local, state or

national listing, except in the case of a Bone Marrow Transplant;

8. any non-medical costs, including but not limited to, temporary lodging or transportation costs for you and/or your family to and from the approved facility; and
9. any artificial heart or mechanical device that replaces either the atrium and/or the ventricle.

Section 3: What Is Not Covered?

Introduction

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

Abortions which are elective.

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

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

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

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

Complementary or Alternative Medicine including, but not limited to, self-care or self-help training; homeopathic medicine and counseling; Ayurvedic medicine such as lifestyle modifications and purification therapies;

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

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

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

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

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

member or caregiver of a Covered Person to return to work.

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

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

Drugs

1. Prescribed for uses other than the Food and Drug Administration (FDA) approved label indications. This exclusion does not apply to any drug that has been proven safe, effective and accepted for the treatment of the specific medical Condition for which the drug has been prescribed, as evidenced by the results of good quality controlled clinical studies published in at least two or more peer-reviewed full length articles in respected national professional medical journals. This exclusion also does not apply to any drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the drug is recognized for treatment of your particular cancer in a Standard Reference Compendium or recommended for treatment

of your particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.

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

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

Food and Food Products prescribed or not, except as covered in the Enteral Formulas category of the “What Is Covered?” section.

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

General Exclusions include, but are not limited to:

1. any Health Care Service received prior to your Effective Date or after the date your coverage terminates;
2. any Health Care Service not within the service categories described in the “What Is Covered?” section, any rider, or Endorsement attached hereto, unless such Services are specifically required to be covered by applicable law;
3. any Health Care Service provided by a Physician or other health care Provider related to you by blood or marriage;
4. any Health Care Service which is not Medically Necessary, as determined by us and defined in this Booklet. The ordering of a Service by a health care Provider does not in itself, make such Service Medically Necessary or a Covered Service;
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) Services that are not patient-specific, as determined solely by us;
 - b) war or an act of war, whether declared or not;
 - c) your participation in, or commission of, any act punishable by law as a misdemeanor or felony, or which constitutes riot, or rebellion;
 - d) your engaging in an illegal occupation;
 - e) Services received at military or government facilities; or
 - f) Services received to treat a Condition arising out of your service in the armed forces, reserves and/or National Guard; or
 - g) the play or practice of collegiate or intercollegiate sports, including collegiate club sports and intramurals.
8. Health Care Services rendered because they were ordered by a court, unless such Services are Covered Services under this Benefit Booklet; and
 9. 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; and
 10. any Health Care Service rendered to Covered Students who specialize in the mental health field and who receive treatment as a part of their training in that field.

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

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

Immunizations except those covered under the Preventive Child Health Supervision Services or Preventive Adult Wellness Services categories of the "What Is Covered?" section.

Maternity Services rendered to a Covered Person who becomes pregnant as a Gestational Surrogate under the terms of, and in accordance with, a Gestational Surrogacy Contract or Arrangement. This exclusion applies to all expenses for prenatal, intra-partal, and post-partal maternity/obstetrical care, and Health Care Services rendered to the Covered Person acting as a Gestational Surrogate.

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

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

Orthomolecular Therapy including nutrients, vitamins, and food supplements.

Oversight of a medical laboratory by a Physician or other health care Provider, including, but not limited to, the oversight of the laboratory to assure timeliness, reliability, and/or usefulness of test results, or the oversight of the calibration of laboratory machines, testing equipment, or laboratory technicians.

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

1. beauty and barber services;
2. clothing including support hose;
3. radio and television;
4. guest meals and accommodations;
5. telephone charges;
6. take-home supplies;
7. travel expenses (other than Medically Necessary Ambulance Services);

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

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

Private Duty Nursing Care rendered at any location.

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

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

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

Smoking Cessation Programs including any Service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and

nicotine products (e.g., gum, transdermal patches, etc.).

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

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

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

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

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

Wigs and/or cranial prosthesis.

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 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.

Section 4: Medical Necessity

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

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

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

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

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

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

Section 5: Understanding Your Share of Health Care Expenses

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

Deductible Types

1. 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. Only those charges indicated on claims we receive for Covered Services will be credited toward the individual Deductible and only up to the applicable Allowed Amount.

2. Family Deductible:

Once your family has met the family Deductible, 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.

Note: Please see your Schedule of Benefits for more information.

Copayment Requirements

Covered Services rendered by certain Providers or at certain locations or settings will be subject to a Copayment requirement. This is the dollar amount you have to pay when you receive these Services. Please refer to your Schedule of Benefits for the specific Covered Services that are subject to a Copayment. Listed below is a

brief description of some of the Copayment requirements that may apply to your plan. If our Allowed Amount or the Provider's actual charge for a Covered Service rendered is less than the Copayment amount, you must pay the lesser of our Allowed Amount or the Provider's actual charge for the Covered Service.

1. Office Services Copayment:

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

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

2. Copayment for Inpatient Facility Services:

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 us for any claim for inpatient Covered Services. The Copayment for inpatient facility Services, if applicable to your plan, applies regardless of the reason for the admission, and applies to all inpatient admissions to a Hospital, Psychiatric Facility or Substance Abuse Facility in or outside the state of Florida.

Additionally, you will be responsible for out-of-pocket expenses for Covered Services provided by Physicians and other health care professionals for inpatient admissions.

Note: Copayments for inpatient facility Services may vary depending on the facility chosen. (Please see your Schedule of Benefits for more information).

3. Copayment for Outpatient Facility Services:

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

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

4. Copayment for Emergency Room Facility Services:

The Copayment for emergency room facility Services, if applicable to your plan, applies regardless of the reason for the visit, is in addition to any applicable Coinsurance amount, and applies to emergency room facility Services in or outside the state of Florida. The Copayment for emergency room facility Services, if applicable to your

plan, must be satisfied by you for each visit. If you are admitted to 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 Requirements

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

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

Out-of-Pocket Maximum

1. 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 we will pay for Covered Services rendered during the remainder of that Benefit Period at 100 percent of the Allowed Amount.

2. 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 the remainder of that Benefit Period and we will pay for Covered Services rendered during the remainder of that Benefit Period at 100 percent of the Allowed Amount. The maximum amount any one Covered Person in your family can contribute toward the family out-of-pocket maximum 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 Copayment and Coinsurance amounts will accumulate toward the out-of-pocket maximums. Any benefit penalty reductions, non-covered charges or any charges in excess of the Allowed Amount will not accumulate toward the out-of-pocket maximums. If the School Master Policy includes prescription drug coverage, any applicable Deductible, Coinsurance or Copayments, under the prescription drug coverage, will not apply to the Deductible or the out-of-pocket maximums under this Booklet.

Prior Coverage Credit

We will give you credit for the satisfaction or partial satisfaction of any Deductible and Coinsurance maximums met by you under a prior blanket insurance policy maintained by the School if the School Master Policy replaces such a policy. This provision only applies if the prior blanket insurance coverage offered by the School was in effect immediately preceding the Effective Date of this Student Medical Insurance Plan. This provision is only applicable for you during the initial period of coverage under the School Master Policy and the following rules apply:

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

For the initial Benefit Period under the School Master Policy only, charges credited by the School's prior insurer, towards your Deductible requirement, for Services rendered during the 90-day period

immediately preceding the Effective Date of the School Master Policy, will be credited to the Deductible requirement under this Booklet.

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

Charges credited by the School's prior insurer, towards your Coinsurance maximum, for Services rendered during the 90-day period immediately preceding the Effective Date of the School Master Policy, will be credited to your out-of-pocket maximum under this Booklet.

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

Prior coverage credit under this Booklet only applies at the initial enrollment of the entire School. You 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. any applicable Copayments;
2. expenses incurred for non-covered Services;
3. charges in excess of any maximum benefit limitation listed in your Schedule of Benefits (e.g., the lifetime maximums and/or Benefit Period maximums);
4. charges in excess of the Allowed Amount for Covered Services rendered by Providers who have not agreed to accept our Allowed Amount as payment in full;
5. any benefit reductions;
6. payment of expenses for claims denied because we did not receive information requested from you regarding whether or not

you have other coverage and the details of such coverage; and

7. charges for Health Care Services which are excluded.

Additionally, you are responsible for any Premium contribution amount required by your School.

How we will Credit Benefit Maximums

Only amounts actually paid by us for Covered Services will be credited towards any applicable benefit maximums and the total maximum benefit per person (lifetime maximum). The amounts we pay which are credited toward your benefit maximums and your total maximum benefit per person will be based on our Allowed Amount for the Covered Services provided.

Section 6: Physicians, Hospitals and Other Provider Options

Introduction

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

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

You are entitled to preferred provider type benefits when you receive Covered Services from In-Network Providers. You are entitled to traditional program type benefits at the point of service when you receive Covered Services from Traditional Program Providers or BlueCard® (Out-of-State) Traditional Program Providers, in conformity with the “BlueCard® (Out-of-State) Program” section of this Benefit Booklet.

Provider Participation Status

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

Your Schedule of Benefits designates the panel of NetworkBlue Providers who are participating for your specific plan of coverage. This is important because these Providers are considered your In-Network Providers for purposes of this Benefit Booklet.

With BlueOptions, you may choose to receive Services from any Provider. However, you will be able to lower the amount you have to pay for Covered Services by receiving care from an In-Network Provider. Although you have the option to select any Provider you choose, we encourage you to select and develop a relationship with an In-Network Family Physician. There are several advantages to selecting a Family Physician. Family 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 Family Physician allows the Physician to become knowledgeable about you and your family’s health history. A Family Physician can help you determine when you need to visit a specialist and also help you find one based on their knowledge of you and your specific health care needs. Types of Family Physicians are Family Practitioners, General Practitioners, Internal Medicine doctors and Pediatricians. Additionally, care rendered by Family Physicians usually results in lower out-of-pocket expenses for you. Whether you select a Family Physician or another type of Physician to render Health Care Services, please remember that using In-Network Providers will result in lower out-of-pocket expenses for you. You should always determine whether a Provider is In-Network or Out-of-Network prior to receiving Services to determine the amount you are responsible for paying out-of-pocket.

Location of Service

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

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

review your current BlueOptions Provider directory;

access the BlueOptions Provider directory on our website at www.bcbsfl.com; and/or call the customer service phone number in this Booklet or on your Identification Card.

In-Network Providers

When you use In-Network Providers, your out-of-pocket expenses for Covered Services will be lower. We will base our payment on the Allowed Amount at the Coinsurance percentage listed in your Schedule of Benefits. Consult your Schedule of Benefits to determine what panel of Providers in the BlueOptions Provider directory is designated as In-Network for your plan.

Out-of-Network Providers

When you use Out-of-Network Providers your out-of-pocket expenses for Covered Services will be higher. We will base our payment on the

Allowed Amount at the Coinsurance percentage listed in your Schedule of Benefits. Further, if the Out-of-Network Provider is a Traditional Program Provider or a BlueCard® (Out-of-State) Traditional Program Provider, our payment to such Provider may be under the terms of that Provider's contract. If your Schedule of Benefits and BlueOptions Provider directory do not include a Provider as In-Network under your benefit plan, the Provider is considered Out-of-Network.

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

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

Physicians

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

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

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

Hospitals

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

We are able to negotiate lower payment amounts with some Hospitals than with others. Because of this, In-Network Hospitals have been divided into two groups which are referred to as "options" on your Schedule of Benefits. The amount you are responsible for paying out-of-pocket may be different for each of these options. Remember that there are also different out-of-pocket expenses for Out-of-Network Hospitals.

Since not all Physicians admit patients to every Hospital, it is important when choosing a Physician that you determine the Hospitals

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

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

Other Providers

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

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

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

rendered at an outpatient facility other than a Hospital there may be an out-of-pocket expense for the facility Provider as well as an out-of-pocket expense for other types of Providers.

Assignment of Benefits to Providers

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

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

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

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

Providers Outside the State of Florida

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

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

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

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

usual BlueCard® method noted above in paragraph one of this section or require a surcharge, we will then calculate your liability for any Covered Services in accordance with the applicable state statute in effect at the time you received your care.

Section 8: Blueprint for Health Programs

Introduction

We have established (and from time to time establish) various customer-focused health education and information programs as well as benefit utilization management and utilization review programs. These programs, collectively called the Blueprint for Health Programs, are designed to 1) provide you with information that will help you make more informed decisions about your health; 2) help us facilitate the management and review of coverage and benefits provided under our policies; and 3) present opportunities, as explained below, to mutually agree upon alternative benefits or payment alternatives for cost-effective medically appropriate Health Care Services.

Admission Notification

Our admission notification requirements vary depending on whether you are admitted to a Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility which is In-Network or Out-of-Network. To find out about the participation status of any of these providers, you can:

1. review the Provider directory then in effect;
2. access our website at www.bcbsfl.com; and/or
3. call the customer service phone number in this Booklet or on your Identification Card.

In-Network

Under the admission notification requirement, we must be notified of all inpatient admissions (i.e., elective, planned, urgent or emergency) to In-Network Hospitals, Psychiatric Facilities, Substance Abuse Facilities or Skilled Nursing Facilities. While it is the sole responsibility of the In-Network Provider located in Florida to comply with our admission notification

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

Out-of-Network

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

Inpatient Facility Program

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

effect, a concurrent review of the inpatient stay may occur at regular intervals. We will provide notification to your Physician when inpatient coverage criteria are no longer met. In administering the inpatient facility program, we may review specific medical facts or information and assess, among other things, the appropriateness of the Services being rendered, health care setting and/or the level of care of an inpatient admission or other health care treatment program. Any such reviews by us, and any reviews or assessments of specific medical facts or information which we conduct, are solely for purposes of making coverage or payment decisions under this Benefit Booklet and not for the purpose of recommending or providing medical care.

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

Provider Focused Utilization Management Program

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

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

Exception for Certain NetworkBlue Physicians

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

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

Member Focused Programs

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

Personal Case Management Program

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

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

Under the personal case management program, we may elect to offer alternative benefits or payment for cost-effective Health Care Services. These alternative benefits or payments may be made available by us on a case-by-case basis when you meet our case management criteria then in effect. Such alternative benefits or payments, if any, will be made available in accordance with a treatment plan with which you, or your representative, and your Physician agree to in writing.

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

Health Information, Promotion, Prevention and Illness Management Programs

These Blueprint for Health Programs may include health information that supports member education and choices for health care issues. These programs focus on keeping you well, help to identify early preventive measures of treatment and help members with chronic problems to enjoy lives that are as productive and healthy as possible. These programs may include prenatal educational programs and illness management programs for Conditions such as diabetes, cancer and heart disease. These programs are voluntary and are designed to enhance your ability to make informed choices and decisions for your unique health care needs. You may call the toll free customer

service number on your Identification Card for more information. Your participation in this program is completely voluntary.

IMPORTANT INFORMATION RELATING TO BCBSF'S BLUEPRINT FOR HEALTH PROGRAMS

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

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

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

Section 9: Pre-existing Conditions Exclusion Period

Introduction

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

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

1. the Covered Student and each Covered Dependent who was covered under the School's prior medical plan on the date immediately preceding the Effective Date of coverage under this Booklet;
2. pregnancy;
3. Genetic Information in the absence of a diagnosis of the Condition;
4. routine follow-up care of breast cancer after the person was determined to be free of breast cancer;
5. Conditions arising from domestic violence; or
6. 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; or
7. you when the School has elected to waive, in writing, at the time of School Application the Pre-existing Conditions exclusionary period for all subsequent

Eligible Students and/or Eligible Dependents;

8. a newborn child or an adopted newborn child properly enrolled under this Booklet; or
9. an adopted child that has Creditable Coverage.

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

Pre-existing Condition Definition

A Pre-existing Condition means any Condition related to a physical or mental Condition, regardless of the cause of the Condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the six-month period immediately preceding your Effective Date of coverage under the School Master Policy.

Reducing the Pre-existing Conditions Exclusionary Period

No matter whether you enroll when first eligible or at a later date you may be able to reduce or even eliminate the Pre-existing Conditions exclusionary period if you have prior Creditable Coverage.

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

If, on the other hand, you are enrolling under this Booklet at any other time as allowed under its terms, your Pre-existing Conditions exclusionary period will be reduced by the amount of any

Creditable Coverage you have; provided there is no more than a 63-day break in coverage prior to your Enrollment Date in this Booklet.

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

Creditable Coverage

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

1. a group health insurance plan;
2. individual health insurance;
3. Medicare Part A 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. State Children's Health Insurance Program (S-CHIP);
12. public health plans established by the federal government; or
13. public health plans established by foreign governments.

Proving Creditable Coverage

You may provide a Prior/Concurrent Coverage Affidavit or Certification of Creditable Coverage to prove the amount of time you were covered under Creditable

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

Section 10: Eligibility for Coverage

Eligibility for Coverage

Some students may be required to maintain adequate health insurance. Your school will tell you if you must have coverage. For example, Federal visa regulations require international J-1 students and their J-2 dependents to maintain adequate health insurance throughout their stay in the United States.

If the above paragraph applies to you and you are not currently insured, or your plan does not provide comparable coverage in South Florida, you will be required to enroll in coverage under this Benefit Booklet.

Each student who is eligible to participate in the Student Medical Insurance Plan, and who meets and continues to meet our eligibility requirements described in this Booklet, shall be entitled to apply for coverage with us under this Booklet. These eligibility requirements are binding upon you and/or your eligible family members as well as the School. No changes in our eligibility requirements will be permitted unless we have been notified of and have agreed in writing to any such change in advance. We may require acceptable documentation that an individual meets and continues to meet the eligibility requirements such as a court order naming the Covered Student as the legal guardian or appropriate adoption documentation described in the "When Coverage Begins and Ends" section.

In order to be eligible to enroll as a Covered Student, an individual must be an Eligible Student. An Eligible Student must fall into one of the student classification types identified on the Student Health and Accident Blanket Insurance Application.

In addition, in order to be covered under this Benefit Booklet, a student must actively attend

classes for at least the first 31 days after the date for which coverage is purchased.

Note: Home study, correspondence and television (TV) courses do not meet the requirement of actively attending classes.

If the eligibility requirements are not met, our only obligation is to refund the Premium, less any claims paid.

The eligibility criteria for Students category may be expanded by the school to include other types of students. Any expansion of the Eligible Student criteria must be approved in writing by us and the School prior to such expansion, and may be subject to different Rates.

Eligibility Requirements for Dependent(s)

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

1. The Covered Student's spouse under a legally valid existing marriage;
2. The Covered Student's natural, newborn, adopted, Foster, or step child(ren) (or a child for whom the Covered Student has been court-appointed as legal guardian or legal custodian) until the end of the Calendar Year in which the child reaches age 25 (or in the case of a Foster Child, is no longer eligible under the Foster Child Program), and who is:
 - a) dependent upon the Covered Student for financial support; and
 - i. living in the household of the Covered Student or is a full-time or part-time student; or
 - ii. the child does not live in the household of the Covered Student

and is not enrolled as a full or part-time student because the child has not met the age requirement to begin elementary school education;
or

3. The newborn child of a Covered Dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Note: It is your sole responsibility as the Covered Student to establish that a child meets the applicable requirements for eligibility. Eligibility will terminate on the date in which the child no longer meets the eligibility criteria required to be an Eligible Dependent.

Section 11: When Coverage Begins and Ends

General Rules for Enrollment

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

Any Eligible Student or Eligible Dependent who is not properly enrolled with us will not be covered under this Booklet. We will have no obligation whatsoever to any individual who is not properly enrolled.

1. Some students will automatically be enrolled in the Student Medical Insurance Plan upon registration for classes, as determined by the School. Coverage can be waived if evidence of other comparable coverage is presented prior to the waiver deadline. See the Waiver Procedure subsection for more information.

Students who have previously waived participation in the Plan may enroll after the deadline, only if there has been a significant life change (i.e. loss of prior coverage), and should contact the Servicing Agent.

2. Any Student and/or Eligible Dependent who is eligible for coverage under this Booklet may apply for coverage by providing the applicable enrollment information to the Servicing Agent.
3. All factual representations must be accurate and complete. Any false, incomplete, or misleading information provided during the enrollment process, or at any other time, may result, in addition to any other legal right(s) we may have, in disqualification for, termination of, or rescission of coverage.
4. We will not provide coverage and benefits to any individual who would not have been entitled to enrollment with us, had accurate and complete information been provided on a timely basis. In such cases, we may

require you or an individual legally responsible for you, to reimburse us for any payments we made on your behalf.

Electing Coverage

To apply for coverage, if not automatically enrolled, you as the Eligible Student must:

1. submit, to the Servicing Agent, the necessary enrollment information, if applicable;
2. provide any additional information needed to determine eligibility, at our request;
3. pay your portion of the required Premium; and
4. submit, to the Servicing Agent, the applicable enrollment information to add Eligible Dependents or delete Covered Dependents.

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

Student Only Coverage - covers the Eligible Student only.

Student/Spouse Coverage - covers the Eligible Student and the student's spouse under a legally valid existing marriage.

Student/Child(ren) Coverage - covers the Eligible Student and the student's eligible child(ren) only.

Student/Family Coverage - covers the Eligible Student and the student's Eligible Dependents.

There may be an additional Premium charge for each Covered Dependent based on the coverage selected by the School.

Enrollment Periods

Eligible Students and their Eligible Dependents may enroll in the Student Health Insurance Plan during the enrollment periods specified by the School on the Student Health and Accident Blanket Insurance Application. These enrollment periods affect when your coverage begins and ends, how long coverage will last through the school year, and the number of days you have to enroll following your first day of eligibility under that enrollment period.

Failure to enroll during the specified enrollment period and before the enrollment period's deadline date, will delay your and your Eligible Dependents' enrollment in coverage until the next applicable enrollment period begins, unless a significant life change occurs.

Waiver Procedure

When students are automatically enrolled, and have other comparable coverage, the student must file a waiver by the deadline established by the School in order to waive participation in the Student Medical Insurance Plan.

If the waiver information has not been received by the Servicing Agent by the indicated deadline, the student will remain enrolled in the School's Student Medical Insurance Plan and the premium charge for the Student Medical Insurance Plan cannot be removed.

Dependent Enrollment

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

Newborn Child – To enroll a newborn child who is an Eligible Dependent, the Covered Student must submit the applicable enrollment information to the Servicing Agent. The Effective Date of coverage for a newborn child will be the date of birth. We must be notified, in writing, and the following

guidelines will be applied when enrolling a newborn child:

- a. If the Servicing Agent receives written notice within 30 days after the date of birth, the Effective Date of coverage will be the date of birth and no Premium will be charged for the newborn child for the first 30 days of coverage.
- b. If the Servicing Agent receives written notice 31 to 60 days after the date of birth, the Effective Date of coverage will be the date of birth and the appropriate Premium will be charged from the date of birth.
- c. If the Servicing Agent receives written notice more than 60 days after the date of birth and an enrollment period specified by the School **has not** occurred since the date of birth, the Effective Date of coverage will be the date of birth and the appropriate Premium will be charged from the date of birth.
- d. If the Servicing Agent receives written notice more than 60 days after the date of birth and an enrollment period specified by the School **has** occurred, the newborn child may not be added until the next applicable enrollment period as specified by the School.

Note: The guidelines above only apply to newborns born after the Effective Date of the Covered Student. If a child is born before the Effective Date of the Covered Student and was not added during the initial enrollment period, the Servicing Agent must receive the applicable enrollment information. If the enrollment information is received within 30 days after the birth of the child, no Premium will be charged for the first 30 days of coverage. If the enrollment information is received 31-60 days after the birth of the child, any applicable Premium must be paid back to the Effective Date of coverage of the Covered Student. In the event the Servicing

Agent is not notified within 60 days of the birth of the newborn child, the Covered Student must make application during the applicable enrollment period as specified by the School.

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

1. **Adopted Newborn Child** – To enroll an adopted newborn child, the Covered Student must submit the applicable enrollment information to the Servicing Agent. The Effective Date of coverage for an adopted newborn child, eligible for coverage, will be the moment of birth, provided that a written agreement to adopt such child has been entered into by the Covered Student prior to the birth of such child, whether or not such an agreement is enforceable. The Servicing Agent may require the Covered Student to provide any information and/or documents which we deem necessary in order to administer this provision. The following guidelines will be applied when enrolling an adopted newborn child. If the Servicing Agent receives written notice within 30 days after the birth, the Effective Date of coverage will be the date of birth and no Premium will be charged for the first 30 days of coverage for the adopted newborn child.
2. If the Servicing Agent receives written notice 31 to 60 days after the birth, the Effective Date of coverage will be the date of birth and the appropriate Premium will be charged from the date of birth.
3. If the Servicing Agent receives written notice more than 60 days after the date of birth and an enrollment period specified by the School **has not** occurred, the Effective Date of coverage

will be the date of birth and the appropriate Premium will be charged from the date of birth.

4. If the Servicing Agent receives written notice more than 60 days after the date of birth and an enrollment period specified by the School **has** occurred, the adopted newborn child may not be added until the next applicable enrollment period as specified by the School.

Note: The guidelines above only apply to adopted newborns born after the Effective Date of the Covered Student. If a child is born before the Effective Date of the Covered Student and was not added during the Initial Enrollment Period, the Servicing Agent must receive the applicable enrollment information. If the enrollment information is received within 30 days after the birth of the child, no Premium will be charged for the first 30 days of coverage. If the enrollment information is received 31-60 days after the birth of the adopted newborn child, any applicable Premium must be paid back to the Effective Date of coverage of the Covered Student. In the event the Servicing Agent is not notified within 60 days of the birth of the adopted newborn child, the Covered Student must make application during the applicable enrollment period as specified by the School.

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

Adopted/Foster Children – To enroll an adopted child or Foster Child, the Covered Student must submit the applicable enrollment information during the 30-day period immediately following the date of placement and pay the additional Premium, if any. The

Effective Date for an adopted child or Foster Child (other than an adopted newborn child) will be the date such adopted or Foster Child is placed in the residence of the Covered Student in compliance with Florida law. If timely notice is given, no additional Premium will be charged for coverage of the adopted child for the duration of the notice period. Any Pre-existing Condition exclusionary period will not apply to an adopted child but will apply to a Foster Child. We may require the Covered Student to provide any information and/or documents we deem necessary, in order to properly administer this section.

In the event the Servicing Agent is not notified within 30 days of the date of placement, the child will be added as of the date of placement so long as the Covered Student provides notice to the School, and the Servicing Agent receives the enrollment information within 60 days of the placement, and any applicable Premium is paid back to the date of placement. In the event the Servicing Agent is not notified within 60 days of the date of placement, the Covered Student must make application during the applicable enrollment period as specified by the School in order for the adopted child or Foster Child to be covered.

For all children covered as adopted children, if the final decree of adoption is not issued, coverage shall not be continued for the proposed adopted child. It is the responsibility of the Covered Student to notify the Servicing Agent if the adoption does not take place. Upon receipt of this notification, we will terminate the coverage of the child as of the Effective Date of the adopted child upon receipt of the written notice.

If the Covered Student's status as a foster parent is terminated, coverage will end for any Foster Child. It is the responsibility of the Covered Student to notify the Servicing Agent in writing that the Foster Child is no longer in the Covered Student's care. Upon receipt of this notification, we will terminate the coverage of the

child on the date provided by the Servicing Agent.

Marital Status –The Covered Student may apply for coverage of an Eligible Dependent spouse due to a legally valid marriage. To apply for coverage, the Covered Student must provide the applicable enrollment information to the Servicing Agent. The Covered Student must make application for enrollment within 30 days of the marriage. The Effective Date of coverage for an Eligible Dependent spouse who is enrolled as a result of marriage is the date of the marriage.

Court Order – The Covered Student may apply for coverage for an Eligible Dependent outside of the Initial Enrollment Period and the applicable enrollment period as specified by the School if a court has ordered coverage to be provided for a minor child under their plan. To apply for coverage, the Covered Student must complete a Student Enrollment Card and send it to the Servicing Agent. The Covered Student must make application for enrollment within 30 days of the court order. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order is the date required by the court.

Termination of a Covered Student's Coverage

If you withdraw from School within the first 31 calendar days of the semester, you will receive a full refund of the insurance premium unless you or your covered dependent files a medical claim. If you withdraw from School after the first 31 calendar days of the semester, your coverage will remain in effect until the end of the period for which you have paid Premium. No refunds will be granted after the first 31 calendar days of the semester.

This also applies to students on leave of absence for medical or academic reasons, graduating students, and students choosing to

enroll in a separate, comparable, or better plan during the policy period.

In addition, a Covered Student's coverage will automatically terminate at 12:01 a.m.:

1. on the date the School Master Policy terminates;
2. on the last day of the period for which you have paid premium;
3. on the date the Covered Student's coverage is terminated for cause (see the Termination of Coverage for Cause subsection); or
4. on the date specified by the Servicing Agent that the Covered Student's coverage terminates.
5. on the date the Covered Student enters the armed forces of any country. A pro rata refund of Premium will be made for such student upon written request, if the referenced request is made within 90 days of the withdrawal from the School.

Termination of a Covered Dependent's Coverage

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

1. on the date the School Master Policy terminates;
2. on the date Covered Student's coverage terminates for any reason;
3. on the date that the Covered Dependent fails to continue to meet any of the applicable eligibility requirements (e.g., a child reaches the limiting age, or a spouse is divorced from the Covered Student);
4. on the date we specify that the Covered Dependent's coverage is terminated by us for cause; or
5. on the date specified by the School that the Covered Dependent's coverage terminates.

6. on the date the Covered Dependent enters the armed forces. A pro rata refund of Premium will be made for such dependent upon written request, if the referenced request is made within 90 days of the dependent's entry in the armed forces.

In the event, you as the Covered Student, wish to delete a Covered Dependent from coverage, the applicable enrollment information should be forwarded to the Servicing Agent.

In the event you as the Covered Student wish to terminate a spouse's coverage, (e.g., in the case of divorce), you must submit the applicable enrollment information to the Servicing Agent, prior to the requested termination date or within 10 days of the date the divorce is final, whichever is applicable.

Termination of Coverage for Cause

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

1. fraud, material misrepresentation or omission in applying for coverage or benefits;
2. the knowing misrepresentation, omission or the giving of false information by or on your behalf; or
3. misuse of the Identification Card.

Notice of Termination

It is the School's responsibility to immediately notify you of termination of the School Master Policy for any reason.

Responsibilities of BCBSF Upon Termination of Your Coverage

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

Certification of Creditable Coverage

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

The certification of Creditable Coverage will indicate the period of time you were enrolled with us. Creditable Coverage may reduce the length of any Pre-existing Condition exclusionary period by the length of time you had prior Creditable Coverage.

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

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

Section 12: Extension of Benefits

Extension of Benefits

In the event the School Master Policy is terminated, we will not provide coverage for any Service rendered on or after the termination date. The extension of benefits provisions described below only apply when the entire School Master Policy is terminated. The extension of benefits described in this section do not apply when your coverage terminates if the School Master Policy remains in effect. The extension of benefits provisions are subject to all of the other provisions, including the limitations and exclusions.

Note: It is your sole responsibility to provide acceptable documentation to us showing that you are entitled to an extension of benefits.

1. In the event you are totally disabled on the termination date of the School Master Policy as a result of a specific Accident or illness incurred while you were covered under this Booklet, as determined by us, we will provide a limited extension of benefits for the disabled individual only. This extension of benefits is for Covered Services necessary to treat the disabling Condition only. This extension of benefits will only continue as long as the disability is continuous and uninterrupted. In any event, this extension of benefits will automatically terminate at the end of the 12-month period beginning on the termination date of the School Master Policy.

For purposes of this section, you will be considered “totally disabled” only if, in our opinion, you are unable to work at any gainful job for which you are suited by education, training, or experience, and you require regular care and attendance by a Physician. You are totally disabled only if, in our opinion, you are unable to perform those

normal day-to-day activities which you would otherwise perform and you require regular care and attendance by a Physician.

2. In the event you are receiving covered dental treatment as of the termination date of the School Master Policy, we will provide a limited extension of such covered dental treatment provided:
 - a) a course of dental treatment or dental procedures were recommended in writing and commenced in accordance with the terms specified herein while you were covered under the School Master Policy;
 - b) the dental procedures were procedures for other than routine examinations, prophylaxis, x-rays, sealants, or orthodontic services; and
 - c) the dental procedures were performed within 90 days after the School Master Policy terminated.

This extension of benefits is for Covered Services necessary to complete the dental treatment only. This extension of benefits will automatically terminate at the end of the 90-day period beginning on the termination date of the School Master Policy or on the date you become covered under a succeeding insurance, health maintenance organization or self-insured plan providing coverage or Services for similar dental procedures. You are not required to be totally disabled in order to be eligible for this extension of benefits.

Please refer to the Dental Services category of the “What Is Covered?” section for a description of the dental care Services covered under this Booklet.

3. In the event you are pregnant as of the termination date of the School Master Policy, we will provide a limited extension of the maternity expense benefits provided by this Booklet, provided the pregnancy commenced while the pregnant individual was covered under the School Master Policy, as determined by us. This extension of benefits is for Covered Services necessary to treat the pregnancy only. This extension of benefits will automatically terminate on the date of the birth of the child. You are not required to be totally disabled in order to be eligible for this extension of benefits.

Section 13: Subrogation and Right of Reimbursement

Subrogation

If you are injured or become ill as a result of another person's or entity's intentional act, negligence or fault, you must notify us concerning the circumstances under which you were injured or became ill. You or your lawyer must notify us, 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, we are legally entitled to recover payments made on your behalf to the doctors, Hospitals, or other Providers who treated you. Our legal right to recover money we have paid in such cases is called "subrogation". We may recover the amount of any payments we made on your behalf minus our pro rata share for any costs and attorney fees incurred by you in pursuing and recovering damages. We may subrogate against all money recovered regardless of the source of the money including, but not limited to, uninsured motorists coverage. Although we may, but are not required to, take into consideration any special factors relating to your specific case in resolving our subrogation claim, we 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 our right of subrogation hereunder and no waiver, release of liability, or other documents executed by you, without notice to us and our written consent, will be binding upon us.

Right of Reimbursement

If any payment under this Booklet is made to you or on your behalf with respect to any injury

or illness resulting from the intentional act, negligence, or fault of a third person or entity, we 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 this Booklet minus a pro rata share for any costs and attorney fees incurred in pursuing and recovering such proceeds.

Our right of reimbursement will be in addition to any subrogation right or claim available to us, 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 us to exercise our right of reimbursement hereunder. You or your lawyer must notify us, by certified or registered mail, if you intend to claim damages from someone for injuries or illness. You must do nothing to prejudice our right of reimbursement hereunder and no waiver, release of liability, or other documents executed by you, without notice to us and our written consent, will be binding upon us.

Section 14: Claims Processing

Types of Claims

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

Post-Service Claims

How to File a Post-Service Claim

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

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

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

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

1. the date the Service was provided;
2. a description of the Service including any applicable procedure code(s);

3. the amount actually charged by the Provider;
4. the diagnosis including any applicable diagnosis code(s);
5. the Provider's name and address;
6. the name of the individual who received the Service; and
7. the Covered Student's name and contract number as they appear on the Identification Card.

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

Note: Please refer to the pharmacy program Endorsement, if applicable, for information on the processing of prescription drug claims. Further, special claims processing rules may apply for Health Care Services you receive outside the state of Florida under the BlueCard® Program (See the "BlueCard® (Out-of-State) Program" section of this Booklet).

The Processing of Post-Service Claims

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

• Payment for Post-Service Claims

When payment is due under the terms of this Benefit Booklet, we will use our best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, we will use our best efforts to pay (in whole or in part) for paper Post-Service Claims within 40 days of receipt. You may receive notice of payment for paper claims within 30 days of receipt.

- Effective November 14, 2008, the reference to the number of days for the payment of electronically submitted Post-Service Claims, from Physicians licensed as Doctors of Medicine (M.D.) or Doctors of Osteopathy (D.O.) only, is changed from 20 days to 15 business days or 20 calendar days, whichever is less.
- Effective November 14, 2008, the reference to the number of days for the payment of paper submitted Post-Service Claims, from Physicians licensed as Doctors of Medicine (M.D.) or Doctors of Osteopathy (D.O.) only, is changed from 40 days to 30 business days or 40 calendar days, whichever is less.

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

- **Contested Post-Service Claims**

In the event we contest an electronically submitted Post-Service Claim, or a portion of such a claim, we will use our best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is contested. In the event we contest a Post-Service Claim submitted on a paper claim form, or a portion of such a claim, we will use our best efforts to provide notice, within 30 days of receipt, that the claim or a portion of the claim is contested.

- Effective August 14, 2008, the reference to the number of days for the notice that a Post-Service Claim, from Physicians licensed as Doctors of Medicine (M.D.) or Doctors of Osteopathy (D.O.) only, is contested or denied for an electronically submitted claim is changed from 20 days to 15 business days or 20 calendar days, whichever is less.

Our notice may identify: 1) the contested portion or portions of the claim; 2) the reason(s) for contesting the claim or a portion of the claim;

and 3) the date that we reasonably expect to notify you of the decision. The notice may also indicate whether additional information is needed in order to complete processing of the claim. If we request additional information, we must receive it within 45 days of our request for the information. **If we do not receive the requested information, the claim or a portion of the claim will be adjudicated based on the information in our possession at the time and may be denied.** Upon receipt of the requested information, we will use our best efforts to complete the processing of the Post-Service Claim within 15 days of receipt of the information.

- **Denial of Post-Service Claims**

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

Additional Processing Information for Post-Service Claims

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

is subject to the payment of simple interest at the rate established by *Florida Insurance Code*.

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

Pre-Service Claims

How to File a Pre-Service Claim

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

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

Appealing a Claim Denial

You, or a representative designated by you in writing, have the right to appeal a denied claim. We will review your appeal through the review process described below. Your appeal must be submitted in writing to us within 365 days of the original claim denial. The following guidelines are applicable to reviews of denied claims:

1. We must receive your appeal of a denied claim in person or in writing;
2. If the claim denial is based on the lack of Medical Necessity of a particular Service or the Experimental or Investigational limitations and exclusions or other similar exclusions or limitations, you may request, free of charge, an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of this Benefit Booklet to your medical circumstances;

Your request for appeal should be sent to the address below:

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

Timing of Our Appeal Review

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

Your Rights Under Florida Statute 627.6141

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

Additional Claims Processing Provisions

1. Release of Information/Cooperation:
In order to process claims, we may need certain information, including information regarding other health care coverage you may have. You must cooperate with us in

our effort to obtain such information by, among other ways, signing any release of information form at our request. Failure by you to fully cooperate with us may result in a denial of the pending claim and we will have no liability for such claim.

2. Legal Actions:

No legal action arising out of or in connection with coverage under this Benefit Booklet may be brought against us within the 60-day period following our receipt of the completed claim as required herein.

Additionally, no such action may be brought after expiration of the applicable statute of limitations.

3. Fraud, Misrepresentation or Omission in Applying for Benefits:

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

4. Explanation of Benefits Form:

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

- a) The specific reason or reason(s) the claim was denied;
- b) Reference to the specific Benefit Booklet provisions upon which the denial is based;
- c) A description of any additional material or information necessary to make the

claim payable and why such material or information is necessary;

- d) A description of the applicable appeal procedures and the time limits applicable to such procedures; and
- e) An explanation of the steps to be taken if you want a claim denial decision reviewed.

5. Circumstances Beyond Our Control:

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

Section 15: General Provisions

Access to Information

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

Right to Receive Necessary Information

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

Amendment

The terms of coverage and benefits to be provided by us may be amended at renewal of the School Master Policy, without the consent of the School, you or any other person, upon 45 days prior written notice to the School. In the event the amendment is unacceptable to the School, the School may terminate the School Master Policy upon at least ten days prior written notice to us. Any such amendment will be without prejudice to claims filed with us and related to Covered Services prior to the date of such amendment. No agent or other person, except a duly authorized officer of BCBSF, has the authority to modify the terms of the School Master Policy, or to bind us in any manner not

expressly described herein, including but not limited to the making of any promise or representation, or by giving or receiving any information. The terms of coverage and benefits to be provided by us may not be amended by the School, unless such amendment is evidenced in writing and signed by a duly authorized officer of BCBSF. The School shall immediately notify you of any such amendment and/or shall assist us in notifying you at our request.

Assignment and Delegation

Your obligations arising hereunder may not be assigned, delegated or otherwise transferred by you without the written consent of BCBSF. We may assign our coverage and/or benefit obligations to our successor in interest or an affiliated entity without the consent of the School at any time. **Any assignment, delegation, or transfer made in violation of this provision shall be void.**

Changes in Premium

We may modify the Rates at any time, without your consent, upon at least 45 days prior notice to the School. It is the School's responsibility to immediately notify you if your financial contribution requirement is changed due to a change in Rates.

Right to Recovery

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

Compliance with State and Federal Laws and Regulations

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

Confidentiality

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

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

Evidence of Coverage

You have been provided with this Benefit Booklet and an Identification Card as evidence of coverage under the School Master Policy issued by us to the School.

Governing Law

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

Identification Cards

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

Modification of Provider Network and the Participation Status

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

Cooperation Required of You and Your Covered Dependents

You must cooperate with us, and must execute and submit to us any consents, releases, assignments, and other documents we may request in order to administer, and exercise our

rights hereunder. Failure to do so may result in the denial of claims and will constitute grounds for termination for cause by us (see the Termination of an Individual's Coverage for Cause subsection in the "When Coverage Begins and Ends" section).

Non-Waiver of Defaults

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

Notices

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

If to us:

To the address printed on the Student Health and Accident Blanket Insurance Application and/or the Identification Card.

If to you:

To the latest address provided by you or the Servicing Agent.

You must notify us immediately of any address change.

If to the School:

To the address indicated on the Student Health and Accident Blanket Insurance Application.

Our Obligations upon Termination

Upon termination of your coverage for any reason, we will have no further liability or

responsibility to you under the School Master Policy, except as specifically described herein.

Promissory Estoppel

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

Relationships Between the Parties

BCBSF and Health Care Providers

Neither BCBSF nor any of its officers, directors or employees provides Health Care Services to you. Rather, we are engaged in making coverage and benefit decisions under this Benefit Booklet. By accepting our coverage and benefits, you agree that making such coverage and benefit decisions does not constitute the rendering of Health Care Services and that health care Providers rendering those Services are not 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 we make concerning appropriateness of setting, or whether any Service is Medically Necessary, shall be deemed to be made solely for purposes of determining whether such Services are covered, and not for purposes of recommending any treatment or non-treatment. In addition, we assume no liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

BCBSF and the School

Neither the School nor any person covered under this Booklet is our agent or representative, and neither shall be liable for any acts or omissions by our agents, servants, employees, or us. Additionally, we will not be liable, whether in tort or contract or otherwise, for any acts or

omissions of any other person or organization with which we have made or hereafter make arrangements for the provision of Covered Services. We are not your agent, servant, or representative nor are we an agent, servant, or representative of the School and we will not be liable for any acts or omissions, or those of the School, its agents, servants, employees, or any person or organization with which the School has entered into any agreement or arrangement. By acceptance of coverage and benefits hereunder, you agree to the foregoing.

Medical Treatment Decisions - Responsibility of Your Physician, Not BCBSF

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

Coordination of Benefits

Coordination of Benefits ("COB") determines the manner in which expenses will be paid when you are covered under more than one health plan, program, or policy providing benefits for Health Care Services. This provision is required by and subject to applicable federal and/or Florida law concerning coordination of health insurance benefits and will be modified to the extent necessary to enable us to comply with such laws.

This Student Medical Insurance Plan will always be considered primary; therefore, we will pay for Covered Services without regard to coverage under other plans.

Florida Agency for Health Care Administration (AHCA) Performance Outcome and Financial Data

The performance outcome and financial data published by AHCA, pursuant to *Florida Statute* 408.05, or any successor statute, located at the website address www.floridahealthstat.com, may be accessed through the link provided on Blue Cross and Blue Shield of Florida's corporate website at www.bcbsfl.com.

Third Party Beneficiary

The School Master Policy under which this Benefit Booklet was issued was entered into solely and specifically for the benefit of BCBSF and the School. The terms and provisions of the School Master Policy shall be binding solely upon, and inure solely to the benefit of, BCBSF and the School and its Covered Students, and no other person shall have any rights, interest or claims thereunder, or under this Benefit Booklet, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. BCBSF and the School hereby specifically express their intent that health care Providers that have not entered into contracts with BCBSF to participate in BCBSF's Provider networks shall not be third-party beneficiaries under the Master Policy or this Benefit Booklet.

Section 16: Definitions

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

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

Accidental Dental Injury means an injury to Sound Natural Teeth 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.

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

1. In the case of an In-Network Provider located in Florida, this amount will be established in accordance with the applicable agreement between that Provider and BCBSF.
2. In the case of an In-Network Provider located outside of Florida, this amount will generally be established in accordance with the negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to us, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the "BlueCard® (Out-of-State) Program" section for more details.
3. In the case of Out-of-Network Providers located in Florida who participate in the Traditional Program, this amount will be

established in accordance with the applicable agreement between that Provider and BCBSF.

4. In the case of Out-of-Network Providers located outside of Florida who participate in the BlueCard® (Out-of-State) Traditional Program, this amount will generally be established in accordance with the negotiated price that the Host Blue passes on to us, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the "BlueCard® (Out-of-State) Program" section for more details.
5. In the case of Out-of-Network Providers that have not entered into any agreement with BCBSF, or with another Blue Cross and/or Blue Shield organization to provide access to Provider discounts under the BlueCard® (Out of State) Program, the Allowed Amount will be the lesser of the Provider's actual charge or an amount established by BCBSF based on several factors including (but not necessarily limited to): BCBSF's medical, payment, and/or administrative guidelines; pre-negotiated payment amounts; diagnostic related grouping(s) (DRG); payment for such Services under the Medicare program; relative value scales; the charge(s) of the Provider; the charge(s) of similar Providers within a particular geographic area established by BCBSF; and/or the cost of providing the Covered Service.

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

You may obtain an estimate of the Allowed Amount for particular services by calling the customer service telephone number included in this Booklet or on your Identification Card. The fact that we may provide you with such information does not mean that the particular Service is a Covered Service. All terms and conditions included in 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.

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

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

Anniversary Date means the date, one year after the Effective Date, stated on the Student Health and Accident Blanket Insurance Application and subsequent annual anniversaries.

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.

Benefit Booklet or Booklet means the certificate of coverage, which is evidence of coverage under the School Master Policy.

Benefit Period means a consecutive period of time specified by BCBSF and the School, in which benefits accumulate toward the satisfaction of Deductibles and Coinsurance and toward any applicable benefit maximums. Please refer to your Schedule of Benefits for your Benefit Period.

Birth Center means a facility or institution, other than a Hospital or Ambulatory Surgical Center, which is properly licensed pursuant to Chapter 383 of the *Florida Statutes*, or a similar applicable law of another state, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy.

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

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

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

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

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative therapy. Human blood precursor cells may be obtained from the patient in an autologous transplant, or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral

part of the treatment involving bone marrow transplantation, the term "Bone Marrow Transplant" includes the transplantation as well as the administration of chemotherapy and the chemotherapy drugs. The term "Bone Marrow Transplant" also includes any Services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all Hospital, Physician or other health care Provider Health Care Services which are rendered in order to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells (e.g., Hospital room and board and ancillary services).

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

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

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

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

Coinsurance means the sharing of health care expenses for Covered Services between BCBSF and you. After your Deductible requirement is met, BCBSF will pay a percentage of the Allowed Amount for Covered Services, as listed

in your Schedule of Benefits. The percentage you are responsible for is your Coinsurance.

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 nurse (ARNP) who operates under a set of clinical protocols that strictly circumscribe the Conditions the ARNP can treat. Although no Physician is present at the Convenient Care Center, medical oversight is based on a written collaborative agreement between a supervising Physician and the ARNP.

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

Covered Dependent means an Eligible Dependent who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the School Master Policy other than as a Covered Student (see the Eligibility Requirements for Dependent(s) subsection of the "Eligibility for Coverage" section).

Covered Person means a Covered Student or a Covered Dependent.

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

Covered Student(s) means an Eligible Student who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the School Master Policy other than as a Covered Dependent (see the Eligibility Requirements for Covered

Students subsection of the “Eligibility for Coverage” section).

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

Deductible means the amount of charges, up to the Allowed Amount, for Covered Services, which you must actually pay to an appropriate licensed health care Provider, who is recognized for payment under this Booklet, before our payment for Covered Services begins.

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

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

Dialysis Center means an outpatient facility certified by the Centers for Medicare and Medicaid Services (CMMS) and the Florida

Agency for Health Care Administration (or a similar regulatory agency of another state) to provide hemodialysis and peritoneal dialysis services and support.

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

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

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

Effective Date means, with respect to the School, 12:01 a.m. on the date specified on the Student Health and Accident Blanket Insurance Application. With respect to individuals covered under this School Master Policy, 12:01 a.m. on the date the School specifies that the coverage will commence as further described in the “When Coverage Begins and Ends” section of this Benefit Booklet.

Eligible Dependent means a Covered Student's:

1. legal spouse under a legally valid, existing marriage; or
2. natural, newborn, adopted, Foster, or step child(ren); or
3. a child for whom the Covered Student has been court-appointed as legal guardian or legal custodian;

who meets and continues to meet all of the eligibility requirements described in the “Eligibility for Coverage” section in this Benefit Booklet.

Eligible Dependent also includes a newborn child of a Covered Dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child. **Refer to the “Eligibility for Coverage” section for limits on eligibility.**

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

Endorsement means an amendment to the School Master Policy or this Booklet issued by BCBSF.

Enrollment Date means the date of enrollment of the individual under the School Master Policy

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

1. such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the Florida Department of Health and approval for marketing has not, in fact, been given at the time such is furnished to you; or
2. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its

objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device; or

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

therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

"Credible scientific evidence" shall mean (as determined by us):

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

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

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

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

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

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

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

Health Care Services or Services includes treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds, and

other services rendered or supplied, by or at the direction of, Providers.

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

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

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

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

The term Hospital does not include: an Ambulatory Surgical Center; a Skilled Nursing Facility; a stand-alone Birthing Center; a Psychiatric Facility; a Substance Abuse Facility; a convalescent, rest or nursing home; or a

facility which primarily provides Custodial, educational, or Rehabilitative Therapies.

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

Identification (ID) Card means the card(s) we issue to Covered Students. The card is our property, and is not transferable to another person. Possession of such card in no way verifies that a particular individual is eligible for, or covered under, the School Master Policy.

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

Independent Diagnostic Testing Facility means a facility, independent of a Hospital or Physician's office, which is a fixed location, a mobile entity, or an individual non-Physician practitioner where diagnostic tests are performed by a licensed Physician or by licensed, certified non-Physician personnel under appropriate Physician supervision. An Independent Diagnostic Testing Facility must be appropriately registered with the Agency for Health Care Administration and must comply

with all applicable Florida 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 Facility.

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

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

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

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

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

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

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

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

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

1. in accordance with Generally Accepted Standards of Medical Practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury or disease;
3. not primarily for your convenience, or that of your Physician or other health care Provider, and not more costly than an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness.

Note: It is important to remember that any review of Medical Necessity by us is solely for the purposes of determining coverage or benefits under this Booklet and not for the

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

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

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

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

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

Morbid Obesity is a Condition where an individual is 100 pounds over their ideal body weight and/or Body Mass Index (BMI) of equal to or greater than 40.

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

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

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

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

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

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

1. did not have a contract with us to participate in NetworkBlue but was participating in our Traditional Program; or
2. did not have a contract with a Host Blue to participate in its local PPO Program for purposes of the BlueCard® (Out-of-State) PPO Program but was participating, for purposes of the BlueCard® (Out-of-State) Program, as a BlueCard® (Out-of-State) Traditional Program Provider; or

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

Outpatient Rehabilitation Facility means an entity which renders, through Providers properly licensed pursuant to Florida law or the similar law or laws of another state: outpatient Physical Therapy; outpatient Speech Therapy; outpatient Occupational Therapy; outpatient cardiac rehabilitation therapy; and outpatient Massage for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition. Further, such an entity must meet 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 in Chapter 59A, *Florida Administrative Code* or the similar law or laws of another state.

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

Partial Hospitalization means treatment in which an individual receives at least seven hours of institutional care during a portion of a 24-hour period and returns home or leaves the

treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered a "home" for purposes of this definition.

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

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

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

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

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

Post-Service Claim means any paper or electronic request or application for coverage, benefits, or payment for a Service actually provided to you (not just proposed or recommended) that is received by us on a properly completed claim form or electronic format acceptable to us in accordance with the provisions of the “Claims Processing” section.

Pre-Service Claim means any request or application for coverage or benefits for a Service that has not yet been provided to you and with respect to which the terms of this Benefit Booklet condition payment for the Service (in

whole or in part) on approval by us of coverage or benefits for the Service before you receive it. A Pre-Service Claim may be a claim involving urgent care. As defined herein, a Pre-Service Claim shall not include a request for a decision or opinion by us regarding coverage, benefits, or payment for a Service that has not actually been rendered to you if the terms of this Benefit Booklet do not require (or condition payment upon) approval by us of coverage or benefits for the Service before it is received.

Premium means the amount required to be paid to BCBSF in order for there to be coverage under the School Master Policy.

Prior/Concurrent Coverage Affidavit means the form that an Eligible Student can submit to us as proof of the amount of time the Eligible Student was covered under Creditable Coverage.

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

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

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

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

Psychologist means a person properly licensed to practice psychology pursuant to Chapter 490

of the *Florida Statutes*, or a similar applicable law of another state.

Rate means the amount BCBSF charges for each type of coverage under the School Master Policy (e.g., Student Only Coverage).

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

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

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

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

School means the college or university through which coverage and benefits are issued by us, and through which you and your Covered Dependents become entitled to coverage and benefits for the Covered Services described herein.

School Master Policy means the written document, which is the agreement between the School and us whereby coverage and benefits will be provided to you and any Covered Dependents. The School Master Policy includes this Benefit Booklet (including the Schedule of Benefits), the Student Health and Accident Blanket Insurance Application, and any

Endorsements to this Benefit Booklet or the School Master Policy.

Self-Administered Injectable Prescription Drug means an FDA-approved injectable Prescription Drug that you may administer to yourself, as recommended by a Physician, by means of injection, excluding Insulin.

Servicing Agent means or refers to an entity that provides overall consultative services to the School for the Student Medical Insurance Plan. The Servicing Agent may also perform administrative functions (e.g., enrollment and billing).

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

Sound Natural Teeth means teeth that are whole or properly restored (restoration with amalgams, resin or composite only); are without impairment, periodontal, or other Conditions; and are not in need of Services provided for any reason other than an Accidental Dental Injury. Teeth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated with endodontics, are not Sound Natural Teeth.

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

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

Standard Reference Compendium means:

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

Student Health and Accident Blanket Insurance Application means the BCBSF form, electronic (where available) or paper, including the underwriting questionnaire form, if any, that the School must submit to BCBSF when requesting the issuance of the School Master Policy.

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

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

Traditional Program means, or refers to, BCBSF's provider contracting programs called Payment for Physician Services (PPS) and Payment for Hospital Services (PHS).

Traditional Program Providers means, or refers to, those health care Providers who are not NetworkBlue Providers, but who, or which, have entered into a contract, then in effect, to participate in BCBSF's Traditional Program as applicable in Florida or in certain counties outside of Florida when such programs exist.

Urgent Care Center means a facility properly licensed that: 1) is available to provide Services to patients at least 60 hours per week with at least twenty-five (25) of those available hours after 5:00 p.m. on weekdays or on Saturday or Sunday; 2) posts instructions for individuals seeking Health Care Services, in a conspicuous

public place, as to where to obtain such Services when the Urgent Care Center is closed; 3) employs or contracts with at least one or more Board Certified or Board Eligible Physicians and Registered Nurses (RNs) who are physically present during all hours of operation. Physicians, RNs, and other medical professional staff must have appropriate training and skills for the care of adults and children; and 4) maintains and operates basic diagnostic radiology and laboratory equipment in compliance with applicable state and/or federal laws and regulations.

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

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

Section 17: Value Added Services - Medical Evacuation and Repatriation

Introduction

This section describes value added Services that may be offered through BCBSF or offered through a third party under contract with BCBSF to provide these value added services.

Medical Evacuation

Medical transportation Services may be covered, provided it is Medically Necessary to transport you from:

3. a Hospital which is unable to provide proper care to the nearest Hospital that can provide proper care; or
4. the place a medical emergency occurs to the nearest Hospital that can provide proper care.

Expenses for evacuation, and fees necessary to arrange for the evacuation, are covered, up to the lifetime maximum listed in your Schedule of Benefits.

The attending Physician must certify, in writing, that the evacuation is Medically Necessary. Medical evacuation Services must be authorized in advance by calling 1-800-810-2503

1. Medical Repatriation

Medical repatriation takes place after you have received medical care and the local attending Physician determines you are able to return home to continue your recovery and/or rehabilitation; or continue your trip. Coverage includes expenses for transportation and fees necessary to arrange for you to be transported from the facility to either your primary residence or back to the place where you were evacuated.

Expenses for transportation and fees necessary to arrange for medical repatriation are covered, up to the lifetime maximum listed in your Schedule of Benefits.

Medical repatriation Services must be authorized in advance by calling 1-800-810-2503

Exclusion:

No coverage is provided for any travel, evacuation, or repatriation expenses arising directly or indirectly as a result of:

1. intentionally self-inflicted harm, suicide or attempted suicide;
2. alcohol or substance abuse or use, or Conditions or physical complications related thereto;
3. normal pregnancy, fertility treatments, childbirth or elective abortion, other than unforeseen complications of pregnancy;
4. participation in, or training for, professional sports or amateur sporting events;
5. all extreme, high risk sports, including bodily contact sports; skydiving, hang gliding, bungee jumping, parachuting, mountain climbing or any high altitude activities, caving, heli-skiing or extreme skiing;
6. scuba diving (unless accompanied by a dive master and deeper than 130 feet);
7. operating or learning to operate any aircraft as pilot or crew;
8. nuclear reaction, radiation or radioactive contamination;
9. natural disasters;
10. epidemic or pandemic;

11. pollution or threat of pollutant release;
12. any unlawful acts committed or attempted by the Covered Person;
13. travel, the purpose of which is to receive medical care, treatment or medication; or
14. Services provided to a Covered Person who provides incorrect data or facts.

Please refer to your Schedule of Benefits for the lifetime maximum benefit for medical evacuation and medical repatriation. Medical evacuation Services are separate from, and in addition to the Ambulance Services described in the “What Is Covered” section of this booklet. Expenses for medical evacuation and medical repatriation do not accumulate toward the Ambulance Services benefit maximum listed in your Schedule of Benefits.

Repatriation of Remains

If a Condition results in loss of life while outside the individual's home country and while covered under the Student Medical Insurance Plan, expenses for preparing and transporting the individual's remains to a funeral facility in the home country of the deceased may be available. This does not include the transportation expenses of anyone accompanying the remains.

All medical transportation services must be authorized in advanced by calling 1-800-810-2503.

Please refer to your Schedule of Benefits for information regarding the lifetime maximum benefit for repatriation of remains.

BlueScript[®] Pharmacy Program Endorsement

This Endorsement and the BlueScript Pharmacy Program Schedule of Benefits are to be attached to, and made a part of, your Blue Cross and Blue Shield of Florida, Inc. ("BCBSF") Benefit Booklet. The Benefit Booklet is hereby amended by adding the following BlueScript Pharmacy Program provisions.

If you have any questions concerning this Endorsement, please call Blue Cross and Blue Shield of Florida toll free at 1-800-FLA-BLUE.

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

References to "we", "us", and "our" throughout refer to BCBSF.

Introduction

Under this BlueScript Pharmacy Program Endorsement, we provide coverage to you for certain Prescription Drugs and Supplies and select Over-the-Counter ("OTC") Drugs purchased at a Pharmacy. In order to obtain benefits under this Endorsement, you must pay, at the time of purchase, the Pharmacy Deductible, if any, and the applicable Copayment or percentage of the Participating Pharmacy Allowance indicated on the BlueScript Pharmacy Program Schedule of Benefits.

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

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

To verify if a Pharmacy is a Participating Pharmacy, you may access the Pharmacy Program Provider Directory at our website at www.bcbsfl.com, call the customer service number on your Identification Card, or refer to the Pharmacy Program Provider Directory then in effect.

Covered Prescription Drugs and Supplies and Covered OTC Drugs

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

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

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

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

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

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

Contraceptive Coverage

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

Exclusion

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

Covered Over-the-Counter (OTC) Drugs

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

Medication Guide are covered and coverage for these OTC Drugs is limited to up to a maximum of a One-Month Supply.

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

Note: OTC Drugs are not covered when purchased at a Non-Participating Pharmacy.

Diabetic Coverage

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

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

Exclusion

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

Mineral Supplements, Fluoride or Vitamins

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

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

Exclusion

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

Limitations and Exclusions

Limitations

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

1. we will not cover more than the maximum supply, as set forth in the BlueScript Pharmacy Program Schedule of Benefits, per Prescription for Covered Prescription Drugs and Supplies or Covered OTC Drugs;
2. Prescription refills beyond the time limit specified by state and/or federal law are not covered.;
3. certain Covered Prescription Drugs and Supplies and Covered OTC Drugs require prior coverage authorization in order to be covered.
4. Retin-A or it's generic or therapeutic equivalent is excluded after age 26.

Exclusions

Expenses for the following are excluded:

1. Prescription Drugs and OTC Drugs that are covered and payable under a specific

subsection of the "What Is Covered?" section of your Benefit Booklet, which this Endorsement amends (e.g., Prescription Drugs which are dispensed and billed by a Hospital or Physician);

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

- d. indicated or used for the treatment of infertility, except when indicated as covered on the BlueScript Pharmacy Program Schedule of Benefits;
 - e. used for cosmetic purposes including but not limited to Minoxidil, Rogaine, Renova. (Retin-A is excluded after age 26);
 - f. prescribed by a Pharmacist;
 - g. used for smoking cessation (e.g., Chantix, Zyban), except when indicated as covered on the BlueScript Pharmacy Program Schedule of Benefits;
 - h. listed in the Homeopathic Pharmacopoeia;
 - i. not Medically Necessary;
 - j. indicated or used for sexual dysfunction (e.g., Cialis, Levitra, Viagra, Caverject,), except when indicated as covered on the BlueScript Pharmacy Program Schedule of Benefits. The exception described in item number 11 does not apply to sexual dysfunction drugs excluded under this paragraph
 - k. purchased outside of the United States; or
 - l. prescribed by any health care professional not licensed in any state or territory (e.g., Puerto Rico, U.S. Virgin Islands or Guam) of the United States of America.
8. Mineral supplements, fluoride or vitamins except for those items listed in the Coverage and Benefit Guidelines for Covered Prescription Drugs and Supplies and Covered OTC Drugs subsection;
 9. Any appetite suppressant and/or other Prescription Drug and/or OTC Drug indicated, or used, for purposes of weight reduction or control, except when indicated as covered on the BlueScript Pharmacy Program Schedule of Benefits;
 10. Immunization agents, biological sera, blood and blood plasma;
 11. Drugs prescribed for uses other than the FDA-approved label indications. This exclusion does not apply to any Drug that has been proven safe, effective and accepted for the treatment of the specific medical Condition for which the Drug has been prescribed, as evidenced by the results of good quality controlled clinical studies published in at least two or more peer reviewed full length articles in respected national professional medical journals. This exclusion also does not apply to any Drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the Drug is recognized for treatment of cancer in a Standard Reference Compendium or recommended for such treatment in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded;
 12. Prescription Drugs and OTC Drugs that have not been approved by the FDA as required by federal law for distribution or delivery into interstate commerce;
 13. Drugs that do not have a valid National Drug Code;
 14. Drugs that are compounded except those that have at least one active ingredient that is an FDA-approved Prescription Drug with a valid National Drug Code;
 15. Any Drug prescribed in excess of the manufacturer's recommended specifications for dosages, frequency of use, or duration of administration as set forth in the manufacturer's insert for such Drug. This exclusion does not apply if:
 - a. the dosages, frequency of use, or duration of administration of a Drug has been shown to be safe and effective as

evidenced in published peer-reviewed medical or pharmacy literature;

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

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

17. Any amount you are required to pay under this Endorsement as indicated on the

BlueScript Pharmacy Program Schedule of Benefits.

- 18. Self-prescribed Drugs or Supplies and Drugs or Supplies prescribed by any person related to you by blood or marriage.
- 19. Any OTC Drug that is not listed in the Medication Guide as a Covered OTC Drug.
- 20. Food or medical food products, whether prescribed or not.

Payment Rules

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

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

A Brand Name Prescription Drug included on the Preferred Medication List then in effect will be reclassified as a Non-Preferred Prescription Drug on the date the FDA approves a bioequivalent Generic Prescription Drug. Non-Preferred Prescription Drugs are subject to a higher Copayment or percentage of the

Participating Pharmacy Allowance set forth in the BlueScript Pharmacy Program Schedule of Benefits.

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

Pharmacy Alternatives

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

Participating Pharmacies

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

With BlueScript, there are two types of Participating Pharmacies:

1. Pharmacies in Florida that have signed a BlueScript Participating Pharmacy Provider Agreement with us;
2. National Network Pharmacies; and

To verify if a Pharmacy is a Participating Pharmacy, you may access the Pharmacy Program Provider Directory at our website at www.bcbsfl.com, call the customer service number included in your Benefit Booklet or on your Identification Card, or refer to the Pharmacy Program Provider Directory then in effect.

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

When charges for Covered Prescription Drugs and Supplies or OTC Drugs by a Participating Pharmacy are less than the required Copayment, the amount you will pay depends on the agreement then in effect between the Pharmacy and us and will be one of the following:

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

Non-Participating Pharmacies

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

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

You may be responsible for paying the full cost of the Covered Prescription Drugs and Supplies at the time of purchase and must submit a claim to us for reimbursement. Our reimbursement for Covered Prescription Drugs and Supplies, will be based on 80% of the applicable Participating Pharmacy Allowance less the Pharmacy Deductible, if any, and the Copayment or percentage of the Participating Pharmacy

Allowance amount set forth in the BlueScript Pharmacy Program Schedule of Benefits.

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

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

Pharmacy Utilization Review Programs

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

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

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

Our pharmacy utilization review programs include the following:

Step Therapy Program

Under this program, we may exclude from coverage certain Prescription Drugs and OTC

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

Prior to filling your Prescription, your Physician may, but is not required to, contact us to request coverage for a Prescription Drug or OTC Drug subject to the step therapy program by following the procedures for prior coverage authorization outlined in this section.

Dose Optimization Program

Under this program, we may exclude from coverage any Prescription Drug or OTC Drug prescribed in excess of the Maximum specified in the Medication Guide.

Prior Coverage Authorization

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

Note: This does not mean that you cannot obtain the Prescription Drug from the Pharmacy. It only means that we will not cover or pay for the Prescription Drug. You are always free to purchase the Prescription Drug at your sole expense.

Information on Prescription Drugs that require prior coverage authorization is published in the Medication Guide provided to you, on our website at www.bcbsfl.com, or you may call the customer service number on your Identification Card. Your Pharmacist may also advise you if a

Prescription Drug requires coverage authorization.

To obtain prior coverage authorization:

1. You or your Physician must call the customer service number on the Identification Card and provide any information required by us in order to process the request for coverage authorization.
2. If you call, we may request that you have your Physician contact us regarding the Prescription Drug, Supply or OTC Drug being prescribed. If the Physician calls, specific medical documentation may be required to be provided to us. This information may also include, but is not limited to, your name, date of birth, Physician's name and Physician's telephone number.
3. Once we make a decision, you or your Physician will be informed.
4. If the decision is made to authorize coverage, you are eligible to obtain the Covered Prescription Drugs and Supplies or Covered OTC Drugs at a Participating Pharmacy subject to the amount you are required to pay as listed in the BlueScript Pharmacy Program Schedule of Benefits.
5. If the decision is made to not authorize coverage, you are still free to purchase the Prescription Drug Supplies or OTC Drug, but you will have to pay the full cost of the medication and will not be entitled to reimbursement under this Endorsement. You have the right to request a reconsideration if coverage authorization is denied. Please refer to the How to Appeal a Claim Denial subsection of the "Claims Processing" section in the current BlueOptions Benefit Booklet for information on how to file an appeal.

To request a reconsideration if coverage authorization is denied:

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

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

Ultimate Responsibility for Medical Decisions

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

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

Any and all decisions that require or pertain to independent professional medical judgments or training, or the need for a Prescription Drug, Supply or OTC Drug, must be made solely by

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

Definitions

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

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

Covered OTC Drug means an Over-the-Counter Drug that is covered under the terms of this Endorsement. Covered OTC Drugs are denoted with a symbol in the Medication Guide.

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

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

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

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

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

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

FDA means the United States Food and Drug Administration.

Generic Prescription Drug means a Prescription Drug containing the same active ingredients as a Brand Name Prescription Drug that either (i) has been approved by the FDA for sale or distribution as the bioequivalent of a Brand Name Prescription Drug through an abbreviated new drug application under 21 U.S.C. 355 (j); or (ii) is a Prescription Drug that is not a Brand Name Prescription Drug, is legally marketed in the United States and, in the judgment of BCBSF, is marketed and sold as a generic competitor to its Brand Name Prescription Drug equivalent. All Generic Drugs are identified by an "established name" under 21

U.S.C. 352 (e), by a generic name assigned by the United States Adopted Names Council, or by an official or non-proprietary name, and may not necessarily have the same inactive ingredients or appearance as the Brand Name Prescription Drug.

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

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

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

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

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

Non-Preferred Prescription Drug means a Generic Prescription Drug or Brand Name

Prescription Drug that is not included on the Preferred Medication List then in effect. Note: The Medication Guide is subject to change at any time. Please refer to our website at www.bcbsfl.com for the most current guide or you may call the customer service number on your Identification Card.

One-Month Supply means a maximum quantity per Prescription up to a 31-day supply as defined by the Drug manufacturer's dosing recommendations.

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

Participating Pharmacy means, as to Pharmacies located in Florida, a Pharmacy that has signed a Participating Pharmacy Provider Agreement with us to participate in the BlueScript Pharmacy Program. National Network Pharmacies are also Participating Pharmacies.

Participating Pharmacy Allowance means the maximum amount allowed to be charged by a Participating Pharmacy per Prescription for Covered Prescription Drug or Covered Prescription Supply under this Endorsement.

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

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

Pharmacy Benefit Manager means an organization that has established, and manages, a pharmacy network and other pharmacy management programs for third party payers and employers which has entered into an

arrangement with us to make such a network and/or programs available to you.

Pharmacy Deductible means the amount of allowed charges for Covered Prescription Drugs and Supplies and Covered OTC Drugs that you must actually pay per 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 Endorsement, before our payment for Covered Prescription Drugs and Supplies and OTC Drugs begins.

Pharmacy Out-of-Pocket Maximum means the maximum amount you will be required to pay per Benefit Period for Covered Prescription Drugs and Supplies and OTC Drugs.

Preferred Brand Name Prescription Drug means a Brand Name Prescription Drug that is included on the Preferred Medication List then in effect. The Preferred Medication List is contained within the Medication Guide. A Preferred Brand Name Prescription Drug on the Preferred Medication List then in effect will be reclassified as a Non-Preferred Prescription Drug on the date the FDA approves a bioequivalent Generic Prescription Drug. Note: The Medication Guide is subject to change at any time. Please refer to our website at www.bcbsfl.com for the most current guide or you may call the customer service number on your Identification Card.

Preferred Generic Prescription Drug means a Generic Prescription Drug on the Preferred Medication List then in effect. The Preferred Medication List is contained within the Medication Guide. Note: The Medication Guide is subject to change at any time. Please refer to our website at www.bcbsfl.com for the most current guide or you may call the customer service number on your Identification Card.

Preferred Medication List means a list of Preferred Prescription Drugs then in effect, which have been designated by us as preferred and for which we provide coverage and benefits,

subject to the exclusions of this Endorsement. The Preferred Medication List is contained within the Medication Guide. Note: The Medication Guide is subject to change at any time. Please refer to our website at www.bcbsfl.com for the most current guide or you may call the customer service number on your Identification Card.

Preferred Prescription Drug means a Prescription Drug that appears on the Preferred Medication List then in effect. A Preferred Prescription Drug may be a Brand Name Prescription Drug or a Generic Prescription Drug. The Preferred Medication List is contained within the Medication Guide. Note: The Medication Guide is subject to change at any time. Please refer to our website at www.bcbsfl.com for the most current guide or you may call the customer service number on your Identification Card.

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

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

Self-Administered Injectable Prescription Drug means an FDA-approved injectable Prescription Drug that you may administer to yourself, as recommended by a Physician, by means of injection, excluding Insulin. Covered Self-Administered Injectable Prescription Drugs

are denoted with a symbol in the Medication Guide.

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

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.

A handwritten signature in black ink, appearing to read "Robert I. Lufrano M.D.", written in a cursive style.

Robert I. Lufrano M.D.
Chairman of the Board and Chief Executive Officer

Medical Evacuation and Repatriation Endorsement

This Endorsement is to be attached to and made a part of the Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Benefit Booklet and any Endorsements attached thereto. The Benefit Booklet is amended as described below.

If you have any questions concerning this Endorsement, please call Blue Cross and Blue Shield of Florida toll free at 1-800-FLA-BLUE.

The "Value Added Services - Medical Evacuation and Repatriation" section is amended by **changing** the telephone number for authorization of Medical evacuation and repatriation Services to 1-800-810-2583.

The "Value Added Services - Medical Evacuation and Repatriation" section is further amended by **adding** the following telephone number for authorization of Medical evacuation and repatriation Services abroad: 1-804-673-1777.

All other provisions of the Benefit Booklet shall remain unchanged. This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Benefit Booklet, other than as specifically stated in the provisions contained in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Benefit Booklet, the provisions contained in this Endorsement shall control to the extent necessary to effectuate the intent of Blue Cross and Blue Shield of Florida, Inc. as expressed herein.

Blue Cross and Blue Shield of Florida, Inc.



Robert I. Lufrano, M.D.
Chairman of the Board and Chief Executive Officer