

# The School Board of Polk County

Effective January 1, 2021

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## OVERVIEW OF THE PLAN

The following provisions of this booklet contain a summary in English of your rights and benefits under the plan. If you have questions about your benefits, please contact our Customer Service Department at 1-855-630-6824. If needed, simply request a translator and one will be provided to assist you in understanding your benefits.

***Las siguientes disposiciones de este folleto contienen un resumen en inglés de sus derechos y beneficios bajo el plan. Si usted tiene preguntas acerca de sus beneficios, por favor póngase en contacto con nuestro Departamento de Servicio al Cliente al 1-855-630-6824. Si es necesario, basta con solicitar un traductor de español y se le proporcionará uno para ayudarle a entender sus beneficios.***

### Purpose of the Plan

The plan is intended to help you and your covered dependents pay for the costs of medical care. The plan does not pay for all of your medical care. For example, you may be required to contribute through payroll deduction before you obtain coverage under the plan. You may also be required to pay deductibles, copayments, and coinsurance.

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

### Using ExploreMyPlan to Get More Information

By being a member of the plan, you get exclusive access to **ExploreMyPlan** – an online service only for members. Use it to easily manage your healthcare coverage. All you have to do is register at [FL.ExploreMyPlan/Register](#). With **ExploreMyPlan**, you have 24-hour access to personalized healthcare information, PLUS easy-to-use online tools that can help you save time and efficiently manage your healthcare:

- Download and print your benefit booklet or Summary of Benefits and Coverage.
- Request replacement or additional ID cards.
- View all your claim reports in one convenient place.
- Find a doctor.
- Track your health progress.
- Take a health assessment quiz.
- Get fitness, nutrition, and wellness tips.
- Get prescription drug information.

### BlueCare Health Advocate

By being a member of the plan, you have access to a BlueCare Health Advocate who serves as a personal coach and advisor. Your BlueCare Health Advocate can explain your benefits, help you to locate a doctor or specialist and help you make an appointment, research and resolve hospital and doctor billing issues, assist you in finding support groups and community services available to you, and much more. To find out more or to contact your BlueCare Health Advocate, call our Customer Service Department at the number on the back of your ID card.

## Definitions

Near the end of this booklet you will find a section called [Definitions](#), which identifies words and phrases that have specialized or particular meanings. In order to make this booklet more readable, we generally do not use initial capitalized letters to denote defined terms. Please take the time to familiarize yourself with these definitions so that you will understand your benefits.

## Receipt of Medical Care

Even if the plan does not cover benefits, you and your provider may decide that care and treatment are necessary. You and your provider are responsible for making this decision.

Generally, after-hours care is provided by your physician. They may have a variety of ways of addressing your needs. You should call your physician for instructions on how to receive medical care after the physician's normal business hours, on weekends and holidays, or to receive non-emergency care for a condition that is not life threatening, but requires medical attention.

If you are in severe pain or your condition is endangering your life, you may obtain emergency care by calling 911 or visiting an emergency room.

Having a primary care physician is a good decision:

Although you are not required to have a primary care physician, it is a good idea to establish a relationship with one. Having a primary care physician has many benefits, including:

- Seeing a physician who knows you and understands your medical history.
- Having someone you can count on as a key resource for your healthcare questions.
- Help when you need to coordinate care with specialists and other providers.

Typically, primary care physicians specialize in family medicine, internal medicine or pediatrics. Find a physician in your area by visiting [FL.ExploreMyPlan/FindADoctor](#).

Seeing a specialist or behavior health provider is easy:

If you need to see a specialist or behavioral health provider, you can contact their office directly to make an appointment. If you choose to see a specialist or Blue Choice Behavioral Health provider, you will have the maximum benefits available for services covered under the plan. If you choose to see an out-of-network specialist or non-Blue Choice behavioral health provider, your benefits could be lower.

## Beginning of Coverage

The section of this booklet called [Eligibility](#) will tell you what is required for you to be covered under the plan and when your coverage begins.

## Limitations and Exclusions

In order to maintain the cost of the plan at an overall level that is reasonable to all plan members, the plan contains a number of provisions that limit benefits. There are also exclusions that you need to pay particular attention to as well. These provisions are found through the remainder of this booklet. You need to be aware of these limits and exclusions in order to take maximum advantage of this plan.

## Medical Necessity and Precertification

The plan will only pay for care that is medically necessary and not investigational, as determined by us. We develop medical necessity standards to aid us when we make medical necessity determinations. We publish these standards at [FL.ExploreMyPlan/policies](#). The definition of medical necessity is found in the [Definitions](#) section of this booklet.

In some cases, the plan requires that you or your treating physician precertify the medical necessity of your care. Please note that precertification relates only to the medical necessity of care; it does not mean that your care will be covered under the plan. Precertification also does not mean that we have been paid all monies necessary for coverage to be in force on the date that services or supplies are rendered. The

section called [Medical Necessity and Precertification](#) later in this booklet tells you when precertification is required and how to obtain precertification.

## **In-Network Benefits**

One way in which the plan tries to manage healthcare costs is through negotiated discounts with in-network providers. As you read the remainder of this booklet, you should pay attention to the type of provider that is treating you. If you receive covered services from an in-network provider, you will normally only be responsible for out-of-pocket costs such as deductibles, copayments, and coinsurance. If you receive services from an out-of-network provider, these services may not be covered at all under the plan. In that case, you will be responsible for all charges billed to you by the out-of-network provider. If the out-of-network services are covered, in most cases, you will have to pay significantly more than what you would pay an in-network provider because of lower benefit levels and higher cost-sharing. As one example, out-of-network facility claims will often include very expensive ancillary charges (such as implantable devices) for which no extra reimbursement is available as these charges are not separately considered under the plan. Additionally, out-of-network providers have not contracted with us or any Blue Cross and/or Blue Shield plan for negotiated discounts and can bill you for amounts in excess of the allowed amounts under the plan.

In-network providers are hospitals, physicians, pharmacies, and other healthcare providers or suppliers that contract with us or any Blue Cross and/or Blue Shield plans (directly or indirectly through, for example, a pharmacy benefit manager) for furnishing healthcare services or supplies at a reduced price.

Examples of the plan's Florida in-network providers are:

- BlueCard PPO
- Participating Hospitals
- Preferred Outpatient Facilities
- Participating Ambulatory Surgical Centers
- Participating Renal Dialysis Providers
- Preferred Medical Doctors (PMD)
- Preferred Medical Laboratories
- Select Lab Network
- Blue Choice Behavioral Health Network
- Participating Chiropractors
- Participating Physician Assistants
- Participating Nurse Practitioners
- Preferred Occupational Therapists
- Preferred Physical Therapists
- Preferred Speech Therapists
- Participating CRNA
- Participating Ground Ambulance
- Participating Licensed Registered Dietitian Network
- Pharmacy Vaccine Network
- Pharmacy Select Network
- Preferred DME Supplier
- Participating Air Medical Transport

	IN-NETWORK	OUT-OF-NETWORK
<b>What expenses are you responsible for paying?</b>	<ul style="list-style-type: none"> <li>Any applicable Copayments, Deductible(s) and/or Coinsurance requirements;</li> <li>Expenses for Services which are not covered;</li> <li>Expenses for Services in excess of any benefit maximum limitations; and</li> <li>Expenses for Services which are excluded.</li> </ul>	
<b>Who is responsible for filing your claims?</b>	The Provider will file the claim for you and payment will be made directly to the Provider.	You are responsible for filing the claim and payment will be made directly to the member.
<b>Can you be billed the difference between what the Provider is paid and the Provider's charge?</b>	NO. You are protected from being billed for the difference in the Allowed Amount and the Provider's charge when you use In-Network Providers. The Provider will accept the Allowed Amount as payment in full for Covered Services except as otherwise permitted under the terms of the Provider's contract and this plan.	YES. You are responsible for paying the difference between what we pay and the Provider's 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. You are also responsible for determining the corresponding payment options, if any; at the time the Health Care Services are rendered.

To locate Florida in-network providers, go to [FL.ExploreMyPlan/FindADoctor](#).

1. Click "Find a Doctor."
2. In the search box, you can select the category you would like to search under (doctor, hospital, dentist, pharmacy, etc.) or keep on All Categories to search all. Type in the provider's name to search or leave blank to see all results.
3. In the "Network or Plan" section, use the drop down menu to select a specific provider network (as noted above).

Search tip: If your search returns zero results, try expanding the number in the "Distance" drop-down.

A special feature of your plan gives you access to the national network of providers called BlueCard PPO. Each local Blue Cross and/or Blue Shield plan designates which of its providers are PPO providers. In order to locate a PPO provider in your area, you should call the BlueCard PPO toll-free access line at 1-800-810-BLUE (2583) or visit [FL.ExploreMyPlan.com](#) and log into your myBlueCross. Search for a specific provider by typing their name in the Search Term box or click Search to see all in-network providers for your plan. To receive in-network PPO benefits for lab services, the laboratory must contract with the Blue Cross and/or Blue Shield plan located in the same state as your physician. When you or your physician orders durable medical equipment (DME) or supplies, the service provider must participate with the Blue Cross and/or Blue Shield plan where the supplies are shipped. If you purchase DME supplies directly from a retail store, they must contract with the Blue Cross and/or Blue Shield plan in the state or service area where the store is located. PPO providers will file claims on your behalf with the local Blue Cross and/or Blue Shield plan where services are rendered. The local Blue Cross and/or Blue Shield plan will then forward the claims to us for verification of eligibility and determination of benefits.

Sometimes a network provider may furnish a service to you that is either not covered under the plan or is not covered under the contract between the provider and Blue Cross and Blue Shield of Florida or the local Blue Cross and/or Blue Shield plan where services are rendered. When this happens, benefits may be denied or may be covered under some other portion of the plan, such as [Other Covered Services](#).



## **Relationship Between Blue Cross and/or Blue Shield Plans and the Blue Cross and Blue Shield Association**

Blue Cross and Blue Shield of Florida is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The Blue Cross and Blue Shield Association permits us to use the Blue Cross and Blue Shield service marks in the state of Florida. Blue Cross and Blue Shield of Florida is not acting as an agent of the Blue Cross and Blue Shield Association. No representation is made that any organization other than Blue Cross and Blue Shield of Florida and your employer will be responsible for honoring this contract. The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of Blue Cross and Blue Shield of Florida not created under the original agreement.

## **Claims and Appeals**

When you receive services from an in-network provider, your provider will generally file claims for you. In other cases, you may be required to pay the provider and then file a claim with us for reimbursement under the terms of the plan. If we deny a claim in whole or in part, you may file an appeal with us. We will give you a full and fair review. Thereafter, you may have the right to an external review by an independent, external reviewer. The provisions of the plan dealing with claims, appeals, and external reviews are found further on in this booklet.

## **Changes in the Plan**

From time to time it may be necessary to change the terms of the plan. The rules we follow for changing the terms of the plan are described later in the section called [Changes in the Plan](#).

## **Termination of Coverage**

The section below called [Eligibility](#) tells you when coverage will terminate under the plan. If coverage terminates, no benefits will be provided thereafter, even if for a condition that began before the plan or your coverage termination. In some cases you will have the opportunity to buy COBRA coverage after your group coverage terminates. COBRA coverage is explained in detail later in this booklet.

## **Your Rights**

As a member of the plan, you have the right to:

- Receive information about us, our services, in-network providers, and your rights and responsibilities.
- Be treated with respect and recognition of your dignity and your right to privacy.
- Participate with providers in making decisions about your healthcare.
- A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about us, or the healthcare the plan provides.
- Make recommendations regarding our member rights and responsibilities policy.

If you would like to voice a complaint, please call the Customer Service Department number on the back of your ID card.

## **Your Responsibilities**

As a member of the plan, you have the responsibility to:

- Supply information (to the extent possible) that we need for payment of your care and your providers need in order to provide care.
- Follow plans and instructions for care that you have agreed to with your providers and verify through the benefit booklet provided to you the coverage or lack thereof under your plan.

- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

## ELIGIBILITY

### Eligibility for the Plan

You are eligible to enroll in this plan if all of the following requirements are satisfied:

- You are an employee and are treated as such by your group. Examples of persons who are not employees include independent contractors, and consultants;
- Your group has determined that you work on average 30 or more hours per week (including vacation and certain leaves of absence that are discussed in the section dealing with termination of coverage) in accordance with the Affordable Care Act;
- You are in a category or classification of employees that is covered by the plan;
- You meet any additional eligibility or participation rules established by your group; and,
- You satisfy any applicable waiting period, as explained below.

You must continue to meet these eligibility conditions for the duration of your participation in the plan.

Covered employees who retire from The School Board of Polk County and elect to continue coverage under this plan will be referred to as retirees.

Only retirees and covered dependents enrolled under this plan at the time of retirement will remain eligible to participate under this plan. To be considered retired under this plan; a retiree must meet one of the following;

- Has met the age and service requirements to qualify for a normal retirement as set forth in s.121.021 (29) of the Florida Statutes; or
- Has attained the age specified by s.72(t)(2)(A)(i) of the Internal Revenue Code (age 59 1/2) and has the years of service required for vesting as set forth in s.121.021(45); or
- Is placed on disability retirement and begins receiving retirement benefits immediately after retirement from employment.

Retirees and their covered dependents who cease to participate as a member under this plan for any reason will not be allowed to re-enroll in the plan at any time or for any reason in the future.

A retiree who continues uninterrupted coverage after retirement may add a new spouse and/or any newly eligible children as a result of the marriage only if the marriage occurs after retirement. A retiree who continues uninterrupted coverage after retirement may add a new dependent child and an existing spouse only if the dependent child is born or adopted after retirement. The new spouse or dependent child must be added within 30 days inclusive of the date of the marriage, birth, or adoption.

Retirees eligible for Medicare and their Medicare Eligible Dependents are not eligible to participate under this plan and are eligible to elect coverage in the Florida School Retiree Benefits Consortium (FSRBC) plan. Covered Dependents of a Medicare Eligible Retiree may continue to be covered under this plan if they are not yet eligible for Medicare, provided the dependents continue to meet the eligibility requirements of this plan. Once a Covered Dependent becomes eligible for Medicare then they will no longer participate in this plan and may elect coverage in the FSRBC.

If a Covered Retiree ceases to participate in this plan for the FSRBC plan for any reason, all Covered Dependents covered under this plan will become ineligible to participate and may be eligible for continuation of coverage under COBRA.

## Waiting Period for Coverage under the Plan

There may be a waiting period under the plan, as determined by your group. You should contact your group to determine if this is the case. Your group will also tell you the length of any applicable waiting period. Under federal law, any waiting period established by your group cannot be longer than 90 days.

Coverage will begin on the date specified below under [Beginning of Coverage](#), but in no event later than the 91st day in which you first meet the eligibility or participation rules established by your group (other than any applicable waiting period).

## Applying for Plan Coverage

Fill out an application form completely and give it to your group. You must name all eligible dependents to be covered on the application. Your group will collect all of the employees' applications and send them to us. Some employers provide for electronic online enrollment. Check with your group to see if this option is available.

## Eligible Dependents

Your eligible dependents are:

- The covered employee's spouse who has met all requirements of a legal marriage in the state of Florida.
- The covered employee's natural, newborn, adopted, foster, or step child(ren) (or a child for whom the covered employee has been court-appointed as legal guardian or legal custodian) who has not reached the end of the month in which he or she reaches age 26 (or in the case of a Foster Child, is no longer eligible under the Foster Child Program), regardless of the dependent child's student or marital status, financial dependency on the covered employee, whether the dependent child resides with the covered employee, or whether the dependent child is eligible for or enrolled in any other group health plan. Eligibility will terminate on the last day of the month in which the dependent child reaches the age of 26.
- 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 or when the covered dependent child loses eligibility for this plan, whichever comes first.
- In the case of a handicapped dependent child, such child is eligible to continue coverage as a covered dependent, beyond the age of 26 in the child is:
  1. Otherwise eligible for coverage under the group health plan;
  2. Incapable of self-sustaining employment by reason of intellectual or physical handicap; and
  3. Chiefly dependent upon the covered employee for support and maintenance provided that the symptoms or causes of the child's handicap existed prior to the child's 26<sup>th</sup> birthday.

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

- If a Covered Retiree dies, the eligible dependents covered at the time of the death shall cease to be eligible dependents under this plan and may be eligible to continue coverage as applicable under COBRA.

## Beginning of Coverage

### *Annual Open Enrollment Period*

If you do not enroll during a regular enrollment or a special open enrollment period described below, you may enroll only during your group's annual open enrollment period, if any. Your coverage will begin on the date specified by your group following your enrollment.

### *Regular Enrollment Period*

If you apply within 30 days after the date on which you meet the plan's eligibility requirements (including any applicable waiting periods established by your group), your coverage will begin as of the date thereafter specified by your group but in no event later than the 91<sup>st</sup> day in which you first meet the eligibility requirements established by your group (other than any applicable waiting periods). If you are a new employee, coverage will not begin earlier than the first day on which you report to active duty.

### *Special Enrollment Period for Individuals Losing Other Minimum Essential Coverage*

An employee or dependent (1) who does not enroll during the first 30 days of eligibility because the employee or dependent has other coverage, (2) whose other coverage was either COBRA coverage that was exhausted or minimum essential coverage by other health plans which ended due to "loss of eligibility" (as described below) or failure of the employer to pay toward that coverage, and (3) who requests enrollment within 30 days of the exhaustion or termination of coverage, may enroll in the plan. Coverage will be effective no later than the first day of the first calendar month beginning after the date the plan receives the request for special enrollment.

Loss of eligibility with respect to a special enrollment period includes loss of coverage as a result of legal separation, divorce, cessation of dependent status, death, termination of employment, reduction in the number of hours of employment, failure of your employer to offer minimum essential coverage to you, and any loss of eligibility that is measured by reference to any of these events, but does not include loss of coverage due to failure to timely pay premiums or termination of coverage for fraud or intentional misrepresentation of a material fact.

### *Special Enrollment Period for Newly Acquired Dependents*

If you have a new dependent as a result of marriage, birth, placement for adoption, adoption, or placement as an eligible foster child, you may enroll yourself and/or your spouse and your new dependent provided that you request enrollment within 30 days of the event. For a newborn child or a child placed for adoption the request for enrollment must be made within 60 days of the event. The effective date of coverage will be the date of birth, placement for adoption, adoption, or placement as an eligible foster child. In the case of a dependent acquired through marriage, the effective date will be no later than the first day of the first calendar month beginning after the date the plan receives the request for special enrollment.

### *Special Enrollment Period Related to Medicaid and SCHIP*

An employee or dependent who loses coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP) because of loss of eligibility for coverage may enroll in the plan provided that the employee or dependent requests enrollment within 60 days of the termination of coverage. An employee or dependent who becomes eligible for premium assistance under Medicaid or SCHIP for coverage under the plan may also enroll in the plan provided that the employee or dependent requests enrollment within 60 days of becoming eligible for such premium assistance. Coverage will be effective no later than the first day of the first calendar month beginning after the date the plan receives the request for special enrollment.

If we accept your application, you will receive an identification card. If we decline your application, all the law requires us to do is refund any fees paid.

## **Qualified Medical Child Support Orders**

If the group (the plan administrator) receives an order from a court or administrative agency directing the plan to cover a child, the group will determine whether the order is a Qualified Medical Child Support Order (QMCSO). A QMCSO is a qualified order from a court or administrative agency directing the plan to cover the employee's child regardless of whether the employee has enrolled the child for coverage. The group has adopted procedures for determining whether such an order is a QMCSO. You have a right to obtain a copy of those procedures free of charge by contacting your group.

The plan will cover an employee's child if required to do so by a QMCSO. If the group determines that an order is a QMCSO, we will enroll the child for coverage effective as of a date specified by the group, but not earlier than the later of the following:

- If we receive a copy of the order within 30 days of the date on which it was entered, along with instructions from the group to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which the order was entered.
- If we receive a copy of the order later than 30 days after the date on which it was entered, along with instructions from the group to enroll the child pursuant to the terms of the order, coverage will begin as of the date on which we receive the order. We will not provide retroactive coverage in this instance.

Coverage may continue for the period specified in the order up to the time the child ceases to satisfy the definition of an eligible dependent. If the employee is required to pay extra to cover the child, the group may increase the employee's payroll deductions. During the period the child is covered under the plan as a result of a QMCSO, all plan provisions and limits remain in effect with respect to the child's coverage except as otherwise required by federal law.

While the QMCSO is in effect we will make benefit payments – other than payments to providers – to the parent or legal guardian who has been awarded custody of the child. We will also provide sufficient information and forms to the child's custodial parent or legal guardian to allow the child to enroll in the plan. We will also send claims reports directly to the child's custodial parent or legal guardian.

## **Relationship to Medicare**

This plan will be primary to Medicare as long as you remain an active employee.

Any Retiree or their Covered Dependent not eligible for Medicare will remain eligible to participate under this plan as long as all eligibility criteria outlined by the plan are met. Any Retiree or their Covered Dependent who is or becomes Medicare eligible, regardless of enrollment in Medicare, will no longer be eligible to participate under this plan and will become eligible to participate in the FSRBC.

As a Retiree, if you or any of your Covered Dependents are or become eligible to participate under Medicare, whether or not you elect to enroll in Medicare, you are no longer eligible to participate under this plan and become eligible to participate in the Florida School Retiree Benefits Consortium (FSRBC) plans.

If you become 65 or become eligible for Medicare due to End Stage Renal Disease ("ESRD"), you must immediately notify The School Board of Polk County.

### **Individuals With End Stage Renal Disease (ESRD)**

If you are entitled to Medicare coverage because of ESRD, coverage under this plan will be provided on a primary basis for 30 months beginning with the earlier of:

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

The Group Health Plan will pay secondary to Medicare after the ESRD coordination period. If you do not notify Medicare of your ESRD entitlement, this plan will pay as though you had. The Group Health Plan will pay no more than it would have paid had you notified Medicare of your ESRD status, satisfied the 30-month coordination period and Medicare had become primary.

### *Disabled Individuals*

If you or a dependent is eligible for Medicare due to disability and is also covered under the plan by virtue of your current employment status with the group, Medicare will be considered the primary payer (and the plan will be secondary) if your group normally employed fewer than 100 employees during the previous calendar year. If your group normally employed 100 or more employees during the previous calendar year, the plan will be primary and Medicare will be secondary.

### *End-Stage Renal Disease*

If you are eligible for Medicare as a result of End-Stage Renal Disease (permanent kidney failure), the plan will generally be primary and Medicare will be secondary for the first 30 months of your Medicare eligibility (regardless of the size of the group). Thereafter, Medicare will be primary and the plan will be secondary.

### *Medicare Part D Prescription Drug Coverage*

If the plan does not provide "creditable" prescription drug benefits – that is, the plan's prescription drug benefits are not at least as good as standard Medicare Part D prescription drug coverage, you should enroll in Part D of Medicare when you become eligible for Medicare. Your group will tell you whether the plan's prescription drug benefits are at least as good as Medicare Part D.

If you have any questions about coordination of your coverage with Medicare, please contact your group for further information. You may also find additional information about Medicare at [www.medicare.gov](http://www.medicare.gov).

## **Termination of Coverage**

Plan coverage ends as a result of the first to occur of the following (generally, coverage will continue to the end of the month in which the event occurs):

- The date on which the employee fails to satisfy the conditions for eligibility to participate in the plan, such as termination of employment or reduction in hours (except during vacation or as otherwise provided in the [Leaves of Absence](#) rules below);
- For spouses, the date of divorce or other termination of marriage;
- For children, the last day of the month that a child ceases to be an eligible dependent;
- For the employee and his or her dependents, the date of the employee's death;
- You fail to pay your group any contribution amount due within 10 days after the day due; or
- At the end of the month of the date the employee's coverage terminates;
- On the date upon discovery of fraud or intentional misrepresentation of a material fact by you.

In all cases, the termination occurs automatically and without notice. All the dates of termination assume that payment for coverage for you and your dependents in the proper amount has been made to that date. If it has not, termination will occur back to the date for which coverage was last paid.

Our contract with your group (and your coverage as administered by us) will end as a result of the first to occur of the following (generally, coverage will continue to the end of the month in which the event occurs):

- On the date the group health plan terminates;
- Your group fails to pay us the amount due within 30 days after the day due;
- Upon discovery of fraud or intentional misrepresentation of a material fact by your group;
- When none of your group's members still live, reside or work in Florida; or,
- On 30-days advance written notice from your group to us.

In all cases except the last item above, the termination occurs automatically and without notice. All the dates of termination assume that payment for coverage for you and all other employees in the proper amount has been made to that date. If it has not, termination will occur back to the date for which coverage was last paid.

## **Leaves of Absence**

If your group is covered by the Family and Medical Leave Act of 1993 (FMLA), you may retain your coverage under the plan during an FMLA leave, provided that you continue to pay your premiums. In general, the FMLA applies to employers who employ 50 or more employees. You should contact your group to determine whether a leave qualifies as FMLA leave.

You may also continue your coverage under the plan for up to 30 days during an employer-approved leave of absence, including sick leave. Contact your group to determine whether such leaves of absence are offered. If your leave of absence also qualifies as FMLA leave, your 30-day leave time runs concurrently with your FMLA leave. This means that you will not be permitted to continue coverage during your 30-day leave time in addition to your FMLA leave.

If you are on military leave covered by the Uniformed Services Employment and Reemployment Rights Act of 1994, you should see your group for information about your rights to continue coverage under the plan.

## COST SHARING

	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible	\$900 individual (\$1,800 family)	\$1,500 individual (\$3,000 family)
Calendar Year Out-of-Pocket Maximum	\$5,000 individual (\$9,000 family)	There is no out-of-pocket maximum for out-of-network services

### Calendar Year Deductible

The calendar year deductible is specified in the table above. Other parts of this booklet will tell you when benefits are subject to the calendar year deductible. The calendar year deductible is the amount you or your family must pay for some medical expenses covered by the plan before your healthcare benefits for those medical expenses begin.

Here are some special rules concerning application of the calendar year deductible:

- The individual calendar year deductible must be satisfied on a per member per calendar year basis, subject to the family calendar year deductible.
- The family calendar year deductible is an aggregate dollar amount. This means that all amounts applied toward the individual calendar year deductible will count toward the family calendar year deductible amount. Once the family calendar year deductible is met, no further family members must satisfy the individual calendar year deductible.
- Only one individual calendar year deductible is required when two or more family members have expenses resulting from injuries received in one accident.
- In all cases, the deductible will be applied to claims in the order in which they are processed regardless of the order in which they are received.

### Calendar Year Out-of-Pocket Maximum

The calendar year out-of-pocket maximum is specified in the table above. All cost-sharing amounts (deductible, copayment and coinsurance) for covered in-network services and out-of-network services for medical emergencies that you or your family are required to pay under the plan apply to the calendar year out-of-pocket maximum. Once the maximum has been reached, you will no longer be subject to cost-sharing for covered expenses of the type that count toward the calendar year out-of-pocket maximum for the remainder of the calendar year.

There may be many expenses you are required to pay under the plan that **do not** count towards the calendar year out-of-pocket maximum, and that you must continue to pay even after you have met the calendar year out-of-pocket maximum. The following are some examples:

- All cost-sharing amounts (deductibles, copayments, coinsurance) paid for any out-of-network services or supplies that may be covered under the plan (except for covered out-of-network services for medical emergencies);
- Amounts paid for non-covered services or supplies;

- Amounts paid for services or supplies in excess of the allowed amount (for example, an out-of-network provider requires you to pay the difference between the allowed amount and the provider's total charges);
- Amounts paid for services or supplies in excess of any plan limits (for example, a limit on the number of covered visits for a particular type of provider); and,
- Amounts paid as a penalty (for example, failure to precertify).

The calendar year out-of-pocket maximum applies on a per member per calendar year basis, subject to the family calendar year out-of-pocket maximum amount. Once a member meets their individual calendar year out-of-pocket maximum, affected benefits for that member will pay at 100% of the allowed amount for the remainder of the calendar year.

The family calendar year out-of-pocket maximum is an aggregate dollar amount. This means that all amounts that count towards the individual calendar year out-of-pocket maximum will count towards the family calendar year out-of-pocket maximum amount. Once the family calendar year out-of-pocket maximum is met, affected benefits for all covered family members will pay at 100% of the allowed amount for the remainder of the calendar year.

## Other Cost Sharing Provisions

The plan may impose other types of cost sharing requirements such as the following:

- **Per admission deductibles:** These apply upon admission to a hospital. Only one per admission deductible is required when two or more family members have expenses resulting from injuries received in one accident.
- **Copayments:** A copayment is a fixed dollar amount you must pay on receipt of care. The most common example is the office visit copayment that must be satisfied when you go to a doctor's office.
- **Coinsurance:** Coinsurance is the amount that you must pay as a percent of the allowed amount.
- **Amounts in excess of the allowed amount:** As a general rule, the allowed amount may often be significantly less than the provider's actual charges. You should be aware that when using out-of-network providers you can incur significant out-of-pocket expenses as the provider has not contracted with us or their local Blue Cross and/or Blue Shield plan for a negotiated rate and they can bill you for amounts in excess of the allowed amount. As one example, out-of-network facility claims may include very expensive ancillary charges (such as implantable devices) for which no extra reimbursement is available as these charges are not separately considered under the plan. This means you will be responsible for these charges if you use an out-of-network provider.

## The BlueCard Program

### A. Inter-Plan Arrangement

BCBSF and its Designated Agent have a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever members access healthcare services outside the geographic area BCBSF's Designated Agent serves (i.e. Alabama), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area BCBSF's Designated Agent serves (i.e. Alabama), members obtain care from healthcare providers that have a contractual agreement ("participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, members may obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. BCBSF remains responsible for fulfilling our contractual obligations to Employer. BCBSF's and/or its Designated Agent's payment practices in



both instances are described below. For purposes of Inter-Plan Arrangements, BCBSF is a Host Plan for services provided within Florida.

This disclosure describes how claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. (Note that Dental Care Benefits, except when not paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by BCBSF and/or its Designated Agent to provide the specific service or services are not processed through Inter-Plan Arrangements.)

## **B. BlueCard® Program**

### **1. Calculation Method Per Claim – In General**

#### **a. Member Liability Calculation**

Unless subject to a fixed dollar copayment, the calculation of the member liability on claims for covered healthcare services will be based on the lower of the participating provider's billed covered charges or the negotiated price made available to BCBSF and/or its Designated Agent by the Host Blue.

#### **b. Employer Liability Calculation**

The calculation of Employer liability on claims for covered healthcare services processed through the BlueCard Program will be based on the negotiated price made available to BCBSF and/or its Designated Agent by the Host Blue (under the contract between the Host Blue and the provider). Sometimes, this negotiated price may be greater for a given service or services than the billed charge in accordance with how the Host Blue has negotiated with its participating healthcare provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, Employer may be liable for the excess amount even when the member's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the provider, even when the contracted price is greater than the billed charge.

### **2. Claims Pricing**

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's provider contracts. The negotiated price made available to BCBSF and/or its Designated Agent by the Host Blue may be represented by one of the following:

- (i) An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or
- (ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim specific basis, retrospective settlements and performance related bonuses or incentives; or
- (iii) An average price. An average price is a percentage of billed covered charges in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether it will use an actual, estimated or average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price Employer pays on a specific claim and the actual amount the Host Blue pays to the

provider. However, the BlueCard Program requires that the amount paid by the member and Employer is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims.

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future claim prices. As a result, the amounts charged to Employer will be adjusted in a following year, as necessary, to account for over- or underestimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from Employer. If Employer terminates, you will not receive a refund or charge from the variance account.

Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

#### BlueCard Program Fees and Compensation

Employer understands and agrees to reimburse BCBSF and/or its Designated Agent for certain fees and compensation which BCBSF is obligated under the BlueCard Program to pay to the Host Blues, to the Association and/or to vendors of BlueCard Program related services. The specific BlueCard Program fees and compensation that are charged to Employer are set forth in this Exhibit B. BlueCard Program Fees and compensation may be revised from time to time.

Only the BlueCard Program access fee may be charged separately each time a claim is processed through the BlueCard Program. All other BlueCard Program related fees are included in the Base Administrative Fee.

The access fee is charged by the Host Blue to BCBSF and/or its Designated Agent for making its applicable provider network available to Employer's members. The access fee will not apply to nonparticipating provider claims. The access fee is charged on a per claim basis and is charged as a percentage of the discount/differential BCBSF and/or its Designated Agent receives from the applicable Host Blue subject to a maximum of \$2,000 per claim. When charged BCBSF and/or its Designated Agent pass the access fee directly on to Employer.

Instances may occur in which the claim payment is zero or BCBSF and/or its Designated Agent pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, BCBSF and/or its Designated Agent will pay the Host Blue's access fee and pass it along directly to Employer as stated above even though Employer paid little or had no claim liability.

A Base Administrative Fee encompasses fees BCBSF and/or its Designated Agent charge to Employer for administering Employer's benefit plan. They may include both local (within BCBSF's Designated Agent's service area, i.e. Alabama) and Inter-Plan fees. For purposes of this Agreement, they include the following BlueCard Program related fees other than the BlueCard Program access fee: namely, administrative expense allowance (AEA) fee, central financial agency fee, ITS transaction fee, toll free number fee, PPO provider directory fee and Blue Cross Blue Shield Global® Core Program fees, if applicable.

### **C. Negotiated Arrangements**

With respect to one or more Host Plans, instead of using the BlueCard Program, BCBSF and/or its Designated Agent may process your member claims for covered healthcare services through

Negotiated Arrangements. Negotiated Arrangements or Negotiated National Account Arrangements are agreements negotiated between a Home Licensee and one or more Host Licensees for any national account that is not delivered through the BlueCard Program.

In addition, if BCBSF and Employer have agreed that (a) Host Blue(s) shall make available (a) custom healthcare provider network(s) in connection with this Agreement, then the terms and conditions set forth in BCBSF's Negotiated Arrangement(s) for National Accounts with such Host Blue(s) shall apply. These include the provisions governing the processing and payment of claims when members access such network(s). In negotiating such arrangement(s), BCBSF is not acting on behalf of or as an agent for Employer, Employer's group health plan or Employer's members.

#### Member Liability Calculation

Member liability calculation will be based on the negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) that the Host Blue makes available to BCBSF and/or its Designated Agent and that allows Employer's members access to negotiated participation agreement networks of specified participating providers outside of BCBSF's Designated Agent's service area (i.e. Alabama).

The amount the member pays for covered healthcare services under such arrangement at the point of service, if not a flat dollar copayment, will be calculated based on the "price" that the Host Blue passed to BCBSF and/or its Designated Agent and that allows Employer's members access to negotiated participation agreement networks of specified participating providers outside of BCBSF's Designated Agent's service area (i.e. Alabama). The "price" may be the:

- (i) Negotiated price/lower of either billed covered charges or negotiated price; or
- (ii) Lower of either billed covered charges or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program).

Under certain circumstances, if BCBSF and/or its Designated Agent pay the healthcare provider amounts that are the responsibility of the member BCBSF and/or its Designated Agent may collect such amounts from the member.

In situations where participating agreements allow for bulk settlement reconciliations for Episode-Based Payment/Bundled Payments, BCBSF and/or its Designated Agent may include a factor for such settlement reconciliations as part of the fees BCBSF and/or its Designated Agent charges to Employer.

#### Fees and Compensation

Employer understands and agrees to reimburse BCBSF and/or its Designated Agent for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement related services. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time. In addition, the participation agreement with the Host Blue may provide that BCBSF and/or its Designated Agent must pay an administrative and/or a network access fee to the Host Blue, and Employer further agrees to reimburse BCBSF and/or its Designated Agent for any such applicable administrative and/or network access fees. The specific fees and compensation that are charged to BCBSF and/or its Designated Agent under Negotiated Arrangements are set forth in this Exhibit B]

## **D. Special Cases: Value-Based Programs**

### Value-Based Programs Definitions

Accountable Care Organization (ACO): A group of healthcare providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability in order to manage the total cost of care for their member populations.

**Global Payment/Total Cost of Care:** A payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as outpatient, physician, ancillary, hospital services and prescription drugs.

**Patient-Centered Medical Home (PCMH):** A model of care in which each patient has an ongoing relationship with a primary care physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified physicians.

**Shared Savings:** A payment mechanism in which the provider and payer share cost savings achieved against a target cost budget based upon agreed upon terms and may include downside risk.

**Value-Based Program (VBP):** An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment.

#### Value-Based Programs Overview

Employer's members may access covered healthcare services from providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

#### Value-Based Programs under the BlueCard Program

Under Value-Based Programs, a Host Blue may pay providers for reaching agreed upon cost/quality goals in the following ways:

The Host Blue may pass these provider payments to BCBSF and/or its Designated Agent, which BCBSF and/or its Designated Agent will pass directly on to Employer as either an amount included in the price of the claim or an amount charged separately in addition to the claim.

- (i) **Actual Pricing:** The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the claim. These charges are passed to Employer via an enhanced provider fee schedule.
- (ii) **Supplemental Factor:** The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the claim as an amount based on a specified supplemental factor (e.g., a small percentage increase in the claim amount). The supplemental factor may be adjusted from time to time.

When such amounts are billed separately from the price of the claim, they may be billed as follows:

- **Per Member Per Month (PMPM) Billings:** Per member per month billings for Value-Based Programs incentives/Shared Savings settlements to accounts are outside of the claim system. BCBSF and/or its Designated Agent will pass these Host Blue charges directly through to Employer as a separately identified amount on the group billings; or,
- Where Host Blues pass on the costs of Value-Based Programs to BCBSF and/or its Designated Agent as PMPM amounts not attached to specific claims, BCBSF and/or its Designated Agent may elect to pass these amounts to Employer as a claim amount.

The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard claim pricing section above) until the

end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

- Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.
- Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.

The Host Blue will not receive compensation resulting from how estimated, average or PMPM price methods, described above, are calculated. If Employer terminates, you will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of this Agreement.

Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

Note: Members will not bear any portion of the cost of Value-Based Programs except when a Host Blue uses either average pricing or actual pricing to pay providers under Value-Based Programs.

#### Care Coordinator Fees

Host Blues may also bill BCBSF and/or its Designated Agent for care coordinator fees for provider services which we will pass on to Employer as follows:

1. PMPM billings; or
2. Individual claim billings through applicable care coordination codes from the most current editions of either Current Procedural Terminology (CPT) published by the American Medical Association (AMA) or Healthcare Common Procedure Coding System (HCPCS) published by the U.S. Centers for Medicare and Medicaid Services (CMS).

As part of this Agreement, BCBSF and Employer will not impose member cost sharing for care coordinator fees.

#### Value-Based Programs under Negotiated Arrangements

If BCBSF has entered into a Negotiated Arrangement/ with a Host Blue to provide Value-Based Programs to Employer's members BCBSF and/or its Designated Agent will follow the same procedures for Value-Based Programs administration and care coordination fees as noted in the BlueCard Program section.]

#### **E. Return of Overpayments**

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

## **F. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees**

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, BCBSF and/or its Designated Agent will disclose any such surcharge, tax or other fee to Employer, which will be Employer's liability.

## **G. Nonparticipating Providers Outside BCBSF's Designated Agent's Service Area (i.e. Alabama)**

- Member Liability Calculation
  - a. In General

When covered healthcare services are provided outside of BCBSF's Designated Agent's service area (i.e. Alabama) by nonparticipating providers, the amount(s) a member pays for such services will be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment BCBSF and/or its Designated Agent will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services will be governed by applicable federal and state law.

### **b. Exceptions**

In some exception cases, at Employer's direction, BCBSF and/or its Designated Agent may pay claims from nonparticipating healthcare providers outside of BCBSF's Designated Agent's service area (i.e., Alabama) based on the provider's billed charge. This may occur in situations where a member did not have reasonable access to a participating provider, as determined by BCBSF and/or its Designated Agent in BCBSF's and/or its Designated Agent's sole and absolute discretion, or by applicable state law. In other exception cases, at Employer's direction, BCBSF and/or its Designated Agent may pay such claims based on the payment BCBSF and/or its Designated Agent would make if BCBSF and/or its Designated Agent were paying a nonparticipating provider inside BCBSF's Designated Agent's service area (i.e. Alabama), as described elsewhere in this Agreement. This may occur where the Host Blue's corresponding payment would be more than BCBSF's Designated Agent's in-service area nonparticipating provider payment. BCBSF and/or its Designated Agent may choose to negotiate a payment with such a provider on an exception basis.

The member may be responsible for the difference between the amount that the nonparticipating healthcare provider bills and the payment BCBSF and/or its Designated Agent will make for the covered services as set forth in this paragraph.

## **2. Fees and Compensation**

Employer understands and agrees to reimburse BCBSF and/or its Designated Agent for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement related services. The specific fees and compensation that are charged to Employer are set forth in this Exhibit B, if applicable. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time.

## **H. Blue Cross Blue Shield Global Core Program**

- General Information

If members are outside the United States, (the Commonwealth of Puerto Rico and the U.S. Virgin Islands) (hereinafter: "BlueCard service area"), they may be able to take advantage of

the Blue Cross Blue Shield Global Core Program when accessing covered healthcare services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when members receive care from providers outside the BlueCard service area, the members will typically have to pay the providers and submit the claims themselves to obtain reimbursement for these services.

- Inpatient Services

In most cases, if members contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require members to pay for covered inpatient services, except for their cost-share amounts. In such cases, the hospital will submit member claims to the Blue Cross Blue Shield Global Core Service Center to initiate claims processing. However, if the member paid in full at the time of service, the member must submit a claim to obtain reimbursement for covered healthcare services. Members must contact BCBSF and/or its Designated Agent to obtain precertification for non-emergency inpatient services.

- Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require members to pay in full at the time of service. Members must submit a claim to obtain reimbursement for covered healthcare services.

- Submitting a Blue Cross Blue Shield Global Core Claim

When members pay for covered healthcare services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, members should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center address on the form to initiate claims processing. The claim form is available from BCBSF and/or its Designated Agent, the Blue Cross Blue Shield Global Core Service Center, or online at [www.bluecardworldwide.com](http://www.bluecardworldwide.com). If members need assistance with their claim submissions, they should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

- 3. Blue Cross Blue Shield Global Core Program-Related Fees

- Employer understands and agrees to reimburse BCBSF and/or its Designated Agent for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement related services. The specific fees and compensation that are charged to Employer under the Blue Cross Blue Shield Global Core Program are set forth in this Exhibit B, if applicable. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time.

(iv)

## **MEDICAL NECESSITY AND PRECERTIFICATION**

The plan will only pay for care that is medically necessary and not investigational, as determined by us. The definitions of medical necessity and investigational are found in the [Definitions](#) section of this booklet.

In some cases described below, the plan requires that you or your treating provider precertify the medical necessity of your care. Please note that precertification relates only to the medical necessity of care; it does not mean that your care will be covered under the plan. Precertification also does not mean that we

have been paid all monies necessary for coverage to be in force on the date that services or supplies are rendered.

In some cases, your provider will initiate the precertification process for you. You should be sure to check with your provider to confirm whether precertification has been obtained. It is your responsibility to ensure that you or your provider obtains precertification.

## **Inpatient Hospital Benefits**

Precertification is required for all hospital admissions (general hospitals and psychiatric specialty hospitals) except for medical emergency services and maternity admissions.

For medical emergency services, we must receive notification within 48 hours of the admission.

If a newborn child remains hospitalized after the mother is discharged, we will treat this as a new admission for the newborn. However, newborns require precertification only in the following instances:

- The baby is transferred to another facility from the original facility; or,
- The baby is discharged and then readmitted.

**For precertification call 1-855-288-8357 (toll-free).**

If precertification is not obtained, there will be a \$500.00 penalty or 20% of the total allowed amount.

There is only one exception to this: If an in-network provider's contract with the local Blue Cross/Shield plan permits reimbursement despite the failure to obtain precertification, benefits will be payable for covered services only if the in-network hospital admission and related services are determined to be medically necessary on retrospective review by the plan.

- Home health and hospice when services are rendered outside the state of Florida.

For precertification, call 1-855-288-8357 (toll free).

## **Outpatient Hospital Benefits, Physician Benefits, Other Covered Services**

Precertification is required for the following outpatient hospital benefits, physician benefits and other covered services. You can find a list of any additional outpatient hospital benefits, physician benefits and other covered services that require precertification at [FL.ExploreMyPlan.com/Precert](http://FL.ExploreMyPlan.com/Precert). This list will be updated quarterly. You should check this list prior to obtaining any outpatient hospital services, physician services and other covered services.

Examples of services that require precertification at the time of the printing of this booklet include:

- Certain outpatient diagnostic lab, X-ray, and pathology when services are rendered in the state of Florida; and,
- Intensive outpatient services and partial hospitalization.

For precertification, call 1-855-288-8357 (toll-free).

- Home health and hospice when services are rendered outside the state of Florida.

For precertification, call 1-855-288-8357 (toll free).

- ABA therapy.

For precertification, call 1-855-288-8357 (toll free).

**If precertification is not obtained, no benefits will be payable under the plan for the services.**



## Provider-Administered Drugs

Precertification (also sometimes referred to as prior authorization) is required for certain provider-administered drugs. You can find a list of the provider-administered drugs that require precertification at [FL.ExploreMyPlan/DrugList](#). This list will be updated monthly.

Provider-administered drugs are drugs that must typically be administered or directly supervised by a provider generally on an outpatient basis in a hospital, other medical facility, physician's office or home healthcare setting. Provider-administered drugs also include gene therapy and cellular immunotherapy. Provider-administered drugs do not include medications that are typically available by prescription order or refill at a pharmacy.

For precertification, call the Customer Service Department number on the back of your ID card.

**If precertification is not obtained, no benefits will be payable under the plan for the provider-administered drug.**

## Prescription Drug Benefits

Precertification (also sometimes referred to as prior authorization) is required for certain prescription drugs. You can find a list of the prescription drugs that require precertification at [FL.ExploreMyPlan/DrugList](#). This list will be updated quarterly.

For precertification, call the Customer Service Department number on the back of your ID card.

**If precertification is not obtained, no benefits will be payable under the plan for the prescription drug.**

# HEALTH BENEFITS

**Attention: Mental Health Disorders and Substance Abuse Benefits**

Benefit levels for most mental health disorders and substance abuse are not separately stated. Please refer to the appropriate subsections below that relate to the services or supplies you receive, such as **Inpatient Hospital Benefits**, **Outpatient Hospital Benefits**, etc.

## Inpatient Hospital Benefits

**Attention:** Precertification is required for all hospital admissions except for medical emergency and maternity admissions. You can find more information about this in the [Medical Necessity and Precertification](#) section of this booklet.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
First 365 days of care during each confinement in a general hospital, psychiatric specialty hospital, or residential treatment facility (combined in-network and out-of-network)	80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible
Days of confinement in a general hospital, psychiatric specialty hospital, or residential treatment facility extending beyond the 365-day benefit maximum	80% of the allowed amount, subject to the calendar year deductible <b>Exception:</b> Benefits for days exceeding 365 days for mental health and substance abuse admissions will be the same as the benefits shown above for the first 365 days	60% of the allowed amount, subject to the calendar year deductible <b>Exception:</b> Benefits for days exceeding 365 days for mental health and substance abuse admissions will be the same as the benefits shown above for the first 365 days
Inpatient rehabilitation Limited to 21 days per calendar year, subject to medical necessity	80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible

**Attention:** If you receive inpatient hospital services in an out-of-network hospital in the Florida service area, no benefits are payable under the plan unless services are to treat an accidental injury or medical emergency.

Inpatient hospital benefits consist of the following if provided during a hospital stay:

- Bed and board and general nursing care in a semiprivate room;
- Use of special hospital units such as intensive care or burn care and the hospital nurses who staff them;
- Use of operating, delivery, recovery, and treatment rooms and the equipment in them;
- Administration of anesthetics by hospital employees and all necessary equipment and supplies;
- Casts, splints, surgical dressings, treatment and dressing trays;
- Diagnostic tests, including laboratory exams, metabolism tests, cardiographic exams, encephalographic exams, and X-rays;

- Physical therapy, hydrotherapy, radiation therapy, and chemotherapy;
- Oxygen and equipment to administer it;
- All drugs and medicines used by you if administered in the hospital;
- Regular nursery care and diaper service for a newborn baby while its mother has coverage;
- Blood transfusions administered by a hospital employee.

If you are discharged from and readmitted to a hospital within 90 days, the days of each stay will apply toward any applicable maximum number of inpatient days.

We may reclassify services or supplies provided to a hospital patient to a level of care determined by us to be medically appropriate given the patient's condition, the services rendered, and the setting in which they were rendered. This means that we may, at times, reclassify an inpatient hospital admission as outpatient services. There may also be times in which we deny benefits altogether based upon our determination that services or supplies were furnished at an inappropriate level of care.

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

## **Inpatient Rehabilitation Benefits**

These inpatient hospital benefits consist of:

- General nursing care;
- Physical therapy and hydrotherapy;
- Speech and hearing therapy;
- Functional occupational therapy.

The patient's condition must require:

- A rehabilitation trained physician available 24 hours a day;
- A rehabilitation trained nurse present 24 hours a day;
- Four hours of therapy provided by a licensed therapist a day;
- Continued progress toward goals requiring you to remain in the hospital. Your record must show conferences with your physician, therapists, and nurses at least weekly about your progress, any problems and their solutions, and review of the goals set for you.

Inpatient care for rehabilitation is excluded:

- If it maintains or is mainly to keep you clean or fed, or to help you take care of yourself;
- If just to make sure you keep to a therapy schedule or take your prescribed medicine;
- If only repeating services that don't require a skilled therapist, e.g., walking, conditioning, or maintenance;
- If your condition warrants that your rehab services could be provided on an outpatient basis;
- If you can't improve further.

Our standards for inpatient stays for rehabilitation are based on physician referral, how weak you are, how many services you need, how often you need them, how skilled the providers must be, and whether these services will improve your condition.

## Outpatient Hospital Benefits

**Attention:** Precertification is required for certain outpatient hospital benefits. You can find more information about this in the [Medical Necessity and Precertification](#) section of this booklet.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Outpatient surgery (including ambulatory surgical centers)	80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible
Birthing centers	80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible
Emergency room – medical emergency	80% of the allowed amount, subject to the calendar year deductible	80% of the allowed amount, subject to the in-network calendar year deductible
Emergency room – accident	80% of the allowed amount, subject to the calendar year deductible	80% of the allowed amount, subject to the calendar year deductible
Outpatient diagnostic lab, X-ray, and pathology <b>Note:</b> Precertification is required when rendered or referred by an out-of-network provider for advanced radiology	80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible
Outpatient Dialysis	80% of the allowed amount, subject to the calendar year deductible	Not covered
Independent clinical lab (Quest Diagnostics)	100% of the allowed amount, no deductible or copayment	60% of the allowed amount, subject to the calendar year deductible
Independent clinical lab (Not by Quest Diagnostics)	80% of the allowed amount, no deductible or copayment	60% of the allowed amount, subject to the calendar year deductible
Diagnostic mammograms	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, no deductible or copayment
Diagnostic colonoscopies <b>Note:</b> All other physician services rendered on the same date of service will receive the same benefit level as the colonoscopy	<b>Ambulatory surgical centers:</b> 100% of the allowed amount, no deductible or copayment <b>Outpatient facility:</b> 80% of the allowed amount, no deductible or copayment	60% of the allowed amount, subject to the calendar year deductible
IV therapy, chemotherapy, and radiation therapy <b>Note:</b> Precertification is required when rendered or referred by an out-of-network provider for advanced radiology	80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible
Services billed by the facility for an emergency room visit when the patient's condition does not meet the definition of a medical emergency (including any lab and X-ray exams and other diagnostic tests associated with the emergency room fee)	80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible
Outpatient hospital services or supplies not listed above and not listed in the section of this booklet called <a href="#">Other Covered Services</a>	80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible
Intensive outpatient services and partial hospitalization for mental health disorders and substance abuse	80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible

**Attention:** If you receive outpatient hospital services in an out-of-network hospital in the Florida service area, no benefits are payable under the plan unless services are to treat an accidental injury or medical emergency.

Outpatient hospital benefits include provider-administered drugs. You can find more information about provider-administered drugs in the [Medical Necessity and Precertification](#) section of this booklet.

We may reclassify services or supplies provided to a hospital patient to a level of care determined by us to be medically appropriate given the patient’s condition, the services rendered, and the setting in which they were rendered. This means that we may, at times, reclassify an outpatient hospital service as an inpatient admission. There may also be times in which we deny benefits altogether based upon our determination that services or supplies were furnished at an inappropriate level of care.

## Physician Benefits

**Attention:** Precertification is required for certain physician benefits. You can find more information about this in the [Medical Necessity and Precertification](#) section of this booklet.

The benefits listed below apply only to the physician’s charges for the services indicated. Claims for outpatient facility charges associated with any of these services will be processed under your outpatient hospital benefits and subject to any applicable outpatient facility copayments. Examples may include 1) laboratory testing performed in the physician’s office, but sent to an outpatient hospital facility for processing; 2) operating room and related services for surgical procedures performed in the outpatient hospital facility.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Office visits, in-person consultations, and psychotherapy <ul style="list-style-type: none"> <li>For specialty and non-specialty drugs administered in the physician's office, the office visit cost share applies for the visit, drug and administration of the drug. The drug does not have a separate cost share.</li> </ul> <p><b>Note:</b> Precertification is required when rendered or referred by an out-of-network provider for advanced radiology</p>	100% of the allowed amount, no deductible; subject to a \$50 copayment <p>Note: Diagnostic laboratory services performed by the physician's office will be subject to deductible and coinsurance unless processed through Quest Diagnostics. See Diagnostic lab and pathology for details.</p>	60% of the allowed amount, subject to the calendar year deductible
Second surgical opinion	100% of the allowed amount, no deductible or copayment	60% of the allowed amount, subject to the calendar year deductible
Polk County School Board Employee Health Clinics <p><b>Note:</b> Includes office visits, labs, x-rays, therapies, and on-site prescriptions</p>	100% of the allowed amount, no deductible or copayment	Not covered
Convenient Care Centers (CCC)	100% of the allowed amount, no deductible; subject to a \$50 copayment	60% of the allowed amount, subject to the calendar year deductible
Urgent Care Centers (UCC)	100% of the allowed amount, no deductible; subject to a \$50 copayment	60% of the allowed amount, subject to the calendar year deductible
E-Office visits	100% of the allowed amount, no deductible; subject to a \$10 copayment	60% of the allowed amount, subject to the calendar year deductible

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Emergency room physician	80% of the allowed amount, subject to the calendar year deductible	80% of the allowed amount, subject to the in-network calendar year deductible
Radiologists, anesthesiologists, and pathologists in an ambulatory surgical center	80% of the allowed amount, subject to the calendar year deductible	80% of the allowed amount, subject to the in-network calendar year deductible
Surgery for a covered service Note: See Special Diagnostic Procedures below for exceptions	In Physician's Office: 100% of the allowed amount, no deductible or copayment  Other Settings: 80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible
Anesthesia for a covered service <b>Note: See Special Diagnostic Procedures below for exceptions</b>	In Physician's Office: 100% of the allowed amount, no deductible or copayment  Other Settings: 80% of the allowed amount, subject to the calendar year deductible	In Physician's Office: 60% of the allowed amount, subject to the calendar year deductible  Other Settings: 80% of the allowed amount, subject to the in-network calendar year deductible
Maternity care <b>Note:</b> Initial office visit is subject to a \$50 copayment	80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible
Applied behavioral analysis (ABA) therapy  Limited to ages 0 - 18 (or if 19 years or older, member is attending high school and was diagnosed before 9 <sup>th</sup> birthday) for Down's Syndrome and Autism Spectrum Disorder	80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible
Inpatient visits	80% of the allowed amount, subject to the calendar year deductible	80% of the allowed amount, subject to the in-network calendar year deductible
Inpatient consultations by a specialty provider (limited to one consult per specialist per stay)	80% of the allowed amount, subject to the calendar year deductible	80% of the allowed amount, subject to the in-network calendar year deductible
Diagnostic X-rays <b>Note: See Special Diagnostic Procedures below for exceptions</b>	In Physician's Office: 100% of the allowed amount, no deductible or copayment  Other Settings: 80% of the allowed amount, subject to the calendar year deductible	In Physician's Office: 60% of the allowed amount, subject to the calendar year deductible  Other Settings: 80% of the allowed amount, subject to the in-network calendar year deductible
Diagnostic lab and pathology <b>Note: See Special Diagnostic Procedures below for exceptions</b>	Quest Diagnostics: 100% of the allowed amount, no deductible or copayment  In Physician's Office: 80% of the allowed amount, subject to the calendar year deductible  Other Settings: 80% of the allowed amount, subject to the calendar year deductible	In Physician's Office: 60% of the allowed amount, subject to the calendar year deductible  Other Settings: 80% of the allowed amount, subject to the in-network calendar year deductible

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Special Diagnostic Procedures performed in the physician's office or free-standing diagnostic center <ul style="list-style-type: none"> <li>• CAT Scan</li> <li>• MRI</li> <li>• PET/SPECT</li> <li>• ERCP</li> <li>• angiography/arteriography</li> <li>• cardiac cath/arteriography</li> <li>• UGI endoscopy</li> <li>• muga-gated cardiac scan</li> </ul>	80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible
Diagnostic mammograms (all locations)	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, no deductible or copayment
Chemotherapy and radiation therapy	In Physician's Office: 100% of the allowed amount, no deductible or copayment  Other Settings: 80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible
Psychological testing	80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible
Allergy testing and treatment	100% of the allowed amount, no deductible; subject to a \$10 copayment	60% of the allowed amount, subject to the calendar year deductible
Dialysis	In Physician's Office: 100% of the allowed amount, no deductible or copayment  Other Settings: 80% of the allowed amount, subject to the calendar year deductible	Not covered
Telephone and online video consultations program  To enroll in the telephone and online video consultations program, go to <a href="http://Teladoc.com">Teladoc.com</a> or call 1-855-477-4549  <b>General Medical:</b> Telephone and online video consultations are available through Teladoc to diagnose, treat and prescribe medication (when necessary) for certain general medical issues (flu, allergies, sinus infection, sore throat, etc.) Telephone consultations are available 24 hours a day, 7 days a week. Online video consultations (where available) are offered 7 days a week, 7 a.m. to 9 p.m.	100% of the allowed amount, no deductible or copayment	Not Covered

The following terms and conditions apply to physician benefits:

- Surgical care includes inpatient and outpatient preoperative and postoperative care, reduction of fractures, endoscopic procedures, and heart catheterization.
- Maternity care includes obstetrical care for pregnancy, childbirth, and the usual care before and after those services.

- Inpatient hospital visits related to a hospital admission for surgery, obstetrical care, or radiation therapy are normally covered under the allowed amount for that surgery, obstetrical care, or radiation therapy. Hospital visits unrelated to the above services are covered separately, if at all.
- If you receive other out-of-network physician services (such as out-of-network laboratory services) for a medical emergency in the emergency room of a hospital, those services will also be paid with the applicable in-network coinsurance and/or copayment amounts for such physician benefits described in the matrix above, but subject to the calendar year deductible. The allowed amount for such out-of-network physician benefits will be determined in accordance with the applicable requirements of the Patient Protection and Affordable Care Act.
- Physician benefits include provider-administered drugs. You can find more information about provider-administered drugs in the [Medical Necessity and Precertification](#) section of this booklet.
- All services rendered in a Physician's office are not subject to a separate Cost Share amount in addition to the office visit Cost Share amount. (Exceptions may apply)

## Physician Preventive Benefits

**Attention:** In some cases, routine immunizations and routine preventive services may be billed separately from your office visit or other facility visit. In that case, the applicable office visit or outpatient facility cost sharing amounts under your physician benefits or outpatient hospital benefits may apply. In any case, applicable office visit or facility visit cost sharing amounts may still apply when the primary purpose for your visit is not routine preventive services and/or routine immunizations.

Under the Affordable Care Act, non-grandfathered plans are required to provide in-network coverage for all of the following without cost-sharing:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force;
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee to Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children, and adolescents, evidenced-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and,
- With respect to women, preventive care and screenings as provided in the binding, comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration, including (but not limited to) all Food and Drug Administration (FDA)-approved contraceptive methods for women, sterilization procedures, and patient education and counseling for all women (including dependent daughters) with reproductive capacity.



SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Routine preventive services and immunizations: See <a href="#">FL.ExploreMyPlan/PreventiveServices</a> for a listing of the specific drugs, immunizations and preventive services or call our Customer Service Department for a paper copy of this listing	100% of the allowed amount, no deductible or copayment  <ul style="list-style-type: none"> <li>Routine Urinalysis (limited to one per member per benefit period, no age or gender restrictions)</li> <li>Routine General Health Panel (limited to one per member per benefit period, no age or gender restrictions)</li> <li>All Preventive Labs</li> </ul>	60% of the allowed amount, subject to the calendar year deductible  <ul style="list-style-type: none"> <li>Routine Urinalysis (limited to one per member per benefit period, no age or gender restrictions)</li> <li>Routine General Health Panel (limited to one per member per benefit period, no age or gender restrictions)</li> <li>All Preventive Labs</li> </ul>
Well child office visits (limits as related to ACA Preventive Services)	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, no deductible or copayment
Colonoscopies (routine) Age 50 and older then frequency schedule applies	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, no deductible or copayment
Mammograms (routine and diagnostic)	100% of the allowed amount, no deductible or copayment	100% of the allowed amount, no deductible or copayment

## Other Covered Services

**Attention:** Precertification is required for certain other covered services. You can find more information about this in the [Medical Necessity and Precertification](#) section of this booklet.

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Accident-related dental services, which consist of treatment of natural teeth injured by force outside your mouth or body if initial services are received within 90 days of the injury; if initial services are received within 90 days of the injury subsequent treatment is allowed for up to 180 days from the date of injury without pre-authorization; subsequent treatment beyond 180 days must be pre-authorized and is limited to 18 months from the date of injury	80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible
Ambulance services Includes ground, air and water transportation- non-emergency air and water transport not covered unless precertified in advance	80% of the allowed amount, no deductible or copayment	80% of billed charges, no deductible or copayment
Child Cleft Lip and Cleft Palate Treatment Includes medical, dental, speech therapy, audiology, and nutrition services for treatment of a child under the age of 18. Limited to services for diagnosis of cleft palate only	80% of the allowed amount, no deductible or copayment	60% of the allowed amount, no deductible or copayment

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
Rehabilitation services: Occupational, Physical, Speech, Cardiac Rehabilitation, and Chiropractic services Limited to a combined maximum of 35 visits per person per calendar year and includes up to 26 spinal manipulations for chiropractic services and therapies	Physician Office: 100% of the allowed amount, no deductible; subject to a \$50 copayment  Outpatient Facility: 100% of the allowed amount, no deductible; subject to a \$50 copayment  Inpatient Rehab Center: 80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible
Occupational, physical, and speech therapy services with autism spectrum disorder diagnosis ages 0 – 18 (or if 19 years or older, member is attending high school and was diagnosed before 9 <sup>th</sup> birthday)	80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible
Dialysis services at a renal dialysis facility	80% of the allowed amount, subject to the calendar year deductible	Not covered
DME: Durable medical equipment and supplies, which consist of the following: (1) artificial arms and other prosthetics, leg braces, and other orthopedic devices; and (2) medical supplies such as oxygen, crutches, casts, catheters, colostomy bags and supplies, orthotics, and splints  <b>Note:</b> For DME the allowed amount will generally be the smaller of the rental or purchase price	80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible
Eyeglasses or contact lenses: One pair will be covered if medically necessary to replace the human lens function as a result of eye surgery or eye injury or defect	80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible
Home health care Home healthcare benefits consist of home IV therapy, intermittent home nursing visits and home phototherapy for newborns ordered by your attending physician Limited to 20 visits per person each calendar year	80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible
Hospice care Hospice benefits consist of physician home visits, medical social services, physical therapy, inpatient respite care, home health aide visits from one to four hours, durable medical equipment and symptom management provided to a member certified by his physician to have less than six months to live	80% of the allowed amount, subject to the calendar year deductible	60% of the allowed amount, subject to the calendar year deductible

<p>Skilled nursing facility</p> <p>Includes facility charges for room, board, and routine nursing care when the patient is recovering from a serious illness or injury, confined to a bed with a long-term illness or injury, or has a terminal condition; the admission must take place within 14 days after the patient leaves the hospital and that hospital stay must have lasted at least three days in a row for the same illness or injury; the patient's doctor must visit him at least once every 30 days and these visits must be written in the patient's medical records; the facility must be an approved skilled nursing facility as defined by the Social Security Act</p> <p>Limited to 60 visits per person each calendar year</p>	<p>80% of the allowed amount, subject to the calendar year deductible</p>	<p>60% of the allowed amount, subject to the calendar year deductible</p>
<p>Sleep Studies</p>	<p>Office setting: 100% of the allowed amount, no deductible; subject to a \$50 copayment</p> <p>Other outpatient setting (including home): 80% of the allowed amount, subject to the calendar year deductible</p>	<p>60% of the allowed amount, subject to the calendar year deductible</p>
<p>Enteral formula</p> <p>Limited to a maximum of \$2,500 per calendar year up to the member's 25th birthday</p>	<p>80% of the allowed amount, subject to the calendar year deductible</p>	<p>60% of the allowed amount, subject to the calendar year deductible</p>
<p>Wigs</p> <p>Following chemotherapy or radiation therapy</p> <p>Limited to a maximum of \$500 per calendar year</p>	<p>80% of the allowed amount, subject to the calendar year deductible</p>	<p>60% of the allowed amount, subject to the calendar year deductible</p>
<p>TMJ Services</p> <p>Limited to treatment for Phase 1 services only</p>	<p>80% of the allowed amount, subject to the calendar year deductible</p>	<p>60% of the allowed amount, subject to the calendar year deductible</p>
<p>Transplants</p> <p>Only at approved facilities</p> <p>Organ procurement limited to a maximum of \$10,000 per transplant</p>	<p>80% of the allowed amount, subject to the calendar year deductible</p>	<p>60% of the allowed amount, subject to the calendar year deductible</p>

## Prescription Drug Benefits

**Attention:** Precertification (sometimes referred to as prior authorization) is required for certain prescription drugs. You can find more information about this in the [Medical Necessity and Precertification](#) section of this booklet.

	IN-NETWORK	OUT-OF-NETWORK
Prescription Drug Deductible	\$50 per person	Not covered
Prescription Drug Out-of-Pocket Maximum	\$1,600 Individual (\$4,200 family)	Not Covered

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
<p><b>Prescription Drug Card</b></p> <p>The pharmacy network for the plan is the <b>ValueONE Retail Network</b>. For participating retail pharmacies go to <a href="#">FL.ExploreMyPlan/PharmacyLocator</a></p> <p>Some drugs require precertification</p> <p>Prescription drugs can be dispensed for up to a 30-day supply</p> <p>Some copays combined for diabetic supplies</p> <p>ABC's of Diabetes will take a \$0 copay for program medications for qualifying employees</p> <p>Erectile dysfunction medications are limited to 6 pills per 30 days at retail</p> <p>Opioid prescriptions limited on first fill to a maximum of 7-day supply</p> <p>Tiers 5 and 6 (specialty) drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for Tiers 5 and 6 (specialty) drugs is the <b>Pharmacy Select Network</b>. Go to <a href="#">FL.ExploreMyPlan/DrugList</a> for a list of these specialty drugs</p> <p>Physician administered specialty and non- specialty drugs rendered in physician's office are not subject to separate charge in addition to the copay</p> <p>Oral oncology drugs will take a \$50 copay for a 30 day supply</p> <p>Members can fill medications at a HealthStat dispensary at no charge for a 30, 60 and 90-day supply. Specialty medications and mail order are not covered at a HealthStat dispensary</p> <p>View the <b>Source Rx 1.0</b> list that applies to the plan at <a href="#">FL.ExploreMyPlan/DrugList</a></p> <p>Some immunizations may be received from in-network pharmacy that participates in the Pharmacy Vaccine Network.</p> <ul style="list-style-type: none"> <li>• A list of eligible vaccines these pharmacies may provide can be found at <a href="#">FL.ExploreMyPlan/DrugList</a></li> </ul>	<p>100% of the allowed amount, subject to the following copayments/coinsurance:</p> <p><b>Tier 1 drugs</b> (Preferred Generic) \$8 copayment</p> <p><b>Tier 2 drugs</b> (Non-Preferred Generic) \$8 copayment</p> <p><b>Tier 3 drugs</b> (Preferred Brand) \$40 copayment and 10% coinsurance/up to a maximum of \$80 per prescription subject to the \$50 deductible per person</p> <p><b>Tier 4 drugs</b> (Non-Preferred Brand) \$80 copayment and 10% coinsurance/up to a maximum of \$160 per prescription subject to the \$50 deductible per person</p> <p><b>Tier 5 drugs</b> (Generic or Preferred Brand Specialty): \$80 copayment after the \$50 deductible per person is met</p> <p><b>Tier 6 drugs</b> (Non-Preferred Brand Specialty) \$160 copayment after the \$50 deductible per person is met</p> <p>If you purchase a brand name medication when a generic is available, you will pay the generic copay plus the difference in the cost between the brand and generic medication</p>	<p>Not covered</p>

Prescription drug benefits are subject to the following terms and conditions:

- To be eligible for benefits, drugs must be FDA-approved legend drugs prescribed by a physician and dispensed by a licensed pharmacist. Legend drugs are medicines which must by law be labeled, "Caution: Federal law prohibits dispensing without a prescription."
- Drugs are classified in tiers generally by their cost to the plan with Tier 1 drugs having the lowest cost to the plan and Tier 6 having the highest cost to the plan. To determine the Tier in which a drug is classified by your plan, log into **myBlueCross** at [FL.ExploreMyPlan.com](#). Once there, you can

search for your drug by clicking the “Find Drug Pricing” link located in the **Manage My Prescriptions** section of our website. The Tier drug classifications are updated periodically.

- Prescription drug coverage is subject to [Drug Coverage Guidelines](#) developed and modified over time based upon daily or monthly limits as recommended by the Food and Drug Administration, the manufacturer of the drug, and/or peer-reviewed medical literature. These guidelines can be found in the pharmacy section of our website. Even though your physician has written a prescription for a drug, the drug may not be covered under the plan, or clinical edit(s) may apply (i.e., prior authorization, step therapy, quantity limitation) in accordance with the guidelines. A drug may not be covered under the plan because, for example, there are safety and/or efficacy concerns or there are over-the-counter equivalent drugs available. The guidelines in some instances also require you to obtain prior authorization as to the medical necessity of the drug. You may call the Customer Service Department number on the back of your ID card for more information.
- Prescription drug benefits are provided only if dispensed by an in-network pharmacy. Except for certain Tiers 5 and 6 specialty drugs, in-network pharmacies are pharmacies that have a contract with Blue Cross and Blue Shield of Florida or its pharmacy benefit manager(s) to dispense prescription drugs under the plan. For certain Tiers 5 and 6 specialty drugs, in-network pharmacies must have a contract with Blue Cross and Blue Shield of Florida or its pharmacy benefit manager(s) to dispense these Tiers 5 and 6 specialty drugs.
- Tiers 5 and 6 specialty drugs are high-cost drugs that may be used to treat certain complex and rare medical conditions and are often self-injected or self-administered. Tiers 5 and 6 specialty drugs often grow out of biotech research and may require refrigeration or special handling.
- Compound drugs are defined as a drug product made or modified to have characteristics that are specifically prescribed for an individual patient when commercial drug products are not available or appropriate. To be eligible for coverage, compounded drugs must contain at least one FDA-approved prescription ingredient and must not be a copy of a commercially available product. All compounded drugs are subject to review and may require prior authorization. Drugs used in compounded drugs may be subject to additional coverage criteria and utilization management edits. Compounds are covered only when medically necessary. Compound drugs are always classified as Tier 4 drugs.

**Attention:** Just because a drug is classified by the plan as Tier 1 or any other classification on our website does not mean the drug is safe or effective for you. Only you and your prescribing physician can make that determination.

- Refills of prescriptions are allowed only after 75% of the allowed amount of the previous prescription has been used (e.g., 23 days in a 30-day supply).
- Maintenance drugs (including certain diabetic supplies) can be dispensed up to a maximum of a 90-day supply. You must satisfy the copayment requirement for each 90-day supply. Go to [FL.ExploreMyPlan/DrugList](#) for a list of maintenance drugs.
- Insulin, needles, and syringes purchased on the same day will have one copayment; otherwise, each has a separate copayment. Blood glucose strips and lancets purchased on the same day will have one copayment. Otherwise, each has a separate copayment. These are the only diabetic supplies available as prescription drug benefits under the plan. Glucose monitors always have a separate copayment.
- If your drug is not covered and you think it should be, you may ask us to make an exception to the drug coverage rules. Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception.

## Extended Supply Network Drug Benefits

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
<p><b>Extended Supply Network</b></p> <p>If you have less than a 90-day prescription, you will still have to pay the same copayment as a 90-day supply when using this mail order pharmacy service</p> <p>Only maintenance drugs can be purchased through the Extended Supply Network</p> <p>Tiers 5 and 6 (specialty) drugs are not available through this pharmacy service</p>	<p>100% of the allowed amount, subject to the following copayments/coinsurance for up to a 90-day supply for each prescription:</p> <p><b>Tier 1 drugs (Preferred Generic)</b> \$20 copayment</p> <p><b>Tier 2 drugs (Non-Preferred Generic)</b> \$20 copayment</p> <p><b>Tier 3 drugs (Preferred Brand)</b> \$120 copay and 10% coinsurance up to a max of \$240 per prescription subject to the \$50 drug deductible</p> <p><b>Tier 4 drugs (Non-Preferred Brand)</b> \$210 copay and 10% coinsurance up to a max of \$420 per prescription subject to the \$50 drug deductible,</p> <p><b>Tier 5 (specialty) drugs</b> Not covered</p> <p><b>Tier 6 (specialty) drugs</b> Not covered</p> <p>If you purchase a brand name medication when a generic is available, you will pay the generic copay plus the difference in the cost between the brand and generic medication</p>	<p>Not covered</p>

## Mail Order Prescription Drug Benefits

SERVICE OR SUPPLY	IN-NETWORK PLAN PAYS	OUT-OF-NETWORK PLAN PAYS
<p><b>Mail order pharmacy service</b></p> <p>To enroll in the mail order pharmacy service, go to <a href="http://FL.ExploreMyPlan.com">FL.ExploreMyPlan.com</a> or call 1-800-391-1886</p> <p>Mail order drugs are available through <b>Home Delivery Network</b> and when purchased through the mail order pharmacy service can be dispensed up to a 90-day supply with one copayment per prescription</p> <p>If you have less than a 90-day prescription, you will still have to pay the same copayment as a 90-day supply when using this mail order pharmacy service</p> <p>View the <b>Source Rx 1.0</b> list that applies to the plan at <a href="http://FL.ExploreMyplan/DrugList">FL.ExploreMyplan/DrugList</a></p> <p>Tiers 4, 5 and 6 (specialty) drugs are not available through this pharmacy service</p>	<p>100% of the allowed amount, subject to the following copayments/coinsurance for up to a 90-day supply for each prescription:</p> <p><b>Tier 1 drugs</b> \$20 copayment</p> <p><b>Tier 2 drugs</b> \$20 copayment</p> <p><b>Tier 3 drugs</b> \$125 copayment subject to the \$50 drug deductible per person</p> <p><b>Tier 4 (specialty) drugs</b> \$200 copayment subject to the \$50 drug deductible per person</p> <p><b>Tier 5 (specialty) drugs</b> Not covered</p> <p><b>Tier 6 (specialty) drugs</b> Not covered</p> <p>If you purchase a brand name medication when a generic is available, you will pay the generic copay plus the difference in the cost between the brand and generic medication</p>	<p>Not covered</p>

## Provider-Administered Drug Benefits

**Attention:** Precertification (sometimes referred to as prior authorization) is required for certain provider-administered drugs. You can find more information about this in the [Medical Necessity and Precertification](#) section of this booklet.

Provider-administered drugs are drugs that must typically be administered or directly supervised by a provider generally on an outpatient basis in a hospital, other medical facility, physician's office or other home healthcare setting. Provider-administered drugs do not include medications that are typically available by prescription order or refill at a pharmacy.

Provider-administered drugs also include gene therapy and cellular immunotherapy. Gene therapy is generally a therapy designed to introduce genetic material into cells to compensate for abnormal genes or to make a beneficial protein. Cellular immunotherapy is generally the artificial stimulation of the immune system to treat cancer, such as cytokines, cancer vaccines oncolytic virus therapy, T-cell therapy and some monoclonal antibodies.

Provider-administered drug coverage is subject to Drug Coverage Guidelines and medical necessity policies found in the pharmacy section of our website. A drug may not be covered under the plan because, for example, there are safety and/or efficacy concerns. The guidelines in some instances also require you to obtain prior authorization as to the medical necessity of the drug. The guidelines in some instances also require the drug be administered by a provider and/or facility approved by the drug manufacturer.

# ADDITIONAL BENEFIT INFORMATION

## Individual Case Management

Unfortunately, some people suffer from catastrophic, long-term or chronic illness or injury. If you suffer due to one of these conditions, a Blue Cross Registered Nurse may work with you, your physician, and other healthcare professionals to design a benefit plan to best meet your healthcare needs. In order to implement the plan, you, your physician, and Blue Cross must agree to the terms of the plan. The program is voluntary to Blue Cross, you, and your physician. Under no circumstances are you required to work with a Blue Cross case management nurse. Benefits provided to you through individual case management are subject to your plan benefit maximums. If you think you may benefit from individual case management, please call our Health Management Department at 1-855-288-8357 (toll-free).

## Chronic Condition Management

You may also qualify to participate in the chronic condition management program. The chronic condition management program is available for members with heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease (COPD), asthma, and other specialized conditions. This program offers personalized care designed to meet your lifestyle and health concerns. Our staff of healthcare professionals will help you cope with your illness and serve as a source of information and education. Participation in the program is completely voluntary. If you would like to enroll in the program or obtain more information, call 1-855-288-8357 (Monday – Friday, 8 a.m. to 4:45 p.m. CST), or e-mail [membermanagement@ExploreMyPlan.com](mailto:membermanagement@ExploreMyPlan.com).

## Baby Yourself Program

Baby Yourself offers individual care by a registered nurse. Please call our nurses at 1-855-288-8356 as soon as you find out you are pregnant. Begin care for you and your baby as early as possible and continue throughout your pregnancy. Your baby has the best chance for a healthy start by early, thorough care while you are pregnant. Successful completion of the Baby Yourself program may qualify you for a financial incentive. Your group can tell you if you qualify and how to obtain any financial incentive.

If you fall into one of the following risk categories, please tell your doctor and your Baby Yourself nurse: age 35 or older; high blood pressure; diabetes; history of previous premature births; multiple births (twins, triplets, etc.).

## Organ and Bone Marrow Transplants

The organs for which there are benefits are: (1) heart; (2) liver; (3) lungs; (4) pancreas/islet cell; (5) kidney; and (6) intestinal/multivisceral. Bone marrow transplants, which include stem cells and marrow to restore or make stronger the bone marrow function, are also included. All organ and bone marrow transplants (excluding kidney) must be performed in a hospital or other facility on our list of approved facilities for that type of transplant and it must have our advance written approval. When we approve a facility for transplant services it is limited to the specific types of transplants stated. Covered transplant benefits for the recipient include any medically necessary hospital, medical-surgical and other services related to the transplant, including blood and blood plasma.

Transplant benefits for cadaveric donor organ costs are limited to search, removal, storage, and transporting the organ and removal team.

Transplant benefits for living donor expenses are limited to:

- solid organs: testing for related and unrelated donors as pre-approved by us
- bone marrow: related-donor testing and unrelated-donor search fees and procurement if billed through the National Marrow Donor Program or other recognized marrow registry
- prediagnostic testing expenses of the actual donor for the approved transplant



- hospital and surgical expenses for removal of the donor organ, and all such services provided to the donor during the admission
- transportation of the donated organ
- post-operative hospital, medical, laboratory and other services for the donor related to the organ transplant limited to up to 90 days of follow-up care after date of donation.

All organ and bone marrow transplant benefits for covered recipient and donor expenses are and will be treated as benefits paid or provided on behalf of the member and will be subject to all terms and conditions of the plan applicable to the member, such as deductibles, copays, coinsurance, and other plan limitations. For example, if the member's coverage terminates, transplant benefits also will not be available for any donor expenses after the effective date of termination.

There are no transplant benefits for: (1) any investigational/experimental artificial or mechanical devices; (2) organ or bone marrow transplants from animals; (3) donor costs available through other group coverage; (4) if any government funding is provided; (5) the recipient if not covered by this plan; (6) donor costs if the recipient is not covered by this plan; (7) recipient or donor lodging, food, or transportation costs, unless otherwise specifically stated in the plan; (8) a condition or disease for which a transplant is considered investigational; (9) transplants (excluding kidney) performed in a facility not on our approved list for that type or for which we have not given written approval in advance.

Tissue, cell and any other transplants not listed above are not included in this organ and bone marrow transplant benefit but may be covered under other applicable provisions of the plan when determined to be medically necessary and not investigational. These transplants include but are not limited to: heart valves, tendon, ligaments, meniscus, cornea, cartilage, skin, bone, veins, etc.

## Women's Health and Cancer Rights Act Information

A member who is receiving benefits in connection with a mastectomy will also receive coverage for reconstruction of the breast on which a mastectomy was performed and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications at all stages of the mastectomy, including lymphedema. Benefits for this treatment will be subject to the same calendar year deductible and coinsurance provisions that apply for other medical and surgical benefits.

## COORDINATION OF BENEFITS (COB)

COB is a provision designed to help manage the cost of healthcare by avoiding duplication of benefits when a person is covered by two or more benefit plans. COB provisions determine which plan is primary and which is secondary. A primary plan is one whose benefits for a person's healthcare coverage must be determined first without taking the existence of any other plan into consideration. A secondary plan is one which takes into consideration the benefits of the primary plan before determining benefits available under its plan. Some COB terms have defined meanings. These terms are set forth at the end of this COB section.

### Order of Benefit Determination

Which plan is primary is decided by the first rule below that applies:

**Noncompliant Plan:** If the other plan is a noncompliant plan, then the other plan shall be primary and this plan shall be secondary unless the COB terms of both plans provide that this plan is primary.

**Employee/Dependent:** The plan covering a patient as an employee, member, subscriber, or contract holder (that is, other than as a dependent) is primary over the plan covering the patient as a dependent. In some cases, depending upon the size of the group, Medicare secondary payer rules may require us to reverse this order of payment. This can occur when the patient is covered as an inactive or retired employee, is also covered as a dependent of an active employee, and is also covered by Medicare. In this case, the order of benefit determination will be as follows: first, the plan covering the patient as a dependent; second, Medicare; and third, the plan covering the patient as an inactive or retired employee.

**Dependent Child – Parents Not Separated or Divorced:** If both plans cover the patient as a dependent child of parents who are married or living together (regardless of whether they have ever been married),

the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary.

**Dependent Child – Separated or Divorced Parents:** If two or more plans cover the patient as a dependent child of parents who are divorced, separated, or no longer living together (regardless of whether they have ever been married), benefits are determined in this order:

1. If there is no court decree allocating responsibility for the child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
  - a. first, the plan of the custodial parent;
  - b. second, the plan covering the custodial parent's spouse;
  - c. third, the plan covering the non-custodial parent; and,
  - d. last, the plan covering the non-custodial parent's spouse.
2. If a court decree states that a parent is responsible for the dependent child's healthcare expenses or healthcare coverage and the plan of that parent has actual knowledge of those terms, the plan of the court-ordered parent is primary.

If the court-ordered parent has no healthcare coverage for the dependent child, benefits will be determined in the following order:

- a. first, the plan of the spouse of the court-ordered parent;
- b. second, the plan of the non-court-ordered parent; and,
- c. third, the plan of the spouse of the non-court-ordered parent.

If a court decree states that both parents are responsible for the dependent child's healthcare expenses or healthcare coverage, the provisions of "Dependent Child – Parents Not Separated or Divorced" (the "birthday rule") above shall determine the order of benefits.

If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the dependent child, the provisions of the "birthday rule" shall determine the order of benefits.

3. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under the "birthday rule" as if those individuals were parents of the child.

**Active Employee or Retired or Laid-Off Employee:**

1. The plan that covers a person as an active employee (that is, an employee who is neither laid off nor retired) or as a dependent of an active employee is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.
2. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. This rule does not apply if the rule in the paragraph "Employee/Dependent" above can determine the order of benefits. For example, if a retired employee is covered under his or her own plan as a retiree and is also covered as a dependent under an active spouse's plan, the retiree plan will be primary and the spouse's active plan will be secondary.

**COBRA or State Continuation Coverage:**

1. If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

3. This rule does not apply if the rule in the paragraph “Employee/Dependent” above can determine the order of benefits. For example, if a former employee is receiving COBRA benefits under his former employer’s plan (the “COBRA plan”) and is also covered as a dependent under an active spouse’s plan, the COBRA plan will be primary and the spouse’s active plan will be secondary. Similarly, if a divorced spouse is receiving COBRA benefits under his or her former spouse’s plan (the “COBRA plan”) and is also covered as a dependent under a new spouse’s plan, the COBRA plan will be primary and the new spouse’s plan will be secondary.

**Longer/Shorter Length of Coverage:** If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

**Equal Division:** If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

## **Determination of Amount of Payment**

1. If this plan is primary, it shall pay benefits as if the secondary plan did not exist.
2. If our records indicate this plan is secondary, we will not process your claims until you have filed them with the primary plan and the primary plan has made its benefit determination.

If this plan is required to make a secondary payment according to the above rules, it will subtract the amount paid by the primary plan from the amount it would have paid in the absence of the primary plan, and pay the difference, if any. In many cases, this will result in no payment by this plan.

## **COB Terms**

**Allowable Expense:** Except as set forth below or where a statute requires a different definition, the term “allowable expense” means any health care expense, including coinsurance, copayments, and any applicable deductible that is covered in full or in part by any of the plans covering the person.

The term “allowable expense” does not include the following:

- An expense or a portion of an expense that is not covered by any of the plans.
- Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person.
- Any type of coverage or benefit not provided under this plan. For example, if this plan does not provide benefits for mental health disorders and substance abuse, dental services and supplies, vision care, prescriptions drugs, or hearing aids, or other similar type of coverage or benefit, then it will have no secondary liability with respect to such coverage or benefit. In addition, the term “allowable expense” does not include the amount of any reduction in benefits under a primary plan because (a) the covered person failed to comply with the primary plan’s provisions concerning second surgical opinions or precertification of admissions or services, or (b), the covered person had a lower benefit because he or she did not use a preferred provider.

**Birthday:** The term “birthday” refers only to month and day in a calendar year and does not include the year in which the individual is born.

**Custodial Parent:** The term “custodial parent” means:

- A parent awarded custody of a child by a court decree; or,
- In the absence of a court decree, the parent with whom the child resides for more than one half of the calendar year without regard to any temporary visitation.

**Group-Type Contract:** The term “group-type contract” means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. The term does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll

deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

**Hospital Indemnity Benefits:** The term “hospital indemnity benefits” means benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

**Noncompliant Plan:** The term “noncompliant plan” means a plan with COB rules that are inconsistent in substance with the order of benefit determination rules of this plan. Examples of noncompliant plans are those that state their benefits are “excess” or “always secondary.”

**Plan:** The term “plan” includes group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

The term “plan” does not include non-group or individual health or medical reimbursement insurance contracts. The term “plan” also does not include hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

**Primary Plan:** The term “primary plan” means a plan whose benefits for a person’s health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

- The plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or,
- All plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

**Secondary Plan:** The term “secondary plan” means a plan that is not a primary plan.

## Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. We are not required to tell or get the consent of any person to do this. Each person claiming benefits under this plan must give us any facts we need to apply these COB rules and to determine benefits payable as a result of these rules.

## Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

## Right of Recovery

If the amount of the payments made by us is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons it has paid to or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

## Special Rules for Coordination with Medicare

Except where otherwise required by federal law, the plan will pay benefits on a secondary basis to Medicare or will pay no benefits at all for services or supplies that are included within the scope of Medicare's coverage, depending upon, among other things, the size of your group, whether your group is a member of an association, and the type of coordination method used by your group. For example, if this plan is secondary to Medicare under federal law, this plan will pay no benefits for services or supplies that are included within the scope of Medicare's coverage if you fail to enroll in Medicare when eligible.

## SUBROGATION

### Right of Subrogation

If we pay or provide any benefits for you under this plan, we are subrogated to all rights of recovery which you have in contract, tort, or otherwise against any person or organization for the amount of benefits we have paid or provided. That means that we may use your right to recover money from that other person or organization.

### Right of Reimbursement

Besides the right of subrogation, we have a separate right to be reimbursed or repaid from any money you, including your family members, recover for an injury or condition for which we have paid plan benefits. This means that you promise to repay us from any money you recover the amount we have paid or provided in plan benefits. It also means that if you recover money as a result of a claim or a lawsuit, whether by settlement or otherwise, you must repay us. And, if you are paid by any person or company besides us, including the person who injured you, that person's insurer, or your own insurer, you must repay us. In these and all other cases, you must repay us.

We have the right to be reimbursed or repaid first from any money you recover, even if you are not paid for all of your claim for damages and you are not made whole for your loss. This means that you promise to repay us first even if the money you recover is for (or said to be for) a loss besides plan benefits, such as pain and suffering. It also means that you promise to repay us first even if another person or company has paid for part of your loss. And it means that you promise to repay us first even if the person who recovers the money is a minor. In these and all other cases, we still have the right to first reimbursement or repayment out of any recovery you receive from any source.

### Right to Recovery

You agree to furnish us promptly all information which you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with us in protecting and obtaining our reimbursement and subrogation rights in accordance with this section.

You or your attorney will notify us before filing any suit or settling any claim so as to enable us to participate in the suit or settlement to protect and enforce this plan's rights under this section. If you do notify us so that we are able to and do recover the amount of our benefit payments for you, we will share proportionately with you in any attorney's fees charged to you by your attorney for obtaining the recovery. If you do not give us that notice, or we retain our own attorney to appear in any court (including bankruptcy court), our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney or under the common fund theory.

You further agree not to allow our reimbursement and subrogation rights under this plan to be limited or harmed by any other acts or failures to act on your part. It is understood and agreed that if you do, we may suspend or terminate payment or provision of any further benefits for you under the plan.

## HEALTH BENEFIT EXCLUSIONS

In addition to other exclusions set forth in this booklet, we **will not** provide benefits under any portion of this booklet for the following:

## A

Services or expenses for elective **abortions**.

Services or expenses for **acupuncture**, biofeedback, behavioral modification and other forms of self-care or self-help training.

**Anesthesia** services or supplies or both by local infiltration.

Services or expenses for or related to **Assisted Reproductive Technology (ART)**. ART is any process of taking human eggs or sperm or both and putting them into a medium or the body to try to cause reproduction. Examples of ART are in vitro fertilization and gamete intrafallopian transfer.

**Autopsy** or postmortem examination services, unless specifically requested by BCBSF or The School Board of Polk County.

## C

Services or expenses of a hospital stay, except one for an emergency, unless we **certify** it before your admission. Services or expenses of a hospital stay for an emergency if we are not notified within 48 hours, or on our next business day after your admission, or if we determine that the admission was not medically necessary.

Services or expenses for which a **claim** is not properly submitted to Blue Cross.

Services or expenses for a **claim we have not received within 12 months** after services were rendered or expenses incurred.

Services or expenses for personal hygiene, **comfort or convenience** items such as: air-conditioners, humidifiers, whirlpool baths, and physical fitness or exercise apparel. Exercise equipment is also excluded. Some examples of exercise equipment are shoes, weights, exercise bicycles or tracks, weights or variable resistance machinery, and equipment producing isolated muscle evaluations and strengthening. Treatment programs, the use of equipment to strengthen muscles according to preset rules, and related services performed during the same therapy session are also excluded.

Services or expenses for sanitarium care, **convalescent care**, or rest care, including care in a nursing home.

Services or expenses for cosmetic surgery. **Cosmetic surgery** is any surgery done primarily to improve or change the way one appears. "Reconstructive surgery" is any surgery done primarily to restore or improve the way the body works or correct deformities that result from disease, trauma or birth defects. Reconstructive surgery is a covered benefit; cosmetic surgery is not. Complications or later surgery related in any way to cosmetic surgery is not covered, even if medically necessary, if caused by an accident, or if done for mental or emotional relief.

- You must contact us prior to surgery to find out whether a procedure will be reconstructive or cosmetic. You and your physician must prove to our satisfaction that surgery is reconstructive and not cosmetic. You must show us history and physical exams, visual field measures, photographs and medical records before and after surgery. We may not be able to determine prior to your surgery whether or not the proposed procedure will be considered cosmetic.
- Some surgery is always cosmetic such as ear piercing, neck tucks, face lifts, buttock and thigh lifts, implants to small but normal breasts (except as provided by the Women's Health and Cancer Rights Act), hair implants for male-pattern baldness and correction of frown lines on the forehead. In other surgery, such as blepharoplasty (eyelids), rhinoplasty (nose), chemical peel and chin implants, it depends on why that procedure was done. For example, a person with a deviated septum may have trouble breathing and may have many sinus infections. To correct this they have septoplasty. During surgery the physician may remove a hump or shorten the nose (rhinoplasty). The septoplasty would be reconstructive surgery while the rhinoplasty would be denied as cosmetic surgery. Surgery to remove excess skin from the eyelids (blepharoplasty) would be cosmetic if done to improve your appearance, but reconstructive if done because your eyelids kept you from seeing very well.

Services or expenses for treatment of injury sustained in the commission of a **crime** (except for treatment of injury as a result of a medical condition or as a result of domestic violence) or for treatment while confined in a prison, jail, or other penal institution.

Services or expenses for **custodial care**. Care is "custodial" when its primary purpose is to provide room and board, routine nursing care, training in personal hygiene, and other forms of self-care or supervisory care by a physician for a person who is mentally or physically disabled.

## D

**Dental** implants into, across, or just above the bone and related appliances. Services or expenses to prepare the mouth for dental implants such as those to increase the upper and lower jaws or their borders, sinus lift process, guided tissue regrowth or any other surgery, bone grafts, hydroxyapatite and similar materials. These services, supplies or expenses are not covered even if they are needed to treat conditions existing at birth, while growing, or resulting from an accident. These services, supplies or expenses are excluded even if they are medically or dentally necessary.

Except as may be otherwise expressly covered in this booklet, **dietary** instructions.

## E

Services, care, or treatment you receive after the **ending date of your coverage**. This means, for example, that if you are in the hospital when your coverage ends, we will not pay for any more hospital days. We do not insure against any condition such as pregnancy or injury. We provide benefits only for services and expenses furnished while this plan is in effect.

**Eyeglasses** or contact lenses or related examinations or fittings, except under the limited circumstances set forth in the section of this booklet called [Other Covered Services](#).

Services or expenses for **eye** exercises, eye refractions, visual training orthoptics, shaping the cornea with contact lenses, or any surgery on the eye to improve vision including radial keratotomy.

## F

Services or expenses in any **federal hospital or facility** except as required by federal law.

**Food and food products** prescribed or not, except Enteral Formulas as outlined in the Other Covered Services section of this document.

Services or expenses for routine **foot care** such as removal of corns or calluses or the trimming of nails (except mycotic nails).

## G

**Genetic screening**, including the evaluation of genes to determine if you are a carrier of an abnormal gene that puts you at risk for a condition, except as provided under the Preventive Health Service.

Unless otherwise required by applicable law, services or expenses covered in whole or in part under the laws of the United States, any state, county, city, town or other **governmental** agency that provides or pays for care, through insurance or any other means.

## H

**Hearing aids** or examinations or fittings for them, except under limited circumstances when determined to be medically necessary.

## I

**Investigational** treatment, procedures, facilities, drugs, drug usage, equipment, or supplies, including investigational services that are part of a clinical trial. Under federal law, the plan cannot deny a member participation in an approved clinical trial, is prohibited from dropping coverage because member chooses

to participate in an approved clinical trial, and from denying coverage for routine care that the plan would otherwise provide just because a member is enrolled in an approved clinical trial. This applies to all approved clinical trials that treat cancer or other life-threatening diseases.

## L

Services or expenses that you are not **legally obligated to pay**, or for which no charge would be made if you had no health coverage.

Services or expenses for treatment which does not require a **licensed provider**, given the level of simplicity and the patient's condition, will not further restore or improve the patient's bodily functions, or is not reasonable as to number, frequency, or duration.

## M

Services or expenses we determine are not **medically necessary**.

Services or supplies to the extent that a member is, or would be, entitled to reimbursement under **Medicare**, regardless of whether the member properly and timely applied for, or submitted claims to Medicare, except as otherwise required by federal law.

Services or expenses for or related to the diagnosis or treatment of **mental retardation**.

## N

Services or expenses of any kind for **nicotine addiction** except as provided under the section of the booklet called [Physician Preventive Benefits](#).

Services, care or treatment you receive during any period of time with respect to which we have **not been paid for your coverage** and that **nonpayment** results in termination.

## O

Except as may be otherwise expressly covered in the booklet, services or expenses for treatment of any condition including, but not limited to, **obesity**, diabetes, or heart disease, which is based upon weight reduction or dietary control or services or expenses of any kind to treat obesity, weight reduction or dietary control. This exclusion includes bariatric surgery and gastric restrictive procedures and any complications arising from bariatric surgery and gastric restrictive procedures (This exclusion does not apply to cardiac or pulmonary rehabilitation, diabetes self-management programs or Plan approved programs for pediatric obesity).

Services or expenses provided by an **out-of-network provider** for any benefits under this plan, unless otherwise specifically stated in the plan.

## P

**Private duty nursing** unless previously stated as a covered service.

## R

Services or expenses for **recreational** or educational therapy (except for plan-approved ABA Therapy, diabetic self-management programs, pulmonary rehabilitation programs, or Phase 1 or 2 cardiac rehabilitation programs).

Hospital admissions or stays primarily for services to **rehabilitate** such as (but not limited to) physical therapy, speech therapy, or occupational therapy. If Blue Cross determines that services during a continuous hospital confinement have developed into primarily rehabilitative services, that portion of the stay beginning on the day of such development shall not be covered. This exclusion does not apply to benefits stated in the [Inpatient Rehabilitation Benefits](#) section.

Services or expenses for learning or vocational **rehabilitation**.



Services or expenses any provider rendered to a member who is **related** to the provider by blood or marriage or who regularly resides in the provider's household. Examples of a provider include a physician, a licensed registered nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed physical therapist.

**Replacement or upgrade** of existing properly functioning durable medical equipment (including prosthetics), even if the warranty has expired.

**Room and board** for hospital admissions in whole or in part when the patient primarily receives services that could have been provided on an outpatient basis based upon the patient's condition and the services provided.

**Routine physical examinations** except for the services described in [Physician Preventive Benefits](#).

**Routine well child care** and routine immunizations except for the services described in [Physician Preventive Benefits](#).

## S

Services or expenses for, or related to, **sexual dysfunctions** or inadequacies not related to organic disease (unless the injury results from an act of domestic violence or a medical condition).

Services or expenses for, or related to **sex therapy** programs or treatment for **sex offenders**.

Services or expenses of any kind for or related to reverse **sterilizations**.

## T

Services or expenses to care for, treat, fill, extract, remove or replace **teeth** or to increase the periodontium. The periodontium includes the gums, the membrane surrounding the root of a tooth, the layer of bone covering the root of a tooth and the upper and lower jaws and their borders, which contain the sockets for the teeth. Care to treat the periodontium, dental pulp or "dead" teeth, irregularities in the position of the teeth, artificial dental structures such as crowns, bridges or dentures, or any other type of dental procedure is excluded. Hydroxyapatite or any other material to make the gums rigid is excluded. It does not matter whether their purpose is to improve conditions inside or outside the mouth (oral cavity). These services, supplies or expenses are not covered even if they are used to prepare a patient for services or procedures that are plan benefits. For example, braces on the teeth are excluded for any purpose. This exclusion does not apply, except as indicated above for braces or other orthodontic appliances, to those services by a physician to treat or replace natural teeth which are harmed by accidental injury covered under [Other Covered Services](#).

Out-of-network **telephone and video** consultations.

Dental treatment for or related to Phase II **temporomandibular joint (TMJ) disorders** according to the guidelines approved by the Academy of Craniomandibular Disorders. These treatments permanently alter the teeth or the way they meet and include such services as balancing the teeth, shaping the teeth, reshaping the teeth, restorative treatment, treatment involving artificial dental structures such as crowns, bridges or dentures, full mouth rehabilitation, dental implants, treatment for irregularities in the position of the teeth (such as braces or other orthodontic appliances) or a combination of these treatments.

Services, supplies, implantable devices, equipment and accessories billed by any out-of-network **third party vendor** that are used in surgery or any operative setting. This exclusion does not apply to services and supplies provided to a member for use in their home pursuant to a physician's prescription.

**Transcutaneous Electrical Nerve Stimulation (TENS)** equipment and all related supplies including TENS units, Conductive Garments, application of electrodes, leads, electrodes, batteries and skin preparation solutions.

Services or expenses for or related to organ, tissue or cell **transplants** except specifically as allowed by this plan.

**Travel**, even if prescribed by your physician (not including ambulance services otherwise covered under the plan).

# W

Services or expenses for an accident or illness resulting from active participation in **war**, or any act of war, declared or undeclared, or from active participation in riot or civil commotion.

Services or expenses rendered for any disease, injury or condition arising out of and in the course of employment for which benefits and/or compensation is available in whole or in part under the provisions of any **workers' compensation** or employers' liability laws, state or federal. This applies whether you fail to file a claim under that law. It applies whether the law is enforced against or assumed by the group. It applies whether the law provides for hospital or medical services as such. It applies whether the provider of those services was authorized as required by the law. Finally, it applies whether your group has insurance coverage for benefits under the law.

## CLAIMS AND APPEALS

Remember that you may always call our Customer Service Department for help if you have a question or problem that you would like us to handle without an appeal. The phone number to reach our Customer Service Department is on the back of your ID card.

Claims for benefits under the plan can be post-service, pre-service, or concurrent. This section of your booklet explains how we process these different types of claims and how you can appeal a partial or complete denial of a claim.

You must act on your own behalf or through an authorized representative if you wish to exercise your rights under this section of your booklet. An authorized representative is someone you designate in writing to act on your behalf. We have developed a form that you must use if you wish to designate an authorized representative. You can obtain the form by calling our Customer Service Department. You can also go to [FL.ExploreMyPlan.com](http://FL.ExploreMyPlan.com) and ask us to mail you a copy of the form. If a person is not properly designated as your authorized representative, we will not be able to deal with him or her in connection with the exercise of your rights under this section of your booklet.

For urgent pre-service claims, we will presume that your provider is your authorized representative unless you tell us otherwise in writing.

### Post-Service Claims

**What Constitutes a Claim:** For you to obtain benefits after medical services have been rendered or supplies purchased (a post-service claim), we must receive a properly completed and filed claim from you or your provider.

In order for us to treat a submission by you or your provider as a post-service claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, must provide us with the data elements that we specify in advance. Most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call our Customer Service Department and ask for a claim form. Tell us the type of service or supply for which you wish to file a claim (for example, hospital, physician, or pharmacy), and we will send you the proper type of claim form. When you receive the form, complete it, attach an itemized bill, and send it to us at Blue Cross and Blue Shield, Birmingham Service Center, P.O. Box 10527, Birmingham, Alabama 35202-0500. Claims must be submitted and received by us within 12 months after the service takes place to be eligible for benefits.

If we receive a submission that does not qualify as a claim, we will notify you or your provider of the additional information we need. Once we receive that information, we will process the submission as a claim.

**Processing of Claims:** Even if we have received all of the information that we need in order to treat a submission as a claim, from time to time we might need additional information in order to determine whether the claim is payable. If we need additional information, we will ask you to furnish it to us, and we will suspend further processing of your claim until the information is received. You will have 90 days to provide the information to us. In order to expedite our receipt of the information, we may request it

directly from your provider. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information on time.

Ordinarily, we will notify you of our decision within 30 days of the date on which your claim is filed. If it is necessary for us to ask for additional information, we will notify you of our decision within 15 days after we receive the requested information. If we do not receive the information, your claim will be considered denied at the expiration of the 90-day period we gave you for furnishing the information to us.

In some cases, we may ask for additional time to process your claim. If you do not wish to give us additional time, we will go ahead and process your claim based on the information we have. This may result in a denial of your claim.

## **Pre-Service Claims**

A pre-service claim is one in which you are required to obtain approval from us before services or supplies are rendered. For example, you may be required to obtain preadmission certification of inpatient hospital benefits. Or you may be required to obtain a pre-procedure review of other medical services or supplies in order to obtain coverage under the plan.

In order to file a pre-service claim you or your provider must call our Health Management Department at 1-855-288-8357 (toll-free). You must tell us your contract number, the name of the facility in which you are being admitted (if applicable), the name of a person we can call back, and a phone number to reach that person. You may also, if you wish, submit pre-service claims in writing.

Written pre-service claims should be sent to us at Blue Cross and Blue Shield, Birmingham Service Center, P.O. Box 10527, Birmingham, Alabama 35202-0500.

Non-urgent pre-service claims (for example, those relating to elective services and supplies) must be submitted to us during our regular business hours. Urgent pre-service claims can be submitted at any time. Emergency admissions to a hospital do not require you to file a pre-service claim so long as you provide notice to us within 48 hours of the admission and we certify the admission as both medically necessary and as an emergency admission. You are not required to precertify an inpatient hospital admission if you are admitted to a Concurrent Utilization Review Program (CURP) hospital by a Preferred Medical Doctor (PMD). CURP is a program implemented by us and in-network hospitals in the Florida service area to simplify the administration of preadmission certifications and concurrent utilization reviews. If your plan provides chiropractic, physical therapy, or occupational therapy benefits and you receive covered treatment from an in-network chiropractor, in-network physical therapist, or in-network occupational therapist, your provider is responsible for initiating the precertification process for you. For home healthcare and hospice benefits (if covered by your plan), see the previous sections of this booklet for instructions on how to precertify treatment.

If you attempt to file a pre-service claim but fail to follow our procedures for doing so, we will notify you of the failure within 24 hours (for urgent pre-service claims) or five days (for non-urgent pre-service claims). Our notification may be oral, unless you ask for it in writing. We will provide this notification to you only if (1) your attempt to submit a pre-service claim was received by a person or organizational unit of our company that is customarily responsible for handling benefit matters, and (2), your submission contains the name of a member, a specific medical condition or symptom, and a specific treatment or service for which approval is being requested.

**Urgent Pre-Service Claims:** We will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function or, in the opinion of your treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim. If your treating physician tells us that your claim is urgent, we will treat it as such.

If your claim is urgent, we will notify you of our decision within 72 hours. If we need more information, we will let you know within 24 hours of your claim. We will tell you what further information we need. You will then have 48 hours to provide this information to us. We will notify you of our decision within 48 hours after we receive the requested information. Our response may be oral; if it is, we will follow it up in writing. If we do not receive the information, your claim will be considered denied at the expiration of the 48-hour period we gave you for furnishing information to us.

**Non-Urgent Pre-Service Claims:** If your claim is not urgent, we will notify you of our decision within 15 days. If we need more information, we will let you know before the 15-day period expires. We will tell you what further information we need. You will then have 90 days to provide this information to us. In order to expedite our receipt of the information, we may request it directly from your provider. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information on time. We will notify you of our decision within 15 days after we receive the requested information. If we do not receive the information, your claim will be considered denied at the expiration of the 90-day period we gave you for furnishing the information to us.

**Courtesy Pre-Determinations:** For some procedures we encourage, but do not require, you to contact us before you have the procedure. For example, if you or your physician thinks a procedure might be excluded as cosmetic, you can ask us to determine beforehand whether the procedure is cosmetic or reconstructive. We call this type of review a courtesy pre-determination. If you ask for a courtesy pre-determination, we will do our best to provide you with a timely response. If we decide that we cannot provide you with a courtesy pre-determination (for example, we cannot get the information we need to make an informed decision), we will let you know. In either case, courtesy pre-determinations are not pre-service claims under the plan. When we process requests for courtesy pre-determinations, we are not bound by the time frames and standards that apply to pre-service claims. In order to request a courtesy pre-determination, you or your provider should call our Customer Service Department.

## Concurrent Care Determinations

**Determinations by Us to Limit or Reduce Previously Approved Care:** If we have previously approved a hospital stay or course of treatment to be provided over a period of time or number of treatments, and we later decide to limit or reduce the previously approved stay or course of treatment, we will give you enough advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow any reasonable rules we establish for the filing of your appeal, such as time limits within which the appeal must be filed.

**Requests by You to Extend Previously Approved Care:** If a previously approved hospital stay or course of treatment is about to expire, you may submit a request to extend your approved care. You may make this request in writing or orally either directly to us or through your treating physician or a hospital representative. The phone numbers to call in order to request an extension of care are as follows:

- For inpatient hospital care, call 1-855-288-8357 (toll-free).
- For in-network chiropractic services, physical therapy, speech therapy, or occupational therapy call 1-844-594-6010.

If your request for additional care is urgent, and if you submit it no later than 24 hours before the end of your pre-approved stay or course of treatment, we will give you our decision within 24 hours of when your request is submitted. If your request is not made before this 24-hour time frame, and your request is urgent, we will give you our determination within 72 hours. If your request is not urgent, we will treat it as a new claim for benefits, and will make a determination on your claim within the pre-service or post-service time frames discussed above.

## Your Right To Information

You have the right, upon request, to receive copies of any documents that we relied on in reaching our decision and any documents that were submitted, considered, or generated by us in the course of reaching our decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that we may have relied upon in reaching our decision. If our decision was based on a medical or scientific determination (such as medical necessity), you may also request that we provide you with a statement explaining our application of those medical and scientific principles to you. If we obtained advice from a healthcare professional (regardless of whether we relied on that advice), you may request that we give you the name of that person. Any request that you make for information under this paragraph must be in writing. We will not charge you for any information that you request under this paragraph.

## Appeals

The rules in this section of this booklet allow you or your authorized representative to appeal any adverse benefit determination. An adverse benefit determination includes any one or more of the following:

- Any determination we make with respect to a post-service claim that results in your owing any money to your provider other than copayments you make, or are required to make, to your provider;
- Our denial of a pre-service claim;
- An adverse concurrent care determination (for example, we deny your request to extend previously approved care); or,
- Your group's denial of your or your dependents' initial eligibility for coverage under the plan or your group's retroactive rescission of your or your dependents' coverage for fraud or intentional misrepresentation of a material fact.

In all cases other than determinations by us to limit or reduce previously approved care and determinations by your group regarding initial eligibility or retroactive rescission, you have 180 days following our adverse benefit determination within which to submit an appeal.

**How to Appeal Your Group's Adverse Eligibility and Rescission Determinations:** If you wish to file an appeal of your group's adverse determination relating to initial eligibility for coverage or retroactive rescission of coverage, you should check with your group regarding your group's appeal procedures.

**How to Appeal Post-Service Adverse Benefit Determinations:** If you wish to file an appeal of an adverse benefit determination relating to a post-service claim we recommend that you use a form that we have developed for this purpose. The form will help you provide us with the information that we need to consider your appeal. To get the form, you may call our Customer Service Department. You may also go to [FL.ExploreMyPlan.com](http://FL.ExploreMyPlan.com). Once there, you may request a copy of the form.

If you choose not to use our appeal form, you may send us a letter. Your letter must contain at least the following information:

- The patient's name;
- The patient's contract number;
- Sufficient information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure (if known), and claim number (if available). (The best way to satisfy this requirement is to include a copy of your claims report with your appeal.); and,
- A statement that you are filing an appeal.

You must send your appeal to the following address:

Blue Cross and Blue Shield  
Birmingham Service Center  
Attention: Customer Service Department – Appeals  
P.O. Box 188  
Birmingham, Alabama 35201-0188

Please note that if you call or write us without following the rules just described for filing an appeal, we will not treat your inquiry as an appeal. We will, of course, do everything we can to resolve your questions or concerns.

**How to Appeal Pre-Service Adverse Benefit Determinations:** You may appeal an adverse benefit determination relating to a pre-service claim in writing or over the phone.

If over the phone, you should call the appropriate phone number listed below:

- For inpatient hospital care and admissions, call 1-855-288-8357 (toll-free).
- For in-network chiropractic services, physical therapy, speech therapy, or occupational therapy call 1-844-594-6010.
- For radiological diagnostic services call 1-855-288-5357 (toll-free).

If in writing, you should send your letter to the appropriate address listed below:

- For inpatient hospital care and admissions:

Blue Cross and Blue Shield  
Birmingham Service Center  
Attention: Health Management Department – Appeals  
P.O. Box 2504  
Birmingham, Alabama 35201-2504

or

- For in-network chiropractic services, physical therapy, speech therapy, or occupational therapy:

Blue Cross and Blue Shield  
Birmingham Service Center  
Attention: Health Management Department – Appeals  
P.O. Box 362025  
Birmingham, Alabama 35236

or

- For radiological diagnostic services:

Radiology Benefits Management  
540 Lake Cook Rd.  
Suite 300  
Deerfield, IL 60015  
Fax: 1-888-583-1005

Your written appeal should provide us with your name, contract number, the name of the facility or provider involved, and the date or dates of service.

Please note that if you call or write us without following the rules just described for filing an appeal, we will not treat your inquiry as an appeal. We will, of course, do everything we can to resolve your questions or concerns.

**Conduct of the Appeal:** We will assign your appeal to one or more persons within our organization who are neither the persons who made the initial determination nor subordinates of those persons. If resolution of your appeal requires us to make a medical judgment (such as whether services or supplies are medically necessary), we will consult a healthcare professional who has appropriate expertise. If we consulted a healthcare professional during our initial decision, we will not consult that same person or a subordinate of that person during our consideration of your appeal.

If we need more information, we will ask you to provide it to us. In some cases we may ask your provider to furnish that information directly to us. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information. If we do not get the information, it may be necessary for us to deny your appeal.

**Time Limits for Our Consideration of Your Appeal:** If your appeal arises from our denial of a post-service claim, we will notify you of our decision within 60 days of the date on which you filed your appeal.

If your appeal arises from our denial of a pre-service claim, and if your claim is urgent, we will consider your appeal and notify you of our decision within 72 hours. If your pre-service claim is not urgent, we will give you a response within 30 days.

If your appeal arises out of a determination by us to limit or reduce a hospital stay or course of treatment that we previously approved for a period of time or number of treatments, (see [Concurrent Care Determinations](#) above), we will make a decision on your appeal as soon as possible, but in any event before we impose the limit or reduction.

If your appeal relates to our decision not to extend a previously approved length of stay or course of treatment (see [Concurrent Care Determinations](#) above), we will make a decision on your appeal within 72

hours (in urgent pre-service cases), 30 days (in non-urgent pre-service cases), or 60 days (in post-service cases).

In some cases, we may ask for additional time to process your appeal. If you do not wish to give us additional time, we will go ahead and decide your appeal based on the information we have. This may result in a denial of your appeal.

**If You Are Dissatisfied After Exhausting Your Mandatory Plan Administrative Remedies:** If you filed an appeal and are dissatisfied with our response, you may do one or more of the following:

- You may ask our Customer Service Department for further help;
- You may file a voluntary appeal (discussed below);
- You may file a claim for external review for a claim involving medical judgment or rescission of your plan coverage (discussed below); or,
- You may file a lawsuit in the forum specified in your plan.

**Voluntary Appeals:** If we have given you our appeal decision and you are still dissatisfied, you may file a second appeal (called a voluntary appeal). If your voluntary appeal relates to a pre-service adverse benefit determination, you may file your appeal in writing or over the phone. If over the phone, you should call the phone number you called to submit your first appeal. If in writing, you should send your letter to the same address you used when you submitted your first appeal.

Your written appeal must state that you are filing a voluntary appeal.

If you file a voluntary appeal (whether oral or written), we will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. We will also agree that any defense based upon timeliness or statutes of limitations will be tolled during the time that your voluntary appeal is pending. In addition, we will not impose any fees or costs on you as part of your voluntary appeal.

You may ask us to provide you with more information about voluntary appeals. This additional information will allow you to make an informed judgment about whether to request a voluntary appeal.

## **External Reviews**

For claims involving medical judgment and/or rescissions of coverage, you may also file a request with us for an independent, external review of our decision. You must request this external review within 4 months of the date of your receipt of our adverse benefit determination or final adverse appeal determination. Your request for an external review must be in writing, must state you are filing a request for external review, and must be submitted to the following address: Blue Cross and Blue Shield, Birmingham Service Center, P.O. Box 1177, Birmingham, Alabama 35201-1177 .

If you request an external review, an independent organization will review our decision. You may submit additional written comments to the review organization. Once your external review is initiated, you will receive instructions about how to do this. If you give the review organization additional information, the review organization will give us copies of this additional information to give us an opportunity to reconsider our denial. Both of us will be notified in writing of the review organization's decision. The decision of the review organization will be final and binding on both of us.

## **Expedited External Reviews for Urgent Pre-Service Claims**

If your pre-service claim meets the definition of urgent under law, the external review of your claim will be conducted as expeditiously as possible. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. If you believe that your pre-service claim is urgent you may request an external review by calling us at 1-855-288-8357 (toll-free) or by faxing your request to 205-220-0833 or 1-877-506-3110 (toll-free).

# COBRA

COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X). If COBRA applies, you may be able to temporarily continue coverage under the plan beyond the point at which coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA coverage may be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of a qualifying event. You are not entitled to buy COBRA coverage if you are employed as a nonresident alien who received no U.S. source income, nor may your family members buy COBRA.

Not all group health plans are covered by COBRA. As a general rule, COBRA applies to all employer sponsored group health plans (other than church plans) if the employer employed 20 or more full or part-time employees on at least 50% of its typical business days during the preceding calendar year. In determining the number of employees of an employer for purposes of COBRA, certain related corporations (parent/subsidiary and brother/sister corporations) must be treated as one employer. Special rules may also apply if the employer participates in an association plan. You must contact your plan administrator (normally your group) to determine whether this plan is covered by COBRA.

By law, COBRA benefits are required to be the same as those made available to similarly situated active employees. If the group changes the plan coverage, coverage will also change for you. You will have to pay for COBRA coverage. Your cost will equal the full cost of the coverage plus a two percent administrative fee. Your cost may change over time, as the cost of benefits under the plan changes.

If the group stops providing health care through Blue Cross, Blue Cross will stop administering your COBRA benefits. You should contact your group to determine if you have further rights under COBRA.

## COBRA Rights for Covered Employees

If you are a covered employee, you will become a qualified beneficiary if you lose coverage under the plan because either one of the following qualifying events happens:

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

COBRA coverage will continue for up to a total of 18 months from the date of your termination of employment or reduction in hours, assuming you pay your premiums on time. If, apart from COBRA, your group continues to provide coverage to you after your termination of employment or reduction in hours (regardless of whether such extended coverage is permitted under the terms of the plan), the extended coverage you receive will ordinarily reduce the time period over which you may buy COBRA benefits.

If you are on a leave of absence covered by the Family and Medical Leave Act of 1993 (FMLA), and you do not return to work, you will be given the opportunity to buy COBRA coverage. The period of your COBRA coverage will begin when you fail to return to work following the expiration of your FMLA leave or you inform your group that you do not intend to return to work, whichever occurs first.

## COBRA Rights for a Covered Spouse and Dependent Children

If you are covered under the plan as a spouse or a dependent child of a covered employee, you will become a qualified beneficiary if you would otherwise lose coverage under the plan as a result of any of the following events:

- The covered employee dies;
- The covered employee's hours of employment are reduced;
- The covered employee's employment ends for any reason other than his or her gross misconduct;
- The covered employee becomes enrolled in Medicare;
- Divorce of the covered employee and spouse; or,
- For a dependent child, the dependent child loses dependent child status under the plan.



When the qualifying event is a divorce or a child losing dependent status under the plan, you must timely notify the plan administrator of the qualifying event. You must provide this notice within 60 days of the event or within 60 days of the date on which coverage would be lost because of the event, whichever is later. See the section called [Notice Procedures](#) for more information about the notice procedures you must use to give this notice.

If you are a covered spouse or dependent child, the period of COBRA coverage will generally last up to a total of 18 months in the case of a termination of employment or reduction in hours and up to a total of 36 months in the case of other qualifying events, provided that premiums are paid on time. If, however, the covered employee became enrolled in Medicare before the end of his or her employment or reduction in hours, COBRA coverage for the covered spouse and dependent children will continue for up to 36 months from the date of Medicare enrollment or 18 months from the date of termination of employment or reduction in hours, whichever period ends last.

If you are a child of the covered employee or former employee and you are receiving benefits under the plan pursuant to a qualified medical child support order, you are entitled to the same rights under COBRA as a dependent child of the covered employee.

If your coverage is canceled in anticipation of divorce and a divorce later occurs, the divorce may be a qualifying event even though you actually lost coverage under the plan earlier. If you timely notify the plan administrator of your divorce and can establish that your coverage was canceled in anticipation of divorce, COBRA coverage may be available to you beginning on the date of your divorce (but not for the period between the date your coverage ended and the date of the divorce).

### **Extensions of COBRA for Disability**

If you or a covered member of your family is or becomes disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act and you timely notify the plan administrator, the 18-month period of COBRA coverage for the disabled person may be extended to up to 11 additional months (for a total of up to 29 months) or the date the disabled person becomes covered by Medicare, whichever occurs sooner. This 29-month period also applies to any non-disabled family members who are receiving COBRA coverage, regardless of whether the disabled individual elects the 29-month period for him or herself. The 29-month period will run from the date of the termination of employment or reduction in hours. For this disability extension to apply, the disability must have started at some time before the 60<sup>th</sup> day of COBRA coverage and must last at least until the end of the 18-month period of COBRA coverage.

The cost for COBRA coverage after the 18<sup>th</sup> month will be 150% of the full cost of coverage under the plan, assuming that the disabled person elects to be covered under the disability extension. If the only persons who elect the disability extension are non-disabled family members, the cost of coverage will remain at 102% of the full cost of coverage.

For a spouse and children, the disability extension may be further extended to 36 months if another qualifying event (death, divorce, enrollment in Medicare, or loss of dependent status) occurs during the 29-month period. See the following discussion under [Extensions of COBRA for Second Qualifying Events](#) for more information about this.

For this disability extension of COBRA coverage to apply, you must give the plan administrator timely notice of Social Security's disability determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of (1) the date of the initial qualifying event, (2) the date on which coverage would be lost because of the initial qualifying event, or (3) the date of Social Security's determination. You must also notify the plan administrator within 30 days of any revocation of Social Security disability benefits. See the section called [Notice Procedures](#) for more information about the notice procedures you must use to give this notice.

### **Extensions of COBRA for Second Qualifying Events**

For a spouse and children receiving COBRA coverage, the 18-month period may be extended to 36 months if another qualifying event occurs during the 18-month period, if you give the plan administrator timely notice of the second qualifying event. The 36-month period will run from the date of the termination of employment or reduction in hours.

This extension is available to a spouse and children receiving COBRA coverage if the covered employee or former employee dies, becomes enrolled in Medicare, or gets divorced, or if the child stops being eligible under the plan as a dependent child, *but only if the event would have caused the spouse or child to lose coverage under the plan had the first qualifying event not occurred.* For example, if a covered employee is terminated from employment, elects family coverage under COBRA, and then later enrolls in Medicare, this second event will rarely be a second qualifying event that would entitle the spouse and children to extended COBRA coverage. This is so because, for almost all plans that are subject to COBRA, this event would not cause the spouse or dependent children to lose coverage under the plan if the covered employee had not been terminated from employment.

For this 18-month extension to apply, you must give the plan administrator timely notice of the second qualifying event within 60 days after the event occurs or within 60 days after the date on which coverage would be lost because of the event, whichever is later. See the section [Notice Procedures](#) for more information about the notice procedures you must use to give this notice.

## Notice Procedures

*If you do not follow these notice procedures or if you do not give the plan administrator notice within the required 60-day notice period, you will not be entitled to COBRA or an extension of COBRA as a result of an initial qualifying event of divorce or loss of dependent child status, a second qualifying event or Social Security's disability determination.*

Any notices of initial qualifying events of divorce or loss of dependent child status, second qualifying events or Social Security disability determinations that you give must be in writing. Your notice must be received by the plan administrator or its designee no later than the last day of the required 60-day notice period unless you mail it. If mailed, your notice must be postmarked no later than the last day of the required 60-day notice period.

For your notice of an initial qualifying event that is a divorce or a child losing dependent status under the plan and for your notice of a second qualifying event, you must mail or hand-deliver your notice to the plan administrator. If the initial or second qualifying event is a divorce, your notice must include a copy of the divorce decree. For your convenience, you may ask the plan administrator for a free copy of the Notice by Qualified Beneficiaries form that you may use to give your notice.

For your notice of Social Security's disability determination, if you are instructed to send your COBRA premiums to Blue Cross, you must mail or hand-deliver your notice to Blue Cross at the following address: Blue Cross and Blue Shield, Birmingham Service Center, Attention: Customer Accounts, P.O. Box 10527, Birmingham, Alabama 35202-0500, or fax your notice to Blue Cross at 205-220-6884 or 1-888-810-6884 (toll-free). If you do not send your COBRA premiums to Blue Cross, you must mail or hand-deliver your notice to the plan administrator. Your notice must also include a copy of Social Security's disability determination. For your convenience, you may ask the plan administrator for a free copy of the Notice by Qualified Beneficiaries form that you may use to give your notice.

## Adding New Dependents to COBRA

You may add new dependents to your COBRA coverage under the circumstances permitted under the plan. Except as explained below, any new dependents that you add to your COBRA coverage will not have independent COBRA rights. This means, for example, that if you die, they will not be able to continue coverage.

If you are the covered employee and you acquire a child by birth or placement for adoption while you are receiving COBRA coverage, then your new child will have independent COBRA rights. This means that if you die, for example, your child may elect to continue receiving COBRA benefits for up to 36 months from the date on which your COBRA benefits began.

If your new child is disabled within the 60-day period beginning on the date of birth or placement of adoption, the child may elect coverage under the disability extension if you timely notify the plan administrator of Social Security's disability determination as explained above.

## Medicare and COBRA Coverage

You should consider whether it is beneficial to purchase COBRA coverage. After you retire or otherwise have a qualifying event under COBRA, your COBRA coverage will be secondary to Medicare with respect to services or supplies that are covered, or would be covered upon proper application, under Medicare. This means that, regardless of whether you have enrolled in Medicare, your COBRA coverage after such qualifying event will not cover most of your hospital, medical and prescription drug expenses. Call the benefits coordinator at your group for more information about this.

If you think you will need both Medicare and COBRA after your retirement or other qualifying event under COBRA, you should enroll in Medicare on or before the date on which you make your election to buy COBRA coverage. If you do this, COBRA coverage for your dependents will continue for a period of 18 months from the date of your retirement or 36 months from the date of your Medicare enrollment, whichever period ends last. Your COBRA coverage will continue for a period of 18 months from the date of your retirement, or other qualifying event under COBRA. If you do not enroll in Medicare on or before the date on which you make your election to buy COBRA coverage, your COBRA benefits will end when your Medicare coverage begins. Your covered dependents will have the opportunity to continue their own COBRA coverage.

If you do not want both Medicare and COBRA for yourself, your covered family members will still have the option to buy COBRA when you retire, or have another qualifying event under COBRA. However, if your covered family members become enrolled in Medicare after electing COBRA, their COBRA coverage will end. See the [Early Termination of COBRA](#) section of this booklet for more information about this.

## Electing COBRA

After the plan administrator receives timely notice that a qualifying event has occurred, the plan administrator is responsible for (1) notifying you that you have the option to buy COBRA, and (2), sending you an application to buy COBRA coverage.

You have 60 days within which to elect to buy COBRA coverage. The 60-day period begins to run from the later of (1) the date you would lose coverage under the plan, or (2), the date on which the group notifies you that you have the option to buy COBRA coverage. Each qualified beneficiary has an independent right to elect COBRA coverage. You may elect COBRA coverage on behalf of your spouse, and parents may elect COBRA coverage on behalf of their children. An election to buy COBRA coverage will be considered made on the date sent back to the group.

Once the group has notified us that your coverage under the plan has ceased, we will retroactively terminate your coverage and rescind payment of all claims incurred after the date coverage ceased. If you elect to buy COBRA during the 60-day election period, and if your premiums are paid on time, we will retroactively reinstate your coverage and process claims incurred during the 60-day election period.

Because there may be a lag between the time your coverage under the plan ends and the time we learn of your loss of coverage, it is possible that we may pay claims incurred during the 60-day election period. If this happens, you should not assume that you have coverage under the plan. The only way your coverage will continue is if you elect to buy COBRA and pay your premiums on time.

## COBRA Premiums

Your first COBRA premium payment must be made no later than 45 days after you elect COBRA coverage. That payment must include all premiums owed from the date on which COBRA coverage began. This means that your first premium could be larger than the monthly premium that you will be required to pay going forward. You are responsible for making sure the amount of your first payment is correct. You may contact the plan administrator to confirm the correct amount of your first payment.

After you make your first payment for COBRA coverage, you must make periodic payments for each subsequent coverage period. Each of these periodic payments is due on the first day of the month for that coverage period. There is a grace period of 30 days for all premium payments after the first payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, any claim you submit for benefits will be suspended as of the first day of the coverage period and then processed by the plan only when the periodic payment is received. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to COBRA coverage under the plan.

Payment of your COBRA premiums is deemed made on the day sent.

## **Early Termination of COBRA**

Your COBRA coverage will terminate early if any of the following events occurs:

- The group no longer provides group health coverage to any of its employees;
- You do not pay the premium for your continuation coverage on time;
- After electing COBRA coverage, you become covered under another group health plan;
- After electing COBRA coverage, you become enrolled in Medicare; or,
- You are covered under the additional 11-month disability extension and there has been a final determination that the disabled person is no longer disabled for Social Security purposes.

In addition, COBRA coverage can be terminated if otherwise permitted under the terms of the plan. For example, if you submit fraudulent claims, your coverage will terminate.

If your group stops providing health care through Blue Cross, you will cease to receive any benefits through us for any and all claims incurred after the effective date of termination of our contract with the group. This is true even if we have been billing your COBRA premiums prior to the date of termination. It is the responsibility of your group, not Blue Cross, to notify you of this termination. You must contact your group directly to determine what arrangements, if any, your group has made for the continuation of your COBRA benefits.

If you have any further questions about COBRA or if you change marital status, or you or your spouse or child changes address, please contact your plan administrator. Additional information about COBRA can also be found at the website of the Employee Benefits Security Administration of the United States Department of Labor.

## **RESPECTING YOUR PRIVACY**

The confidentiality of your personal health information is important to us. Under a federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), plans such as this one are generally required to limit the use and disclosure of your protected health information to treatment, payment, and healthcare operations and to put in place appropriate safeguards to protect your protected health information. This section of this booklet explains some of HIPAA's requirements. Additional information is contained in the plan's notice of privacy practices. You may request a copy of this notice by contacting your group's human resources office.

### **Disclosures of Protected Health Information to the Plan Sponsor:**

In order for your benefits to be properly administered, the plan needs to share your protected health information with the plan sponsor (your group). Following are circumstances under which the plan may disclose your protected health information to the plan sponsor:

- The plan may inform the plan sponsor whether you are enrolled in the plan.
- The plan may disclose summary health information to the plan sponsor. The plan sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.
- The plan may disclose your protected health information to the plan sponsor for plan administrative purposes. This is because employees of the plan sponsor perform some of the administrative functions necessary for the management and operation of the plan.

Following are the restrictions that apply to the plan sponsor's use and disclosure of your protected health information:

- The plan sponsor will only use or disclose your protected health information for plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the plan's privacy

notice for more information about permitted uses and disclosures of protected health information under HIPAA.

- If the plan sponsor discloses any of your protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep your protected health information as required by the HIPAA regulations.
- The plan sponsor will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the plan sponsor.
- The plan sponsor will promptly report to the plan any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of this booklet.
- The plan sponsor will allow you or the plan to inspect and copy any protected health information about you that is in the plan sponsor's custody and control. The HIPAA regulations set forth the rules that you and the plan must follow in this regard. There are some exceptions.
- The plan sponsor will amend, or allow the plan to amend, any portion of your protected health information to the extent permitted or required under the HIPAA regulations.
- With respect to some types of disclosures, the plan sponsor will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). You have a right to see the disclosure log. The plan sponsor does not have to maintain the log if disclosures are for certain plan related purposes, such as payment of benefits or healthcare operations.
- The plan sponsor will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to the plan and to the U.S. Department of Health and Human Services, or its designee.
- The plan sponsor will, if feasible, return or destroy all of your protected health information in the plan sponsor's custody or control that the plan sponsor has received from the plan or from any business associate when the plan sponsor no longer needs your protected health information to administer the plan. If it is not feasible for the plan sponsor to return or destroy your protected health information, the plan sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

The following classes of employees or other workforce members under the control of the plan sponsor may use or disclose your protected health information in accordance with the HIPAA regulations that have just been explained:

- Human Resources Department

If any of the foregoing employees or workforce members of the plan sponsor use or disclose your protected health information in violation of the rules that are explained above, the employees or workforce members will be subject to disciplinary action and sanctions – which may include termination of employment. If the plan sponsor becomes aware of any such violation, the plan sponsor will promptly report the violation to the plan and will cooperate with the plan to correct the violation, to impose appropriate sanctions, and to relieve any harmful effects to you.

### **Security of Your Personal Health Information:**

Following are restrictions that will apply to the plan sponsor's storage and transmission of your electronic protected health information:

- The plan sponsor will have in place appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of your electronic protected health information, as well as to ensure that only those classes of employees or other workforce members of the plan sponsor described above have access to use or disclose your electronic protected health information in accordance with the HIPAA regulations.
- If the plan sponsor discloses any of your electronic protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to have in place the appropriate safeguards as required by the HIPAA regulations.

The plan sponsor will report to the plan any security incident of which it becomes aware in accordance with the HIPAA regulations.

### **Our Use and Disclosure of Your Personal Health Information:**

As a business associate of the plan, we (Blue Cross and Blue Shield of Florida) have an agreement with the plan that allows us to use your personal health information for treatment, payment, healthcare operations, and other purposes permitted or required by HIPAA. In addition, by applying for coverage and participating in the plan, you agree that we may obtain, use and release all records about you and your minor dependents that we need to administer the plan or to perform any function authorized or permitted by law. You also agree that we may call you at any telephone number provided to us by you, your employer, or any healthcare provider in accordance with applicable law. You further direct all persons to release all records to us about you and your minor dependents that we need in order to administer the plan.

## **GENERAL INFORMATION**

### **Delegation of Discretionary Authority to Blue Cross**

The group has delegated to us the discretionary responsibility and authority to determine claims under the plan, to construe, interpret, and administer the plan, and to perform every other act necessary or appropriate in connection with our provision of benefits and/or administrative services under the plan.

Whenever we make reasonable determinations that are neither arbitrary nor capricious in our administration of the plan, those determinations will be final and binding on you, subject only to your right of review under the plan (including, when applicable, arbitration) and thereafter to judicial review to determine whether our determination was arbitrary or capricious or correct using the standard of review set forth in any applicable arbitration provisions of this booklet.

### **Notice**

We give you notice when we mail it or send it electronically to you or your group at the latest address we have. You and your group are assumed to receive notice three days after we mail it. Your group is your agent to receive notices from us about the plan. The group is responsible for giving you all notices from us. We are not responsible if your group fails to do so.

Unless otherwise specified in this booklet, if you are required to provide notice to us, you should do so in writing, including your full name and contract number, and mail the notice to us at Blue Cross and Blue Shield, Birmingham Service Center, P.O. Box 10527, Birmingham, Alabama 35202-05001.

### **Correcting Payments**

While we try to pay all claims quickly and correctly, we do make mistakes. If we pay you or a provider in error, the payee must repay us. If he does not, we may deduct the amount paid in error from any future amount paid to you or the provider. If we deduct it from an amount paid to you, it will be reflected in your claims report.

### **Responsibility for Providers**

We are not responsible for what providers do or fail to do. If they refuse to treat you or give you poor or dangerous care, we are not responsible. We need not do anything to enable them to treat you.

### **Misrepresentation**

If you commit fraud or make any intentional material misrepresentation in applying for coverage, when we learn of this we may terminate your coverage back to the effective date on which your coverage began as listed in our records. We need not refund any payment for your coverage. If your group commits fraud or makes an intentional material misrepresentation in its application, it will be as though the plan never took effect, and we need not refund any payment for any member.

## **Governing Law**

The plan and all rights and obligations related to the plan shall be governed by, and construed in accordance with, the laws of the state of Florida, and any applicable federal laws, without regard to any conflicts of law principles or other laws that would result in the applicability of other state laws to the plan.

## **Termination of Benefits and Termination of the Plan**

Our obligation to provide or administer benefits under the plan may be terminated at any time by either the group or us by giving written notice to the other as provided for in the contract. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

If the group fails to pay us the amounts due under the contract within the time period specified therein, our obligation to provide or administer benefits under the plan will terminate automatically and without notice to you or the group as of the date due for payment. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

Subject to any conditions or restrictions in our contract with the group, the group may terminate the plan at any time through action by its authorized officers. In the event of termination of the plan, all benefit payments by us will cease as of the effective date of termination, regardless of whether notice of the termination has been provided to you by the group or us. The fiduciary obligation, if any, to notify you of this termination belongs to the group, not to us.

If for any reason our services are terminated under the contract, you will cease to receive any benefits by us for any and all claims incurred after the effective date of termination. In some cases, this may mean retroactive cancellation by us of your plan benefits. This is true for active contract holders, retirees, COBRA beneficiaries and dependents of either. Any fiduciary obligation to notify you of our termination belongs to the group, not to us.

## **Changes in the Plan**

Subject to any conditions or restrictions in our contract with the group, any and all of the provisions of the plan may be amended by the group at any time by an instrument in writing. In many cases, this instrument will consist of a new booklet (including any riders or supplements to the booklet) that we have prepared and sent to the group in draft format. This means that from time to time the benefit booklet you have in your possession may not be the most current. If you have any question whether your booklet is up to date, you should contact your group. Any fiduciary obligation to notify you of changes in the plan belongs to the group, not to us.

The new benefit booklet (including any riders or supplements to the booklet) will state the effective date applicable to it. In some cases, this effective date may be retroactive to the first day of the plan year to which the changes relate. The changes will apply to all benefits for services you receive on or after the stated effective date.

Except as otherwise provided in the contract, no representative, employee, or agent of Blue Cross is authorized to amend or vary the terms and conditions of the plan or to make any agreement or promise not specifically contained in the plan documents or to waive any provision of the plan documents.

## **No Assignment**

As discussed in more detail in the [Claims and Appeals](#) section of this booklet, most providers are aware of our claim filing requirements and will file claims for you. If your provider does not file your claim for you, you should call our Customer Service Department and ask for a claim form. However, regardless of who files a claim for benefits under the plan, we will not honor an assignment by you of payment of your claim to anyone. What this means is that we will pay covered benefits to you or your in-network provider (as required by our contract with your in-network provider) – even if you have assigned payment of your claim to someone else. With out-of-network providers, we may choose whether to pay you or the provider-even if you have assigned payment of your claim to someone else. When we pay you or your provider, this completes our obligation to you under the plan. Upon your death or incompetence, or if you are a minor, we may pay your estate, your guardian or any relative we believe is due to be paid. This, too, completes our plan obligation to you.



# DEFINITIONS

**ABA Therapy:** ABA therapy is defined as the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

**Accidental Injury:** A traumatic injury to you caused solely by an accident.

**Affordable Care Act:** The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Educational Reconciliation Act, and its implementing rules and regulations.

**Allowed Amount:** Benefit payments for covered services are based on the amount of the provider's charge that we recognize for payment of benefits. This amount is limited to the lesser of the provider's charge for care or the amount of that charge that is determined by us to be allowable depending on the type of provider utilized and the state in which services are rendered, as described below:

**In-Network Providers:** Blue Cross and/or Blue Shield plans contract with providers to furnish care for a negotiated price. This negotiated price is often a discounted rate, and the in-network provider normally accepts this rate (subject to any applicable copayments, coinsurance, or deductibles that are the responsibility of the patient) as payment in full for covered care. The negotiated price applies only to services that are covered under the plan and also covered under the contract that has been signed with the in-network provider.

Each local Blue Cross and/or Blue Shield plan determines (1) which of the providers in its service area will be considered in-network providers, (2), which subset of those providers will be considered BlueCard PPO providers, and (3), the services or supplies that are covered under the contract between the local Blue Cross and/or Blue Shield plan and the provider.

See [Out-of-Area Services](#), earlier in this booklet, for a description of the contracting arrangements that exist outside the state of Florida.

**Out-of-Network Providers:** In accordance with Blue Cross and Blue Shield of Florida's applicable provider payment policies in effect at the time the service is rendered, the allowed amount for care rendered by out-of-network providers may be based on the negotiated rate payable to in-network providers for the care in the area, may be based on the average charge for the care in the area, or may be based on a percentage of what Medicare would typically pay for the care in the area (or, if no Medicare rates are available, an approximation of what Medicare would pay for care using various sources). In other cases, Blue Cross and Blue Shield of Florida determines the allowed amount using historical data and information from various sources such as, but not limited to:

- The charge or average charge for the same or a similar service;
- The relative complexity of the service;
- The in-network allowance in Florida for the same or a similar service;
- Applicable state healthcare factors;
- The rate of inflation using a recognized measure; and,
- Other reasonable limits, as may be required with respect to outpatient prescription drug costs.

For services provided by an out-of-network provider, the provider may bill the member for charges in excess of the allowed amount. The allowed amount will not exceed the amount of the provider's charge.

For emergency services for medical emergencies provided within the emergency room department of an out-of-network hospital, the allowed amount will be determined in accordance with the requirements of the Affordable Care Act.



**Ambulatory Surgical Center:** A facility that provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient, acute care hospital bed. In order to be considered an ambulatory surgical facility under the plan, the facility must meet the conditions for participation in Medicare.

**Assisted Reproductive Technology (ART):** Any combination of chemical and/or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples of ART include, but are not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer and pronuclear stage tubal transfer.

**Bariatrics:** Services, conditions, or expenses which are based upon weight reduction or dietary control or services or expenses of any kind to treat obesity, weight reduction, or dietary control. This includes bariatric surgery and gastric restrictive procedures and complications arising from bariatric surgery and gastric restrictive procedures.

**Blue Cross:** Blue Cross and Blue Shield of Florida, except where the context designates otherwise.

**BlueCard Program:** An arrangement among Blue Cross and/or Blue Shield plans by which a member of one Blue Cross and/or Blue Shield plan receives benefits available through another Blue Cross and/or Blue Shield plan located in the area where services occur. The BlueCard program is explained in more detail in other sections of this booklet, such as [In-Network Benefits](#) and [Out-of-Area Services](#).

**Concurrent Utilization Review Program (CURP):** A program implemented by us and in-network hospitals in the Florida service area to simplify the administration of preadmission certifications and concurrent utilization reviews.

**Contract:** Unless the context requires otherwise, the terms "contract" and "plan" are used interchangeably. The contract includes our financial agreement or administrative services agreement with the group.

**Cosmetic Surgery:** Any surgery done primarily to improve or change the way one appears, cosmetic surgery does not primarily improve the way the body works or correct deformities resulting from disease, trauma, or birth defect. For important information on cosmetic surgery, see the exclusion under [Health Benefit Exclusions](#) for cosmetic surgery.

**Custodial Care:** Care primarily to provide room and board for a person who is mentally or physically disabled.

**Diagnostic:** Services performed in response to signs or symptoms of illness, condition, or disease or in some cases where there is family history of illness, condition, or disease.

**Durable Medical Equipment (DME):** Equipment we approve as medically necessary to diagnose or treat an illness or injury or to prevent a condition from becoming worse. To be durable medical equipment an item must be made to withstand repeated use, be for a medical purpose rather than for comfort or convenience, be useful only if you are sick or injured, and be related to your condition and prescribed by your physician to use in your home.

**E-Office Visit:** Services are provided to established patients in response to an online inquiry sent to the Physician. The term 'established patient' as used in this category, shall mean that the covered individual has received professional services from the Physician who provided the E-Visit, or another physician who belongs to the same group practice as that Physician, within the past three years.

**Elective Abortion:** An abortion performed for reasons other than the compromised physical health of the mother, severe chromosomal or fetal deformity, or conception due to incest or rape.

**General Hospital:** Any institution that is classified by us as a "general" hospital using, as we deem applicable, generally available sources of information.

**Group:** The employer or other organization that has contracted with us to provide or administer group health benefits pursuant to the plan.

**Home Health Agency:** An organization that provides care at home for homebound patients who need skilled nursing or skilled therapy. In order to be considered a home healthcare agency under the terms of the plan, the organization must meet the conditions for participation in Medicare.

**Hospice:** An organization whose primary purpose is the provision of palliative care. Palliative care means the care of patients whose disease is not responsive to curative treatments or interventions. Palliative care consists of relief of pain and nausea and psychological, social, and spiritual support services. In order for an organization to be considered a hospice under this plan, it must meet the conditions for participation in Medicare.

**Implantables:** An implantable device is a biocompatible mechanical device, biomedical material, or therapeutic agent that is implanted in whole or in part and serves to support or replace a biological structure, support and/or enhance the command and control of a biological process, or provide a therapeutic effect. Examples include, but are not limited to, cochlear implants, neurostimulators, indwelling orthopedic devices, cultured tissues, tissue markers, radioactive seeds, and infusion pumps.

**In-Network Provider:** See the [In-Network Benefits](#) subsection of the Overview of the Plan section of the booklet.

**Inpatient:** A registered bed patient in a hospital; provided that we reserve the right in appropriate cases to reclassify inpatient stays as outpatient services, as explained above in [Inpatient Hospital Benefits](#) and [Outpatient Hospital Benefits](#).

**Intensive Outpatient:** Mental health disorder and substance abuse services provided in a licensed facility by a licensed provider for a minimum of three hours per day at least three days per week with active psychosocial treatment and medication management as needed.

**Investigational:** Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either we have not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice. When possible, we develop written criteria (called medical criteria) concerning services or supplies that we consider to be investigational. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put these medical criteria in policies that we make available to the medical community and our members. We do this so that you and your providers will know in advance, when possible, what we will pay for. If a service or supply is considered investigational according to one of our published medical criteria policies, we will not pay for it. If the investigational nature of a service or supply is not addressed by one of our published medical criteria policies, we will consider it to be non-investigational only if the following requirements are met:

- The technology must have final approval from the appropriate government regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and,
- The improvement must be attainable outside the investigational setting.

It is important for you to remember that when we make determinations about the investigational nature of a service or supply we are making them solely for the purpose of determining whether to pay for the service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

**Medical Emergency:** A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

**Medically Necessary or Medical Necessity:** We use these terms to help us determine whether a particular service or supply will be covered. When possible, we develop written criteria (called medical criteria) that we use to determine medical necessity. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put these medical criteria in policies that we make available to the medical community and our members. We do this so that you and your providers will know in advance, when possible, what we will pay for. If a service or supply is not medically necessary according to one of our published medical criteria policies, we will not pay for it. If a

service or supply is not addressed by one of our published medical criteria policies, we will consider it to be medically necessary only if we determine that it is:

- Appropriate and necessary for the symptoms, diagnosis, or treatment of your medical condition;
- Provided for the diagnosis or direct care and treatment of your medical condition;
- In accordance with standards of good medical practice accepted by the organized medical community;
- Not primarily for the convenience and/or comfort of you, your family, your physician, or another provider of services;
- Not "investigational"; and,
- Performed in the least costly setting, method, or manner, or with the least costly supplies, required by your medical condition. A "setting" may be your home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital when you are an inpatient, or another type of facility providing a lesser level of care. Only your medical condition is considered in deciding which setting is medically necessary. Your financial or family situation, the distance you live from a hospital or other facility, or any other non-medical factor is not considered. As your medical condition changes, the setting you need may also change. Ask your physician if any of your services can be performed on an outpatient basis or in a less costly setting.

It is important for you to remember that when we make medical necessity determinations, we are making them solely for the purpose of determining whether to pay for a medical service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

**Member:** You or your eligible dependent who has coverage under the plan.

**Mental Health Disorders:** These are mental disorders, mental illness, psychiatric illness, mental conditions, and psychiatric conditions. These disorders, illnesses, and conditions are considered mental health disorders whether they are of organic, biological, chemical, or genetic origin. They are considered mental health disorders regardless of how they are caused, based, or brought on. Mental health disorders include, but are not limited to, psychoses, neuroses, schizophrenic-affective disorders, personality disorders, and psychological or behavioral abnormalities associated with temporary or permanent dysfunction of the brain or related system of hormones controlled by nerves. They are generally intended to include disorders, conditions, and illnesses listed in the current Diagnostic and Statistical Manual of Mental Disorders.

**Out-of-Network Provider:** A provider who is not an in-network provider.

**Outpatient:** A patient who is not a registered bed patient of a hospital. For example, a patient receiving services in the outpatient department of a hospital or in a physician's office is an outpatient; provided that we reserve the right in appropriate cases to reclassify outpatient services as inpatient stays, as explained above in [Inpatient Hospital Benefits](#) and [Outpatient Hospital Benefits](#).

**Partial Hospitalization:** Mental health disorder and substance abuse services provided in a licensed facility by a licensed provider for a minimum of six hours per day, five days per week with active psychosocial treatment and medication management as needed.

**Physician:** Any healthcare provider when licensed and acting within the scope of that license or certification at the time and place you are treated or receive services.

**Plan:** The plan is the group health benefit plan of the group, as amended from time to time. The plan documents consist of the following:

- This benefit booklet, as amended;
- Our contract with the group, as amended;
- Any benefit matrices upon which we have relied with respect to the administration of the plan; and,

- Any draft benefit booklets that we are treating as operative. By “operative,” we mean that we have provided a draft of the booklet to the group that will serve as the primary, but not the sole, instrument upon which we base our administration of the plan, without regard to whether the group finalizes the booklet or distributes it to the plan’s members.

If there is any conflict between any of the foregoing documents, we will resolve that conflict in a manner that best reflects the intent of the group and us as of the date on which claims were incurred. Unless the context requires otherwise, the terms "plan" and "contract" have the same meaning.

**Plan Administrator:** The group that sponsors the plan and is responsible for its overall administration.

**Precertification:** The procedures used to determine the medical necessity of the treatment prior to the service.

**Pregnancy:** The condition of and complications arising from a woman having a fertilized ovum, embryo or fetus in her body – usually, but not always, in the uterus – and lasting from the time of conception to the time of childbirth, abortion, miscarriage or other termination.

**Preventive or Routine:** Services performed prior to the onset of signs or symptoms of illness, condition or disease or services which are not diagnostic.

**Private Duty Nursing:** A session of four or more hours during which continuous skilled nursing care is furnished to you alone.

**Psychiatric Specialty Hospital:** An institution that is classified as a psychiatric specialty facility by such relevant credentialing organizations as we or any Blue Cross and/or Blue Shield plan (or its affiliates) determines. A psychiatric specialty hospital does not include a substance abuse facility.

**Rehabilitative Services:** Healthcare services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled.

**Residential Treatment:** Continuous 24 hour per day care provided at live-in facility for mental health or substance abuse disorders.

**Skilled Nursing Facility:** Any Medicare participating skilled nursing facility which provides non-acute care for patients needing skilled nursing services 24 hours a day. This facility must be staffed and equipped to perform skilled nursing care and other related health services. A skilled nursing facility does not provide custodial or part-time care.

**Substance Abuse:** The uncontrollable or excessive abuse of addictive substances, such as (but not limited to) alcohol, drugs, or other chemicals and the resultant physiological and/or psychological dependency that develops with continued use.

**Substance Abuse Facility:** Any institution that is classified as a substance abuse facility by such relevant credentialing organizations as we or any Blue Cross and/or Blue Shield plan (or its affiliates) determine and that provides outpatient substance abuse services.

**We, Us, Our:** Blue Cross and Blue Shield of Florida.

**You, Your:** The contract holder or member as shown by the context.

## ADMINISTRATIVE INFORMATION

This is the Summary Plan Description (SPD). It describes your coverage, benefits, limitations and exclusions for the self-funded Group Health Benefit Plan (“Group Health Plan” or “Group Plan”) established and maintained by School Board of Polk County Health Benefits Plan.

The School Board of Polk County is the Plan Sponsor and has contracted with a Third Party Administrator (TPA), Blue Cross Blue Shield of Florida, Inc. (BCBSF), under an Administrative Services Only Agreement (“ASO Agreement”), to provide certain third party administrative services, including claims processing,

customer service, and other services, and access to certain of its Provider networks. BCBSF provides certain administrative services only and does not assume any financial risk or obligation with respect to Health Care Services rendered to Covered Persons or claims submitted for processing under this plan for such Services. The payment of claims under the Group Health Plan depends exclusively upon the funding provided by The School Board of Polk County Health Benefits Plan.

#### Responsibilities for Plan Administration

- The plan's official name is: The School Board of Polk County Group Healthcare Plan.
- The plan sponsor and plan administrator is the group. The group is responsible for discharging all obligations such as delivering summary plan descriptions, annual reports, and COBRA notices when required by law.
- The plan number assigned by the plan sponsor is: 501.
- The IRS Employer Identification Number (EIN) of the sponsor is: 59-6000807.
- The plan provides hospital and medical benefits as administered under an administrative services agreement between Blue Cross and Blue Shield of Florida and the group. Blue Cross has complete discretion to interpret and administer the provisions of the plan. Blue Cross and Blue Shield of Florida provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. The administrative functions performed by Blue Cross include paying claims, determining medical necessity, etc. The plan benefits are self-insured.
- The agent for legal process is the group.
- The records of the health plan are kept on the basis of a plan year which begins on January 1st and ends on the following December 31st.
- The group currently intends to continue the plan as described herein, but reserves the right, in its discretion, to amend, reduce or terminate the plan and coverage at any time for active employees, retirees, former employees, and all dependents.
- This is an employer-employee shared cost plan. The sources of the contributions to this plan are currently the group and the employee in relative amounts as determined by the group from time to time. While the group may change its level of contribution at any time, the group must always contribute at least a portion of the employee's premiums. Any information concerning what is to be paid by the employee in the future will be furnished by the group in writing and will constitute a part of this plan. Your contribution is determined by the group based on the plan's experience and other factors.
- Plan Administrator Contact Information:

Please mail or hand-deliver all COBRA notices to your plan administrator at the following address:

Attention: Employee Benefits (COBRA)  
The School Board of Polk County  
1915 South Floral Avenue  
Bartow, Florida 33830-7124

## **NOTICE OF NONDISCRIMINATION**

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

We:

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

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Florida, Birmingham Service Center, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-844-594-6009, 711 (TTY), 1-205-220-2984 (fax), [Grievance1557@exploremyplan.com](mailto:Grievance1557@exploremyplan.com) (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## FOREIGN LANGUAGE ASSISTANCE

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de lingüística. Llame al 1-844-594-6009 (TTY: 711)

**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-594-6009 (TTY: 711)번으로 전화해 주십시오.

**Chinese:** 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電1-844-594-6009 (TTY: 711)。

**Vietnamese:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-594-6009 (TTY: 711).

**Arabic:** انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل بـ 1-844-594-6009 (الهاتف النصي: 711).

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-594-6009 (TTY: 711).

**French:** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-594-6009 (ATS: 711).

**French Creole:** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-594-6009 (TTY: 711).

**Gujarati:** ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. 1-844-594-6009 પર કોલ કરો (TTY: 711).

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-594-6009 (TTY: 711).

**Hindi:** ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ नि:शुल्क उपलब्ध हैं। 1-844-594-6009 (TTY: 711) पर कॉल करें।

**Laotian:** ໂປດສະຫຼາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີຮັບໃຫ້ທ່ານ. ໂທ 1-844-594-6009 (TTY: 711).

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-594-6009 (телетайп: 711).

**Portuguese:** ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-594-6009 (TTY: 711).

**Polish:** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-594-6009 (TTY: 711).

**Turkish:** DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-844-594-6009 (TTY: 711) irtibat numaralarını arayın.

**Italian:** ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-594-6009 (TTY: 711).

**Japanese:** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-594-6009（TTY: 711）まで、お電話にてご連絡ください。

Birmingham Service Center  
P.O. Box 10527  
Birmingham, Alabama 35202-0500

**Customer Service Department:**

1-855-630-6824 (TTY 711) toll-free

Preadmission Certification:

1-855-288-8357

**Website:**

[FL.ExploreMyPlan.com](http://FL.ExploreMyPlan.com)

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Health Plan

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