BlueChoice

Benefit Booklet

A Self-funded Group Health Benefit Plan
for Covered Plan Participants of Diocese of Palm Beach Health Plan Trust

Effective: 08-01-24 (Laity)

This Booklet Contains a Deductible Provision

98620
ASO BCH Plans 0702 0727 (Lai.)
Divisions: 005 CC5 R05 008 CC8 R08

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For Customer Service Assistance: (800) 345-3885

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HOW TO USE YOUR BOOKLET

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

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

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

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

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

When reading your Booklet, please remember:

1. You should read this Booklet in its entirety in order to determine if a particular Health Care Service is covered. Certain coverage information may be provided in the form of an Endorsement to this Booklet, if so, an Endorsement will either be inserted after the section that it modifies, or at the end of the Booklet. Be sure to always check for these additional documents before making benefit decisions.
2. The headings of sections contained in this Benefit Booklet are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.
3. References to “you” or “your” throughout refer to you as the Covered Plan Participant and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references, which refer solely to you as the Covered Plan Participant or solely to your Covered Dependents, will be noted as such.
4. References to “we”, “us”, “our” and “Florida Blue” throughout refer to Blue Cross and Blue Shield of Florida, Inc.
5. If a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If the word or phrase has a special meaning, it will either be defined in the DEFINITIONS section or within the particular section where it is used.

Where do I find information on…	**…go to:**
What is **covered**?	The **WHAT IS COVERED?** section.
What is **not covered**?	The **WHAT IS NOT COVERED?** section, along with the **WHAT IS COVERED?** section.
What is **covered** under my **retail pharmacy plan?**	The **PRESCRIPTION DRUG PROGRAM** section
How do I know what **Providers** I can use, and how the Providers I use will affect my **Cost Share** amount?	The **HEALTH CARE PROVIDER OPTIONS** section, along with the current **BlueChoice Provider Directory**.
How much do I pay for Health Care Services?	The **YOUR SHARE OF HEALTH CARE EXPENSES** section along with the **Schedule of Benefits**.
What happens if **I receive a surprise bill?**	The **Surprise Billing** subsection in the **YOUR SHARE OF HEALTH CARE EXPENSES** section
How do I access Services when I'm **out-of-state?**	The **BLUECARD® PROGRAM** section.
How do I **add or remove a Dependent?**	The **ENROLLMENT AND EFFECTIVE DATE OF COVERAGE** section and the **TERMINATION OF COVERAGE** section.
What if I am covered under **BlueChoice** and **another health plan?**	The **COORDINATION OF BENEFITS** section.
What happens when **my coverage ends?**	The **TERMINATION OF COVERAGE** section, along with the **CONTINUING COVERAGE** section.
What do the **terms used** throughout this Booklet **mean?**	The **DEFINITIONS** section.
Who do I call if I have **questions or complaints?**	Call our **customer service** department at (800) 345-3885 (this phone number can also be found on your **ID Card)**.

WHAT IS COVERED?

Introduction

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

Remember that exclusions and limitations also apply to your coverage. Exclusions and limitations that are specific to a type of Service are included with the benefit description in this section. There are other exclusions and limitations listed in the WHAT IS NOT COVERED? section. More than one limitation or exclusion may apply to a specific Service or a particular situation.

The Health Care Services listed in this section are covered only if they are:

1. authorized in advance, if prior coverage authorization is required (see the BLUEPRINT FOR HEALTH PROGRAMS section);
2. within the Covered Services Categories in this section;
3. actually rendered to you (not just recommended) by an appropriately licensed health care Provider who is recognized for payment under this Booklet;
4. billed to us on a claim form or itemized statement that lists the procedures and Services rendered to you. Claims and statements should include procedure codes, diagnosis codes and other information we require to process the claim;
5. Medically Necessary, as defined in this Booklet and determined by us or the Group in accordance with our Medical Necessity coverage criteria in effect at the time Services are provided or authorized;
6. within the benefit guidelines listed in this section;
7. rendered while your coverage is in force; and
8. not specifically or generally limited or excluded under this Booklet.

We or the Group will determine whether Health Care Services are Covered Services under this Booklet after you have obtained them and we have received a claim for them. In some cases we or the Group may determine if Services are Covered Services under this Booklet before they are rendered to you. For example, we or the Group may determine if a proposed transplant would be a Covered Service under this Booklet before you have the transplant.

Neither Florida Blue nor Diocese of Palm Beach Health Plan Trust are obligated to determine if a Service that has not been provided to you will be covered unless we have designated that the Service must be authorized in advance in the BLUEPRINT FOR HEALTH PROGRAMS section. We or Diocese of Palm Beach Health Plan Trust are also not obligated to cover or pay for any Service that has not actually been rendered to you.

In determining if Health Care Services are Covered Services under this Booklet, no written or verbal representation by any employee or agent of Florida Blue or Diocese of Palm Beach Health Plan Trust or by any other person shall waive or modify the terms of this Booklet and therefore, neither you, nor Diocese of Palm Beach Health Plan Trust, nor any health care Provider or other person should rely on any such written or verbal representation.

Our Benefit Guidelines

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

1. Payment is based on our Allowed Amount and not necessarily the Provider's billed charges.
2. Payment for certain Health Care Services is included within the Allowed Amount for the primary procedure, and the Plan will not pay any additional amounts for any such Services.
3. Payment is based on the Allowed Amount for the actual Service you received. Payment is not based on:
   a) a Service which is more complex than the Service you actually received;
   b) the method used to perform the Service; or
   c) the day of the week or the time of day the procedure is performed.
4. Some Services that have several components can be described by a single procedure code. In these cases, payment for such Services includes all components of the Service under that one procedure code. This is also true when a Service is an essential or integral part of the associated therapeutic/diagnostic Service rendered.

Covered Services Categories

Acupuncture

Acupuncture rendered by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or Acupuncurist.

Allergy Testing and Treatments

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

Ambulance Services

Ground Ambulance

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

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

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

Air and Water Ambulance

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

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

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

Exclusion

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

1. Ambulance Services for a patient who is legally pronounced dead before the Ambulance is summoned.
2. Aid rendered by an Ambulance crew without transport. Examples include, but are not limited to situations when an Ambulance is dispatched and:
   a) the crew renders aid until a helicopter can be sent;
   b) the patient refuses care or transport; or
   c) only basic first aid is rendered.
3. Non-emergency transport to or from a patient's home or a residential, domiciliary or custodial facility.
4. Transfers by medical vans or commercial transportation (such as Physician owned limousines, public transportation, cab, etc.).
5. Ambulance transport for patient convenience or patient and/or family preference. Examples include but are not limited to:
   a) patient wants to be at a certain Hospital or facility for personal/preference reasons;
   b) patient is in a foreign country, or out-of-state, and wants to return home for a surgical procedure or treatment (or for continued treatment) or after being discharged from inpatient care; or
   c) patient is going for a routine Service and is medically able to use another mode of transportation but can't pay for, find and/or prefers not to use such transportation.
6. Air and water Ambulance Services in the absence of an Emergency Medical Condition, unless such Services are authorized by us in advance.

Ambulatory Surgical Center

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

1. use of operating and recovery rooms;
2. respiratory therapy, such as oxygen;
3. drugs and medicines administered at the Ambulatory Surgical Center (except for take-home Drugs);
4. intravenous solutions;

5. dressings, including ordinary casts;
6. anesthetics and their administration;
7. administration and cost of whole blood or blood products (except as outlined in the Drugs exclusion of the WHAT IS NOT COVERED? section);
8. transfusion supplies and equipment;
9. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing, such as EKG;
10. chemotherapy and radiation treatment for proven malignant disease; and
11. other Medically Necessary Services.

Anesthesia Administration Services

Anesthesia administered by a Physician or Certified Registered Nurse Anesthetist ("CRNA") may be covered. When the CRNA is actively directed by a Physician other than the Physician who performed the surgery, the Allowed Amount for Covered Services will include both the CRNA and the Physician's charges and will be based on the lower-directed-Services Allowed Amount according to our payment program then in effect for such Covered Services.

Exclusion

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

Autism Spectrum Disorder and Down Syndrome

Services provided to a Covered Dependent consisting of:

1. well-baby and well-child screening for the presence of Autism Spectrum Disorder;
2. Applied Behavior Analysis, when rendered by a person certified per Florida Statutes Section 393.17 or licensed under Chapters 490 or 491; and
3. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist. Covered therapies provided in the treatment of Autism Spectrum Disorder and Down Syndrome are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

Payment Rules for Autism Spectrum Disorder and Down Syndrome

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

Behavioral Health Services

Mental Health Services

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

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

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

Exclusion

1. Services rendered for a Condition that is not a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder.
2. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or intellectual disabilities.
3. Services beyond the period necessary for evaluation and diagnosis of learning disabilities or for intellectual disabilities, except for Services that meet the definition of Medical Necessity for the Condition.
4. Services for educational purposes, except for Services that meet the definition of Medical Necessity for the Condition.
5. Services for marriage counseling unless related to a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder.
6. Services for pre-marital counseling.
7. Services for court-ordered care or testing, or required as a condition of parole or probation, except for Services that meet the definition of Medical Necessity for the Condition.
8. Services to test aptitude, ability, intelligence or interest, except as covered under the Autism Spectrum Disorder and Down Syndrome category.
9. Services required to maintain employment.
10. Services for cognitive remediation.
11. Inpatient stays that are primarily intended as a change of environment or any other Service primarily for your convenience or that of your family members or the Provider.

<u>Substance Dependency Treatment Services</u>

When there is a sudden drop in consumption after prolonged heavy use of a substance a person may experience withdrawal, often causing both physiologic and cognitive symptoms. The symptoms of withdrawal vary greatly, ranging from minimal changes to potentially life threatening states. Detoxification Services can be rendered in different types of locations, depending on the severity of the withdrawal symptoms.

Care and treatment for Substance Dependency includes the following:

1. Inpatient and outpatient Health Care Services rendered by a Physician, Psychologist or Mental Health Professional in a program accredited by The Joint Commission or approved by the state of Florida for Detoxification or Substance Dependency.
2. Physician, Psychologist and Mental Health Professional outpatient visits for the care and treatment of Substance Dependency.

We may provide you with information on resources available to you for non-medical ancillary services like vocational rehabilitation or employment counseling, when we are able to. The Plan doesn't pay for any services that are provided to you by any of these resources; they are to be provided solely at your expense.

Exclusion

Long term Services for alcoholism or drug addiction, including specialized inpatient units or inpatient stays that are primarily intended as a change of environment.

Breast Reconstructive Surgery

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

Child Cleft Lip and Cleft Palate Treatment

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

Clinical Trials

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

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

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

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

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

Exclusion

1. Costs that are generally covered by the clinical trial, including, but not limited to:
   a) Research costs related to conducting the clinical trial such as research Physician and nurse time, analysis of results, and clinical tests performed only for research purposes.
   b) The investigational item, device or Service itself.
   c) Services inconsistent with widely accepted and established standards of care for a particular diagnosis.
2. Services related to an Approved Clinical Trial received outside of the United States.

Concurrent Physician Care

Concurrent care means care that is rendered to you by more than one Physician on the same date or during the same inpatient stay. Concurrent Physician care Services are only covered when documentation shows that:

1. the additional Physician actively participates in your treatment;
2. the Condition involves more than one body system or is so severe or complex that one Physician cannot provide the care unassisted; and
3. the Physicians have different specialties or have the same specialty with different subspecialties.

Consultations

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

Dental Services

Dental Services are limited to the following:

1. Care and stabilization Services for the treatment of damage to Sound Natural Teeth, rendered within 62 days of an Accidental Dental Injury.
2. Extraction of teeth required prior to radiation therapy when you have a diagnosis of cancer of the head and/or neck.
3. Anesthesia Services for dental care including general anesthesia and hospitalization Services necessary to assure the safe delivery of necessary dental care provided to you in a Hospital or Ambulatory Surgical Center if:
   a) a Covered Dependent is under eight years of age and a dentist and the Covered Dependent's Physician determine that:
      1. dental treatment is necessary due to a dental Condition that is significantly complex; or
      2. the Covered Dependent has a developmental disability in which patient management in the dental office has proven to be ineffective; or
   b) you or your Covered Dependent have one or more medical Conditions that would create significant or undue medical risk in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

Exclusion

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

Diabetes Treatment Services

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

1. outpatient self-management training and educational Services when provided under the direct supervision of a certified Diabetes Educator or a board-certified Physician specializing in endocrinology;
2. nutrition counseling provided by a licensed dietitian;
3. equipment and supplies to treat diabetes, such as insulin pumps and tubing; and

   Note: Blood glucose meters, lancets and test strips are covered under your pharmacy benefit.
4. trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications) for the treatment of severe diabetic foot disease.

Diagnostic Services

Diagnostic Services may be covered and include the following:

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

Exclusion

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

Dialysis Services

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

Durable Medical Equipment

Durable Medical Equipment may be covered when provided by a Durable Medical Equipment Provider and when prescribed by a Physician and is limited to the most cost-effective Durable Equipment as determined by us. Replacement of Durable Medical Equipment due to growth of a child or significant change in functional status and repair of equipment you own or are buying are also Covered Services.

Examples of Durable Medical Equipment include: wheelchairs, crutches, canes, walkers, hospital beds, and oxygen equipment.

Payment Rules for Durable Medical Equipment

Benefits for Durable Medical Equipment will be based on the lowest of the following:

1. the purchase price;
2. the lease/purchase price;
3. the rental rate; or
4. our Allowed Amount. Our Allowed Amount for rental equipment will not exceed the total purchase price.

Note: Remember that your Cost Share is applied as claims are received and paid. This is important because if you are leasing to purchase Durable Medical Equipment, your Cost Share will apply throughout the lease period and continue until the equipment has been completely paid for in full.

For example, you may lease to purchase a piece of equipment in the last month of your Benefit Period after you have met your Deductible for that Benefit Period, but if the lease continues into the next Benefit Period, or if the purchase is made in the next Benefit Period, the Plan will not make any more payments until you have met your Deductible again.

Exclusion

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

Emergency and Urgent Care Services

Emergency Services

Emergency Services for treatment of an Emergency Medical Condition are covered In-Network and Out-of-Network without the need for any prior authorization from us.

Urgent Care Services

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

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

Enteral Formulas

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

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

Eye Care

Coverage includes the following Services:

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

Exclusion

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

External Hearing Aids

External hearing aids and Services related to the fitting are covered, including repairs, when prescribed by a Physician who is an ENT or audiology specialist regardless of the Condition or cause of hearing loss. The benefit maximum listed in your Schedule of Benefits will apply to these Services.

You must pay for these Services and submit the receipt to us in the time period allowed as set forth in theCLAIMS PROCESSING section, in order to receive payment for these Services.

Family Planning

Family planning Services are covered and include:

Family planning counseling and Services, such as counseling and sex education, including prevention of venereal disease.

Exclusion

Contraceptive injections, medications, devices and appliances, or other Health Care Services when provided for contraception are not covered.

Home Health Care

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

1. you are unable to leave your home without considerable effort and assistance because you are bedridden or chairbound or because you are restricted in ambulation, whether or not you use assistive devices; or you are significantly limited in physical activities due to a Condition;
2. the Home Health Care Services rendered have been prescribed by a Physician;
3. the Home Health Care Services are provided by or through a Home Health Agency; and
4. you are meeting or achieving the desired treatment goals as documented in the clinical progress notes.

Home Health Care Services are limited to:

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

Exclusion

1. homemaker or domestic maid services;
2. sitter or companion services;
3. Services rendered by an employee or operator of an adult congregate living facility; an adult foster home; an adult day care center, or a nursing home facility;
4. Speech Therapy provided for diagnosis of developmental delay;

5. Custodial Care;
6. food, housing, and home delivered meals; and
7. Services rendered in a Hospital, nursing home, or intermediate care facility.

Hospice Services

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

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

Recertification is required every six months.

Hospital Services

Covered Hospital Services include:

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

Exclusion

1. All expenses for Hospital Services (including the Hospital charges, Physician charges and any other charges related to an inpatient stay) are excluded when Services could have been rendered without admitting you to the Hospital.
2. gowns and slippers;
3. shampoo, toothpaste, body lotions and hygiene packets;
4. take-home Drugs;
5. telephone and television;

6. guest meals or gourmet menus; and
7. admission kits.

Inpatient Rehabilitation

Inpatient Rehabilitation Services may be covered when all of the following criteria are met:

1. Services must be provided under the direction of a Physician and must be provided by a Medicare certified facility in accordance with a comprehensive rehabilitation program;
2. a plan of care must be developed and managed by a coordinated multi-disciplinary team;
3. coverage is subject to our Medical Necessity coverage criteria then in effect;
4. you must be able to actively participate in at least two of the following therapies: Cardiac Therapy, Physical Therapy, pulmonary therapy or Speech Therapy and be able to tolerate at least three hours per day of skilled Rehabilitative Services for at least five days a week and your Condition must be likely to result in significant improvement; and
5. Rehabilitation Services must be required at such intensity, frequency and duration that further progress cannot be achieved in a less intensive setting.

If your plan includes a maximum number of days, it will be listed on your Schedule of Benefits.

Exclusion

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

Mammograms

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

In accordance with the Florida Statute 627.6613, coverage is available under the following circumstances:

1. A baseline mammogram for any woman who is 35 years of age or older, but younger than 40 years of age.
2. A mammogram every 2 years for any woman who is 40 years of age or older, but younger than 50 years of age, or more frequently based on the patient's Physician's recommendation.
3. A mammogram every year for any woman who is 50 years of age or older.
4. One or more mammograms a year, based upon a Physician's recommendation, for any woman who is at risk for breast cancer because of a personal or family history of breast cancer, because of having a history of biopsy-proven benign breast disease, because of having a mother, sister, or daughter who has or has had breast cancer, or because a woman has not given birth before the age of 30.

Mastectomy Services

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

Maternity Services

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

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

Hospital or Birth Center Services for labor and delivery of the baby. This includes a physical assessment of the mother and any necessary clinical tests in keeping with prevailing medical standards, newborn assessment and room and board for the mother and routine nursery care. Your Cost Share for these Services is listed on your Schedule of Benefits and is in addition to your Cost Share for the obstetrician or Midwife. You may also choose to deliver your baby at home, in which case, the Hospital or Birth Center Cost Share would not apply.

Routine nursery care for the newborn child during the covered portion of the mother's maternity stay is included under this benefit. However, when an infant requires non-routine treatment during or after the mother's stay, the newborn is considered a patient in his or her own right and will be covered separately only if the newborn is properly enrolled. The newborn's hospital admission in this case is subject to separate Cost Share amounts.

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

Medical Pharmacy

Prescription Drugs that are provided in a Physician's office may have a separate Cost Share amount that is in addition to the office visit Cost Share amount. The Medical Pharmacy Cost Share amount applies to each Prescription Drug but does not include the cost for the Services of the person who administers the Prescription Drug to you. Allergy injections and immunizations are not part of the Medical Pharmacy benefit.

You or your Physician must contact us to request coverage for a Prescription Drug covered under this category before administering it to you by following the process for prior coverage authorization outlined in the Medication Guide.

Your plan may also include a maximum amount that you have to pay out-of-pocket for Medical Pharmacy Prescription Drugs you receive each month. If your plan includes a Medical Pharmacy out-of-pocket maximum, it will be listed on your Schedule of Benefits and only applies after you have met your Deductible, if applicable.

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

Newborn Care

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

Newborn Assessment

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

Newborn Ambulance Services

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

Nutrition Counseling

Nutrition counseling by a licensed Dietitian as described in the Diabetes Treatment Services category or as part of the treatment of a Mental and Nervous Disorder or Substance Dependency Condition or Services that meet the definition of Medical Necessity for treatment of a Condition.

Orthotic Devices

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

Benefits may be provided for necessary replacement of an Orthotic Device you own when due to irreparable damage, wear, a change in your Condition, or when necessary due to growth of a child.

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

Coverage for Orthotic Devices is based on the most cost-effective Orthotic Device which meets your medical needs, as determined by us.

Exclusion

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

Osteoporosis Screening, Diagnosis, and Treatment

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

1. are estrogen-deficient and at clinical risk for osteoporosis;
2. have vertebral abnormalities;
3. are receiving long-term glucocorticoid (steroid) therapy;

4. have primary hyperparathyroidism; or
5. have a family history of osteoporosis.

Outpatient Therapies and Spinal Manipulation Services

1. The outpatient therapies listed below may be Covered Services when ordered by a Physician or other health care professional licensed to perform such Services. These are the only outpatient therapies covered under this Booklet. Some therapies may also be covered in other health care settings; see the Home Health Care, Hospital and Skilled Nursing Facility categories in this section.

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

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

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

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

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

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

      Exclusion

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

      Payment Rules for Massage and Physical Therapy

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

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

   Payment Rules for Spinal Manipulation

   It is important that you understand the difference between a spinal manipulation and a visit in order to understand how the benefit limits work. During a visit, more than one Service can be rendered and

billed. Spinal manipulation is a treatment modality or method and more than one spinal manipulation can occur and be billed during a single visit to a Provider. There are limits under this coverage for the number of spinal manipulations and also for the number of visits the Plan will cover during a Benefit Period.

a) Coverage for covered Spinal Manipulation is limited to the number of spinal manipulations listed in your Schedule of Benefits each Benefit Period, or the maximum number of visits listed in the Schedule of Benefits, whichever occurs first.

b) Payment for covered Physical Therapy Services rendered on the same day as spinal manipulation is limited to one Physical Therapy treatment per day, not to exceed 15 minutes in length.

Oxygen

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

Physician Services

Covered Services include medical Services such as office visits and allergy testing and treatment or surgical Health Care Services provided by a Physician, including Services rendered in the Physician's office or in an outpatient facility.

Exclusion

Expenses for failure to keep a scheduled appointment and for telephone consultations (except as indicated as covered under the Preventive Services category of this section).

Preventive Services

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

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

1. consistent with 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 (USPSTF) established under the Public Health Service Act;
2. consistent with immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention established under the Public Health Service Act with respect to the individual involved;
3. with respect to infants, children, and adolescents, evidence- informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. with respect to women, such additional preventive care and screenings not described in paragraph number one as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

More detailed information, such as medical management programs or limitations on Services that are covered under the Preventive Services category is available in the Preventive Services Guide located on our website at www.floridablue.com/healthresources. Drugs or Supplies covered as preventive Services are described in the Medication Guide. In order to be covered as a preventive Service under this section the Service must be provided as described in the Preventive Services Guide or, for Drugs and Supplies, in the Medication Guide.

Note: From time to time medical standards that are based on the recommendations of the entities listed in numbers 1 through 4 above change. Services may be added to the recommendations and sometimes may be removed. It is important to understand that your coverage for these preventive Services is based on what is in effect on your Effective Date. If any of the recommendations or guidelines change after your Effective Date, your coverage will not change until your Group's first Anniversary Date one year after the recommendations or guidelines go into effect.

For example, if the USPSTF adds a new recommendation for a preventive Service that the Plan does not cover and you are already covered under this Booklet; that new Service will not be a Covered Service under this category right away. The coverage for a new Service will start on your Group's Anniversary Date one year after the new recommendation goes into effect.

Additionally, Health Care Services that violate the most recent version of the Ethical Religious Directives for Catholic Facilities issued by the National Catholic Conference of Bishops are not covered.

Exclusion

Routine vision and hearing examinations and screenings are not covered as preventive Services, except as required under paragraph number one and/or number three above.

Prosthetic Devices

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

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

Covered Prosthetic Devices (except cardiac pacemakers and prosthetic devices incident to Mastectomy) are limited to the first permanent prosthesis (including the first temporary prosthesis if it is determine to be necessary) prescribed for each specific Condition. Coverage for Prosthetic Devices is based on the most cost-effective Prosthetic Device which meets your medical needs as determined by us.

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

Exclusion

1. Expenses for performance enhancing Prosthetic Devices, such as carbon-fiber racing legs.
2. Expenses for cosmetic enhancements to artificial limbs.

Self-Administered Prescription Drugs

Self-Administered Prescription Drugs are generally covered under the Pharmacy benefit (PRESCRIPTION DRUG PROGRAM section). However, there are times when these Drugs would be covered under the medical benefits. The following Self-Administered Drugs may be covered under the medical benefit:

1. Self-Administered Prescription Drugs used in the treatment of diabetes, cancer, Conditions requiring immediate stabilization (e.g. anaphylaxis), or in the administration of dialysis; and
2. Self-Administered Prescription Drugs identified as Specialty Drugs with a special symbol in the Medication Guide when delivered to you at home and purchased at a Specialty Pharmacy or a Provider that provides Specialty Drugs who is not an In-Network Provider.

Skilled Nursing Facilities

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

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

Exclusion

Expenses for an inpatient admission to a Skilled Nursing Facility for Custodial Care, convalescent care, or any other Service primarily for your convenience or that of your family members or the Provider are not covered.

Surgical Procedures

Surgical procedures rendered by a Physician, including surgical assistant Services rendered by a Physician, Registered Nurse First Assistant (RNFA) or a Physician Assistant acting as a surgical assistant when such assistance is Medically Necessary include the following:

1. surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes;
2. oral surgical procedures for excision of tumors, cysts, abscesses, and lesions of the mouth;
3. surgical procedures involving bones or joints of the jaw such as temporomandibular joint (TMJ) and facial region if, under accepted medical standards, such surgery is necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury;
4. Services of a Physician for the purpose of rendering a second surgical opinion and related diagnostic Services to help determine the need for surgery; and
5. surgical procedures performed for the treatment of morbid obesity, such as intestinal bypass, stomach stapling and balloon dilation, and any associated care, in accordance with our Medical Necessity coverage guidelines then in effect.

Payment Rules for Surgical Procedures

1. When multiple surgical procedures are performed in addition to the primary surgical procedure, on the same or different areas of the body, during the same operative session, payment will be based on 50 percent of the Allowed Amount for any secondary procedures and is subject the Cost Share (if any)

indicated on your Schedule of Benefits. This guideline is applicable to all bilateral procedures and all surgical procedures performed on the same date of service.

2. Payment for incidental surgical procedures is limited to the Allowed Amount for the primary procedure, and there is no additional payment for any incidental procedure. An "incidental surgical procedure" includes surgery where one, or more than one, surgical procedure is performed through the same incision or operative approach as the primary surgical procedure which, in our opinion, is not clearly identified and/or does not add significant time or complexity to the surgical session. For example, the removal of a normal appendix performed in conjunction with a Medically Necessary hysterectomy is an incidental surgical procedure (there is no payment for the removal of the normal appendix in the example).
3. Payment for surgical procedures for fracture care, dislocation treatment, debridement, wound repair, unna boot, and other related Health Care Services, is included in the Allowed Amount for the surgical procedure.

Note: Any and all Health Care Services that violate the most recent version of the Ethical Religious Directives for Catholic Facilities issued by the National Catholic Conference of Bishops are not covered.

Transplant Services

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

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

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

Exclusion

1. Transplant procedures not included in the list above, or otherwise excluded under this Booklet, such as Experimental or Investigational transplant procedures.
2. Transplant procedures involving the transplantation of any non-human animal organ or tissue.
3. Transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered by us.

4. Transplant procedures involving the implant of an artificial organ tissue, including the implant of the artificial organ, except for an approved artificial heart device that meets our Medical Necessity criteria then in effect.
5. Any organ, tissue, marrow, or stem cells which are sold rather than donated.
6. Any Bone Marrow Transplant, as defined herein, which is not specifically listed in the applicable chapter of the Florida Administrative Code or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual.
7. Any Service in connection with identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant.
8. Any non-medical costs, including, but not limited to, temporary lodging or transportation costs for you and/or your family to and from the approved facility.

Virtual Visits

Your plan covers Virtual Visits between you and a Virtual Care Provider when rendered consistent with Florida laws, regulations and our payment policies in effect at the time Services are rendered. Not all Conditions can be treated through Virtual Visits. The Virtual Care Provider should let you know if a Condition requires a face-to-face visit with a Physician.

Coverage includes Virtual Visits between you and an In-Network Provider who offers Virtual Visits at the time the Services are rendered. The Cost Shares for Virtual Care Provider Services are listed in your Schedule of Benefits.

Exclusion

1. Expenses for failure to keep a scheduled Virtual Visit.
2. Virtual Visits rendered by any Provider other than a Virtual Care Provider, as defined in the DEFINITIONS section.

WHAT IS NOT COVERED?

Introduction

The following exclusions are in addition to any that are specified in the WHAT IS COVERED?, including any Endorsement that is a part of this Booklet.

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

Any and all Health Care Services that violate the most recent version of the Ethical Religious Directives for Catholic Facilities issued by the National Catholic Conference of Bishops are not covered.

Exclusions

Abortions as described in the most recent version of the Ethical and Religious Directives for Catholic Health Care Services issued by the National Catholic Conference of Bishops.

Ambulance Services including, but not limited to:

1. Services for situations that are not Medically Necessary because they do not require Ambulance transportation.
2. Ambulance Services for a patient who is legally pronounced dead before the Ambulance is summoned.
3. Aid rendered by an Ambulance crew without transport. Examples include, but are not limited to situations when an Ambulance is dispatched and:
   a) the crew renders aid until a helicopter can be sent;
   b) the patient refuses care or transport; or
   c) only basic first aid is rendered.
4. Non-emergency transport to or from a patient's home or a residential, domiciliary or custodial facility.
5. Transfers by medical vans or commercial transportation (such as Physician owned limousines, public transportation, cab, etc.).
6. Ambulance transport for patient convenience or patient and/or family preference. Examples include but are not limited to:
   a) patient wants to be at a certain Hospital or facility for personal/preference reasons;
   b) patient is in a foreign country, or out-of-state, and wants to return home for a surgical procedure or treatment, (or for continued treatment), or after being discharged from inpatient care; or
   c) patient is going for a routine Service and is medically able to use another mode of transportation but can't pay for, find and/or prefers not to use such transportation.
7. Air and water Ambulance Services in the absence of an Emergency Medical Condition, unless such Services are authorized by us in advance.

Anesthesia administration Services rendered by an operating Physician who performed the surgery, his or her partner or associate

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

Behavioral Health Services except as indicated in the WHAT IS COVERED? section, including:

1. Mental health Services which are (a) for a Condition that is not a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder; (b) for psychological testing associated with the evaluation and diagnosis of learning disabilities or for intellectual disability; (c) beyond the period necessary for evaluation and diagnosis of learning disabilities, except for Services that meet the definition of Medical Necessity for the Condition; (d) or for educational purposes or for intellectual disability, except for Services that meet the definition of Medical Necessity for the Condition; (e) for marriage counseling unless related to a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder; (f) for pre-marital counseling; (g) for court ordered care or testing, or required as a condition of parole or probation, except for Services that meet the definition of Medical Necessity for the Condition; (h) to test aptitude, ability, intelligence or interest, except as covered under the Autism Spectrum Disorder and Down Syndrome category of the WHAT IS COVERED? section; (i) required to maintain employment; (j) for cognitive remediation; or (k) inpatient stays for Custodial Care, convalescent care, change of environmentor any other Service primarily for your convenience or that of your family members or the Provider.
2. Substance dependency care and treatment Services that are long-term inpatient Services for alcoholism or drug addiction, including specialized inpatient units or inpatient stays that are primarily intended as a change of environment.

Clinical Trial expenses including:

1. Costs that are generally covered by the clinical trial, including, but not limited to:
   a) Research costs related to conducting the clinical trial such as research Physician and nurse time, analysis of results, and clinical tests performed only for research purposes.
   b) The investigational item, device or Service itself.
   c) Services inconsistent with widely accepted and established standards of care for a particular diagnosis.
2. Services related to an Approved Clinical Trial received outside of the United States.

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

Contraceptive medications, injections, devices, appliances, or other Health Care Services when provided for contraception.

Cosmetic Services, including any Service to improve the appearance or self-perception of an individual (except as covered under the Breast Reconstructive Surgery category), including and without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A), and hair implants/transplants, or services used to improve the gender specific appearance of an individual including, but not limited to breast augmentation and reduction mammoplasty except as specifically indicated as a Covered Service elsewhere in this Booklet, reduction thyroid chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification surgery, and hair removal/hairplasty.

Cost Share amounts you are required to pay even when a Provider waives the Cost Share.

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

Dental Services, or treatment of the teeth or their supporting structures or gums, or dental procedures, including but not limited to: extraction of teeth, restoration of teeth with or without fillings, crowns or other materials, bridges, cleaning of teeth, dental implants, dentures, periodontal or endodontic procedures, orthodontic treatment (e.g., braces), intraoral prosthetic devices, palatal expansion devices, bruxism appliances, and dental x-rays. This exclusion also applies to Phase II treatments (as defined by the American Dental Association) for TMJ dysfunction. This exclusion does not apply to Accidental Dental Care or Child Cleft Lip and Cleft Palate Treatment Services.

Drugs

1. Prescribed for uses other than the United States Food and Drug Administration (FDA) approved label indications. This exclusion does not apply to any Drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the Drug is recognized for treatment of your particular cancer in a Standard Reference Compendium or is recommended for treatment of your particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.
2. Drugs dispensed to, or purchased by you from a Pharmacy. This exclusion does not apply to Drugs dispensed to you when:
   a) you are an inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility, or Hospice facility;
   b) you are in the outpatient department of a Hospital;
   c) dispensed to your Physician for administration to you in the Physician's office and prior coverage authorization has been obtained (if required); or
   d) You are receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills us for such Drugs.
3. Any non-Prescription medicines, remedies, vaccines, biological products (except insulin), pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, Over-the-Counter Drugs, products, or health foods.
4. Any Drug which is indicated or used for sexual dysfunction such as Cialis, Levitra, Viagra and Caverject.
5. Any Self-Administered Prescription Drug except when indicated as covered in the WHAT IS COVERED? section of this Booklet.
6. Any Drug which requires prior coverage authorization when prior coverage authorization is not obtained.
7. Blood or blood products used to treat hemophilia, except when provided to you for:
   a) emergency stabilization;
   b) during a covered inpatient stay, or
   c) when proximately related to a surgical procedure.

   The exceptions to the exclusion for Drugs purchased or dispensed by a Pharmacy described in exclusion two above, do not apply to hemophilia Drugs excluded under this subparagraph.
8. New Prescription Drug(s), as defined in the DEFINITIONS section.
9. Convenience Kits, as defined in the DEFINITIONS section.

10. Drugs that are FDA approved, but lack proven benefits and/or efficacy as defined in the product prescribing information or noted in our coverage policy as an output from our Pharmacy and Therapeutics Committee, Medical Policy Committee or any other nationally recognized source.

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

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

Eye Care Services except as indicated in the WHAT IS COVERED? section, including:

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

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

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

General Exclusions include, but are not limited to:

1. Any Health Care Service received prior to your Effective Date or after the date your coverage terminates.
2. Any Health Care Service not within the Covered Services Categories described in the WHAT IS COVERED? or PRESCRIPTION DRUG PROGRAM sections or any Endorsement that is part of this Booklet, unless such Services are specifically required to be covered by applicable law.
3. Any Health Care Service you render to yourself or those rendered by a Physician or other health care Provider related to you by blood or marriage.
4. Any Health Care Service that is not Medically Necessary as defined in this Booklet and determined by us. The ordering of a Service by a health care Provider does not, in itself, make such Service Medically Necessary or a Covered Service.
5. Any Health Care Service rendered at no charge.
6. Expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage.
7. Any Health Care Service to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with:

    a) war or an act of war, whether declared or not;

b) your participation in, or commission of, any act punishable by law as a felony, whether or not you are charged or convicted, or which constitutes riot, or rebellion except for an injury resulting from an act of domestic violence or a medical Condition;

c) your engaging in illegal occupation, except for an injury resulting from an act of domestic violence or a medical condition except for an injury resulting from an act of domestic violence or a medical Condition;

d) Services received at military or government facilities to treat a Condition arising out of your service in the armed forces, reserves and/or National Guard; or

e) Services received to treat a Condition arising out of your service in the armed forces, reserves and/or National Guard.

8. Services that are not patient-specific, as determined solely by us, such as office infection control charges.
9. Health Care Services rendered because they were ordered by a court, unless such Services are otherwise Covered Services under this Booklet.
10. Any Health Care Service rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group.
11. Expenses for completion of any form and/or medical information and for copies or your records, charts or any costs associated with forwarding or mailing copies of your records or charts.
12. Health Care Services that do not comply with the most recent version of the Ethical and Religious Directives for Catholic Health Care Services issued by the National Catholic Conference of Bishops.

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

Hearing Services including routine hearing exams and screenings, except as provided under the External Hearing Aids and Preventive Services categories of the WHAT IS COVERED? section, and implantable hearing aids and Services related to the fitting or provision of such hearing aids, including tinnitus maskers, batteries, and repair costs.

Home Health Care Services that (1) are rendered by an employee or operator of an adult congregate living facility; an adult foster home; an adult day care center, or a nursing home facility; (2) are rendered in a nursing home, or intermediate care facility; or (3) is Speech Therapy provided for diagnosis of developmental delay.

Hospital Expenses including the Hospital charges, Physician charges and any other charges related to an inpatient stay are not covered when Services could have been rendered without admitting you to the Hospital.

Immunizations except those covered under the WHAT IS COVERED? section.

Infertility Treatment including Services beyond what is necessary to determine the cause or reason for infertility and Services rendered to assist in achieving pregnancy are excluded. These Services include, but are not limited to:

1. Services provided to treat infertility;
2. Reversal of previous surgical sterilization procedures;
3. All infertility treatment medications;
4. Assisted reproductive therapy including, but not limited to, Artificial Insemination (AI); In Vitro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT); Zygote Intrafallopian Transfer (ZIFT); and any Services associated with these procedures; and

5. All Services associated with the donation or purchase of sperm.

Missed Appointment including any costs you incur for not going to a scheduled appointment, regardless of the reason for missing the appointment.

Motor Vehicle Accident Injuries and Services you incur due to an accident involving any motor vehicle for which no-fault insurance is available.

Oral Surgery for the primary purpose of improving the appearance or self-perception of an individual, except as provided under the WHAT IS COVERED? section.

Orthomolecular Therapy, including nutrients, vitamins, and food supplements.

Orthotic Devices except as indicated in the WHAT IS COVERED? section, including:

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

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

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

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

1. homemaker or domestic maid services;
2. sitter or companion services;
3. food, housing and home-delivered meals;
4. beauty and barber services,
5. personal hygiene supplies such as shampoo, toothpaste, body lotions and hygiene packets;
6. clothing, including support hose;
7. radio and television;
8. guest meals and accommodations;
9. telephone charges;
10. take-home supplies;
11. travel expenses (other than Medically Necessary Ambulance Services);

12. motel/hotel accommodations;
13. air conditioners, furnaces, air filters, air or water purification systems, water softening systems, humidifiers, dehumidifiers, vacuum cleaners or any other similar equipment and devices used for environmental control or to enhance an environmental setting;
14. hot tubs, Jacuzzis, heated spas, pools, or memberships to health clubs;
15. heating pads, hot water bottles, or ice packs;
16. physical fitness equipment;
17. hand rails and grab bars; and
18. Massage except as set forth in the WHAT IS COVERED? section.

Private Duty Nursing Care rendered at any location.

Prosthetic Devices except as indicated in the WHAT IS COVERED? section, including:

1. Expenses for cosmetic enhancements to artificial limbs; and
2. expenses for performance enhancing Prosthetic Devices (such as carbon-fiber racing legs).

Rehabilitative Therapies provided to you on an inpatient or outpatient basis, except as provided in the Hospital, Skilled Nursing Facility, Home Health Care, and Outpatient Therapies and Spinal Manipulation category of the WHAT IS COVERED? section.

Services to Treat Complications of Non-Covered Services, including any Services(s) to diagnose or treat any Condition which would not have occurred but for your receipt of a non-Covered Service such as, for example, treatment for a complication of cosmetic surgery (e.g. an implant leakage or capsular contracture after cosmetic breast augmentation unrelated to breast cancer reconstruction surgery requiring removal, repair, and/or replacement of the implant; repair of cosmetic or functional abnormalities as a result of cosmetic surgery complications). This exclusion applies when the Service(s) from which the complication resulted was/were not a Covered Service(s) under this Booklet or another BCBSF/HOI policy. It also applies if the non-Covered Service(s) was/were performed while you were covered by a previous carrier or self-funded plan at any time prior to coverage under this Booklet even if the Service(s) were covered under the prior carrier or self-funded plan.

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

Smoking Cessation Programs, except as provided under the Preventive Services category of the WHAT IS COVERED?.

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

Surgical Sterilization voluntary surgical sterilization (tubal ligations and vasectomies), regardless of Medical Necessity.

Telephone Consultations, except as provided under the Preventive Services category of the WHAT IS COVERED? section.

Training and Educational Programs, or materials, including, but not limited to programs or materials for Pain Management and vocational rehabilitation, except as provided under the Diabetes Treatment Services category of the WHAT IS COVERED? section.

Transplant Services except as indicated in the WHAT IS COVERED? section, including:

1. Transplant procedures not included in the Transplant Services category of the WHAT IS COVERED? section, or otherwise excluded under this Booklet, such as Experimental or Investigational transplant procedures.
2. Transplant procedures involving the transplantation of any non-human animal organ or tissue.
3. Transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered by us.
4. Transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ tissue, except for an approved artificial heart device that meets our Medical Necessity criteria then in effect.
5. Any organ, tissue, marrow, or stem cells which are sold rather than donated.
6. Any Bone Marrow Transplant, as defined herein, which is not specifically listed in the applicable chapter of the Florida Administrative Code or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual.
7. Any Service in connection with the identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant.
8. Any non-medical costs, including but not limited to, temporary lodging or transportation costs for you and/or your family to and from the approved facility.

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

Virtual Visits, except as described in the WHAT IS COVERED? section. Services rendered by a Virtual Care Provider that is not designated by us to provide Virtual Visits under this Booklet.

Volunteer Services or Services which would normally be provided free of charge.

Weight Control Services including any Service to lose, gain, or maintain weight regardless of the reason for the Service or whether the Service is part of a treatment plan for a Condition, except as indicated as covered under the Preventive Health Services and Surgical Services categories of the WHAT IS COVERED? section. This exclusion includes, but is not limited to weight control/loss programs; appetite suppressants and other medications; dietary regimens; food or food supplements; exercise programs; exercise or other equipment.

Wigs and/or cranial prosthesis.

Wilderness Treatment Programs whether provided as part of a Residential Treatment Facility or not, if the primary Services provided:

1. can be provided without a Residential Treatment Facility license under Florida law or a similar applicable law of another state; and/or
2. constitute Services that are provided by:
   a) a licensed outdoor youth program, and/or
   b) a school or any such related or similar programs. This includes but is not limited to: educational and therapeutic programs within a school setting, health resorts, outdoor skills programs, and relaxation or lifestyle programs.

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

MEDICAL NECESSITY

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

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

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

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

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

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

YOUR SHARE OF HEALTH CARE EXPENSES

This section explains what your share of the health care expenses may be for Covered Services you receive. Since not all plans include all the different types of Cost Share explained in this section, it is important that you look at your Schedule of Benefits to see your share of the cost for specific Covered Services.

WARNING: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered nonemergency service, benefit payments to the provider are not based upon the amount the provider charges. The basis of the payment will be determined according to your policy's out-of-network reimbursement benefit. Nonparticipating providers may bill insureds for any difference in the amount. YOU MAY BE REQUIRED TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT. Participating providers have agreed to accept discounted payments for services with no additional billing to you other than coinsurance, copayment, and deductible amounts. You may obtain further information about the providers who have contracted with your health plan by consulting your health plan's website.

Deductibles

A deductible is a fixed dollar amount that you must pay before the Plan begins to pay for Covered Services. There are different types of deductibles; some that apply to most Covered Services on your plan and some that apply only to a specific type of Service. Listed below are the different types of deductibles and a brief explanation of how they work. You will need to look at your Schedule of Benefits to find out what types of deductibles (if any) apply to your plan.

Rules for applying charges to deductibles:

- We can only apply charges for claims we actually receive;
- Only charges for Covered Services will be applied; and
- We will only apply the amount of charges up to our Allowed Amount.

Overall Deductible (DED)

This deductible applies to most of the Covered Services on your plan before the Plan begins to pay for Covered Services. When we talk about this type we just call it “Deductible” and on the Schedule of Benefits “DED”. Some Covered Services do not apply the Deductible when you use In-Network Providers, so be sure to look at your Schedule of Benefits. After the Deductible has been met, neither you nor your Covered Dependents (if any) will have any additional Deductible amount for the rest of the Benefit Period.

Individual Deductible

If you are the only person on your plan, you only have to reach the individual Deductible and the family Deductible listed on your Schedule of Benefits does not apply to you. This amount, when applicable, must be satisfied by you each Benefit Period before any payment will be made by the Plan.

Family Deductible

If you have one or more family members on your plan, the Deductible can be satisfied by a combination of Covered Persons. The family Deductible is met when any combination of family members meet the Family Deductible amount.

Embedded Deductible

If your Schedule of Benefits indicates that the Deductible is embedded, each Covered Person only needs to satisfy the individual Deductible and not the entire family Deductible, prior to the Plan paying for Covered Services for that Covered Person. The Plan will not begin to pay for Covered Services for the other family members until they either satisfy the individual Deductible or until the family Deductible is met. The family Deductible is met when any combination of family members' costs for Covered Services meets the family Deductible limit. The maximum amount that any one Covered Person in your family can contribute toward the family Deductible is the amount applied toward that person's individual Deductible.

Shared Deductible

If your Schedule of Benefits indicates that the family Deductible is Shared, the entire family Deductible must be met by any one Covered Person or a combination of any or all Covered Persons before the Plan will begin to pay for Covered Services for any Covered Person under your plan.

Per Visit Deductible (PVD)

This is a deductible that applies after any overall Deductible, but only applies to a specific type of Covered Service on your plan before the Plan begins to pay for Covered Services. When we talk about this type we call it "Per Visit Deductible" and on the Schedule of Benefits "PVD". The Per Visit Deductible applies before any other type of Cost Share (except the overall Deductible) and must be paid by you for each visit. Not all plans have a Per Visit Deductible, so be sure to look at your Schedule of Benefits.

Inpatient Per Admission Deductible (PAD)

This is a deductible that applies after any overall Deductible, but only applies to a specific type of Covered Service on your plan before the Plan begins to pay for Covered Services. When we talk about this type we call it "Per Admission Deductible" and on the Schedule of Benefits "PAD". The Per Admission Deductible only applies to an inpatient facility (such as a Hospital), applies before any other type of Cost Share (except the overall Deductible) and must be paid by you for each inpatient admission. Not all plans have a Per Admission Deductible, so be sure to look at your Schedule of Benefits.

Copayments

A Copayment is a fixed dollar amount you must pay when you receive certain Covered Services. Listed below are the different types of Copayments and a brief explanation of how they work. If our Allowed Amount or the Provider's actual charge for a Covered Service rendered is less than the Copayment amount, you may only have to pay the lesser of our Allowed Amount or the Provider's actual charge for the Covered Service. Not all plans have Copayments, so be sure to look at your Schedule of Benefits.

Copayments:

- must be paid at the time you receive the Services;
- apply before any payment will be made by the Plan;
- apply regardless of the reason for the Service; and
- usually apply to all Services rendered during the visit, but there are exceptions to this rule, so be sure to check your Schedule of Benefits and the brief explanations below.

Office Services Copayment

An office Services Copayment applies to each office visit and applies to all Covered Services rendered during that visit, except for Durable Medical Equipment, Medical Pharmacy, Orthotics and Prosthetics, which may require Cost Share amounts in addition to the Copayment.

Inpatient Facility Services Copayment

The inpatient facility Copayment only applies to the inpatient facility (such as a Hospital) and you must pay it for each inpatient admission. Remember that there may be additional Cost Share amounts you will have to pay for Covered Services provided by Physicians and other health care professionals while you are an inpatient.

Outpatient Facility Services Copayment

The outpatient facility Copayment only applies to an outpatient facility and you must pay it for each outpatient visit. Remember that there may be additional Cost Share amounts you will have to pay for Covered Services provided by Physicians and other health care professionals while using these facilities.

Note: Copayments for outpatient facility Services may vary depending on the type of facility chosen and the Services received. Please see your Schedule of Benefits for more information. If you are admitted to the Hospital as an inpatient at the time of the emergency room visit, you will pay the Cost Share that applies to inpatient facility Services, as indicated on your Schedule of Benefits.

Coinsurance

Coinsurance is a percentage of our Allowed Amount that you must pay before the Plan will pay its portion of the Allowed Amount for Covered Services. The Coinsurance percentage is usually figured after all other Cost Share amounts for a given Service, such as Deductible.

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

For example, if the In-Network Coinsurance for your plan were 80%, the Coinsurance percentage that would be used as a base for Covered Services as described above would be between 70% and 80% of the Allowed Amount. In this example, the Coinsurance percentage used as the basis for payment would not be less than 70% of the Allowed Amount.

Application of Multiple Cost Share Types

When a Service is subject to more than one type of Cost Share, the Schedule of Benefits will list the Cost Share types in the order in which they apply to the Service. For example, when the Schedule shows "$100 + DED"; this means that the Copay is applied first and then, if you have not reached the Deductible; the Deductible is applied to the remainder of that Service, up to the Allowed Amount. If you have already met the plan Deductible; then only the Copay is applied.

Remember that when you use Out-of-Network Providers, your Cost Share amounts only apply to the Allowed Amount. Any Out-of-Network Provider charges over the Allowed Amount are not covered and do not count towards your Cost Share or Out-of-Pocket Maximums.

Out-of-Pocket Maximums

An out-of-pocket maximum is the Benefit Period limit on Cost Share amounts that you have to pay for a given Benefit Period for Health Care Services that are Covered Services under this Booklet. After you have paid this dollar amount in Cost Share, you will have no additional Cost Share for the rest of that Benefit Period and the Plan will pay 100 percent of the Allowed Amount for Covered Services rendered during the rest of that Benefit Period.

Individual Out-of-Pocket Maximum

If you are the only person on your plan, only the individual out-of-pocket maximum applies to you and the family out-of-pocket maximum listed on your Schedule of Benefits does not apply to you. After you have reached the individual out-of-pocket maximum amount listed in your Schedule of Benefits, you will have

no additional out-of-pocket responsibility for the remainder of that Benefit Period and the Plan will pay 100 percent of the Allowed Amount for Covered Services rendered during the remainder of that Benefit Period.

Family Out-of-Pocket Maximum

If you have one or more family members on your plan, the family out-of-pocket maximum can be satisfied by any one Covered Person or a combination of Covered Persons depending on the type of out-of-pocket maximum described below.

Embedded Out-of-Pocket Maximum

If your Schedule of Benefits indicates that the out-of-pocket maximum is embedded, when any one Covered Person meets the individual out-of-pocket maximum, that Covered Person will have no additional Cost Sharefor the rest of the Benefit Period. The rest of the family must continue satisfying their out-of-pocket maximum until the family out-of-pocket maximum is met. The maximum amount that any one Covered Person in your family can contribute toward the family out-of-pocket maximum is the amount applied toward that person's individual out-of-pocket maximum.

Shared Out-of-Pocket Maximum

If your Schedule of Benefits indicates that the out-of-pocket maximum is shared, any one Covered Person or a combination of any or all Covered Persons can meet the family out-of-pocket maximum. Once the family out-of-pocket maximum is met, neither you nor your Covered Dependents will have to pay any additional Cost Share for Covered Services for the rest of the Benefit Period.

Please see your Schedule of Benefits for more information. All Cost Share amounts you pay toward the Covered Services explained in this Booklet will apply to the out-of-pocket maximum, such as Deductibles, Copayments and Coinsurance. The following charges **will not apply** to the out-of-pocket maximums and when you have reached the out-of-pocket maximum, **you will still have to pay** these charges:

- contribution amounts you must pay to the Group;
- charges for Services that are not covered;
- charges that are in excess of our Allowed Amount; and
- any benefit penalties.

How Benefit Maximums are Credited

Only the amounts the Plan actually pays for Covered Services will be credited to any benefit maximums. The amounts the Plan pays are based on the Allowed Amount for the Covered Services provided. You will need to look at your Schedule of Benefits to find out if any benefit maximums apply to your plan.

Prior Coverage Credit

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

Prior Coverage Credit for Deductible

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

Prior Coverage Credit for Coinsurance

Charges credited by the Group's prior policy or plan, toward your Coinsurance maximum, for Services rendered during the 90-day period immediately preceding the Effective Date of this Plan, will be credited to your out-of-pocket maximum under this Booklet.

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

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

Calculation of Cost Share

You can get an estimate on our website at www.floridablue.com, of the Cost Share amount you will have to pay for certain Covered Services, as required under section 627.6385 of the Florida Statutes.

Additional Expenses You Must Pay

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

1. charges in excess of any maximum benefit limitation listed in your Schedule of Benefits;
2. expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage;
3. charges in excess of the Allowed Amount for Covered Services rendered by Providers who have not agreed to accept our Allowed Amount as payment in full;
4. any benefit reductions/benefit penalties;
5. charges for Health Care Services which are non-Covered Services or excluded; and
6. any contribution amount required by Diocese of Palm Beach Health Plan Trust.

Surprise Billing

Sometimes you may receive Covered Services from Out-of-Network Providers who will not accept the plan's payment as payment in full. Out-of-Network Providers in the specific situations described below are prohibited from balance billing you for amounts over what the Plan pays. Should you receive a bill for more than your Cost Share (as described below) from the Out-of-Network Provider in these situations, please send that information to us at the address on your ID card and we will attempt to work with the Out-of-Network Provider to appropriately honor their obligation to not balance bill you, if applicable.

Out-of-Network Services where I should not be balance billed

Please note, in the following specific circumstances federal and/or Florida state law prohibits Out-of-Network Providers from balance billing you for receipt of Covered Services.

- **Emergency Services for an Emergency Medical Condition** provided at an Out-of-Network facility to Stabilize you (which may include part or all of an inpatient admission from the Emergency Room of an Out-of-Network Hospital); and

- **Certain non-Emergency Services or ancillary Services** provided by an Out-of-Network Provider at an In-Network facility including but not limited to:
  - Surgery
  - Anesthesiology
  - Pathology
  - Radiology
  - Hospital Services
  - Laboratory Services

  Note: If the Out-of-Network Provider rendering the non-Emergency Services referenced above has given you the following, in advance: (a) the estimated charges for the Covered Services to be rendered; (b) notice that the Provider is an Out-of-Network Provider; and (c) notice for your approval in writing to the treatment to be rendered by the Out-of-Network Provider, then the Provider may be able to balance bill you and this Surprise Billing subsection will not apply.
- **Air Ambulance Services if the Services** are Covered Services under this Benefit Booklet regardless of whether or not the Services are due to an Emergency Medical Condition.

Please note that an authorization is never required for Covered Services for the treatment of an Emergency Medical Condition. Not all Air Ambulance Services are Covered Services under this Benefit Booklet. Please refer to the Ambulance Services category in the WHAT IS COVERED? section of this Benefit Booklet.

Facility, as used above means:

- hospital (as defined in section 1861 of the Social Security Act)
- hospital outpatient department
- critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act)
- an ambulatory surgical center (as defined in section 1833(i)(1)(A) of the Social Security Act)
- and for an Emergency Medical Condition only, an independent freestanding emergency medical department

How Much the Plan will Pay Out-of-Network Providers

Generally, Florida state law prohibits Out-of-Network Providers rendering Covered Services subject to this Surprise Billing section from balance billing you. If section 627.64194(4), Florida Statutes applies, then the Allowed Amount (i.e., the amount we base payment on) will generally be calculated in accordance with the definition within this Benefit Booklet. In certain circumstances, the Allowed Amount will be calculated for Out-of-Network Providers, including all Covered Services rendered by Out-of-Network Air Ambulance Providers, based upon the Median Contracted Rate. The term “Median Contracted Rate” as used here means, generally:

1. The rate that is the median contracted rate for all In-Network Providers for the same or similar item(s) or Service(s) for all plans offered by us:

   c) in the same insurance market (i.e., individual, small group or large group); and,

   d) provided in the same geographic region as the Covered Service provided to you.

Important Note: The above definition of “Median Contracted Rate” has been simplified here to make it easier to understand. The term “Median Contracted Rate”, as defined by federal law, is complicated. We will calculate the “Median Contracted Rate” more specifically in accordance with the federal law (and regulations then in effect) known as the federal No Surprises Act (H.R. 133, P.L. 116-260).

Calculating Your Share of the Cost

If you receive Covered Services subject to this Surprise Billing subsection, your Cost Share (e.g., Deductibles and/or Coinsurance) will be calculated based upon the Allowed Amount the Plan initially paid the Out-of-Network Provider as described above. Should the Plan decide to pay more, or if the federal Independent Dispute Resolution Process results in the Plan paying the Out-of-Network Provider more, your Cost Share will not change.

Any Cost Share you paid with respect to Covered Services identified in this subsection will be applied

toward your In-Network Deductible and out-of-pocket maximum, if applicable. We will provide notice of payment or denial no later than 30 calendar days after receipt of the bill from the Provider.

Important Note: It is not a surprise bill when you knowingly choose to go to an Out-of-Network Provider for a planned Service or have signed a consent as noted above, in advance for the Covered Services. In such a case, you are responsible for all charges.

HEALTH CARE PROVIDER OPTIONS

Introduction

It is important that you understand how the Providers you choose to use for medical care and the type of Service you receive will affect how much you have to pay for medical Services. This section explains payment rules when receiving Covered Services from different types of Providers under this Booklet. This section does not include the specific Cost Share amounts under your plan; as you read this section, please keep in mind that you will have to check your Schedule of Benefits for those details. For information on Pharmacy Provider options, please refer to the PRESCRIPTION DRUG PROGRAM section.

Provider Participation Status

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

In-Network Providers

With BlueChoice, you may choose to receive Services from any Provider. However, you will be able to lower the amount you have to pay for Covered Services by receiving care from an In-Network Provider. PPC Providers are the In-Network Providers under this Booklet. You should use In-Network Providers whenever possible to reduce your out-of-pocket expenses. Using In-Network Providers will result in significant savings. In-Network Providers will also file their claims for you and payment will be made directly to the Provider.

Remember that using In-Network Providers will result in lower Cost Share for you. You should always check to see whether a Provider is In-Network or Out-of-Network before you receive Services to find out how much of the cost you will have to pay.

Primary Care Provider Program

We encourage you to select and develop a relationship with an In-Network Primary Care Provider ("PCP"). There are several advantages to selecting a Primary Care Provider (Family Practitioners, General Practitioners, Internal Medicine doctors and Pediatricians):

- PCPs are trained to provide a broad range of medical care and can be a valuable resource to coordinate your overall health care needs.
- Developing and continuing a relationship with a PCP allows the Provider to become knowledgeable about you and your family's health history.
- A PCP can help you determine when you need to visit a specialist and also help you find one based on their knowledge of you and your specific health care needs.
- Care rendered by PCPs usually results in lower Cost Share for you.

We will check our records periodically to see if you have visited a PCP. If not, we may provide your name and contact information to an In-Network PCP who will call you and offer to schedule a wellness visit. This program is completely voluntary and although we encourage you to schedule this visit, you are not obligated to do so. The applicable PCP Cost Share will apply to this visit.

You are responsible for checking to see if a Provider is In-Network for your plan prior to receiving Services. To find out if a Provider is In-Network, refer to the current Provider directory at www.floridablue.com or call the customer service phone number on your ID Card.

Out-of-Network Providers

When you use Out-of-Network Providers your Cost Share for Covered Services will be higher. We will base the payment on the Allowed Amount at the Coinsurance percentage listed in the Schedule of Benefits. Further, if the Out-of-Network Provider is a Traditional Program Provider or a BlueCard Traditional Program Provider, payment to such Provider may be under the terms of that Provider's contract. If the BlueChoice Provider directory does not include a Provider as In-Network under your benefit plan, the Provider is considered Out-of-Network.

You are entitled to Traditional Program type benefits at the point of service when you receive Covered Services from Traditional Program Providers or BlueCard Traditional Program Providers, in conformity with the BLUECARD PROGRAM section.

When you use Out-of-Network Providers, you may have to pay the Provider in full and then file claims to us for reimbursement. You are responsible for paying the difference between what the Plan pays and the Provider's charge.

Provider Financial Incentive Disclosure

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

Location of Service

The location or setting where you receive Services can also affect the amount you pay. For example, the amount you must pay will vary whether you receive Services in a Hospital, a Provider's office, or an Ambulatory Surgical Center. After you and your Physician have determined the plan of treatment most appropriate for your care, you should refer to the WHAT IS COVERED? section and your Schedule of Benefits to find out if the Services are covered and how much you will have to pay. You should also consult with your Physician to determine the most appropriate setting based on your health care and financial needs.

Physicians

When you receive Covered Services from a Physician, several factors will determine your Cost Share, including whether the Physician is In-Network or Out-of-Network, the location of Service, the type of Service rendered, whether the Physician participates in certain Florida Blue programs, and the Physician's specialty (as determined by us).

Value Choice Providers

Some Providers, designated by us, may provide Services other than maternity and Medical Pharmacy at a lower Cost Share. The Deductible will be waived for these Services and your Cost Share is lower when they are rendered in the Value Choice Provider's office or Independent Diagnostic Testing Centers designated as Value Choice Providers. The chart below lists the Services included and the Cost Share amounts:

Value Choice Provider Type	Services Included	Cost Share
Primary Care Provider	• Office Visits* • Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) • Diagnostic Testing (such as lab work and x-rays done in the office)	$25
	• Allergy Testing and Injections • Occupational Therapy and Physical Therapy	$0
Specialist Physician	• Office Visits* • Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine) • Diagnostic Testing (such as lab work and x-rays done in the office)	$50**
	• Occupational Therapy and Physical Therapy	$20
Dietician / Nutritionist	Covered Services such as Diabetic Education	$0
Independent Diagnostic Testing Center	Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$20**
Urgent Care Center	Covered urgent care Services for the first 2 visits per Covered Person, per Benefit Period	$0 for first 2 visits***

* Maternity and Medical Pharmacy Services will remain at the Cost Share listed on your Schedule of Benefits.

** Or the Specialist Physician office Cost Share listed on your Schedule of Benefits; whichever is lower.

*** After the first 2 visits, the urgent care Cost Share visits are $15 when rendered with a Value Choice Provider.

To find a Value Choice Provider, access the most recent provider directory at www.floridablue.com and look for Providers with “Value Choice Providers” under “Programs”.

Hospitals

Each time you receive inpatient or outpatient Covered Services at a Hospital, in addition to any Cost Share for Physician Services, you will have to pay the Cost Share related to Hospital Services.

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

your Physician admits to by contacting the Physician's office. This information will help you figure out what your Cost Share may be in the event you are hospitalized.

Specialty Pharmacy

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

Using the Specialty Pharmacy to provide these Specialty Drugs should lower the amount you have to pay for these medications. Please refer to the Medication Guide for a list of Specialty Pharmacies.

Other Providers

With BlueChoice you have access to other Providers in addition to the ones described in this section. Other Providers include facilities that provide alternative outpatient settings or other persons and entities that specialize in specific Services. While these Providers may be recognized for payment, they may not be In-Network Providers for your plan. Also, all of the Services that are within the scope of certain Providers' licenses may not be Covered Services under this Booklet. Please refer to the WHAT IS COVERED? and WHAT IS NOT COVERED? sections of this Booklet and your Schedule of Benefits to find out what your Cost Share may be for Covered Services rendered by these Providers.

You may be able to receive certain outpatient Services at a location other than a Hospital. Your Cost Share for Services rendered at some alternative facilities is generally less than if you had received those same Services at a Hospital.

Continuity of Coverage and Care Upon Termination of a Provider Contract Under Federal Law

Federal law (42 U.S. Code § 300gg –113) provides for continuity of Services for enrollees of health plans when there is a change in the plans' Provider network resulting in a Provider no longer being In-Network for the enrollee's benefit plan. These protections extend to individuals defined as a "Continuing Care Patient" and include patients who are undergoing a course of treatment for:

1. a serious or complex Condition,
    a) in the case of an acute illness, a Condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or
    b) in the case of a chronic illness or Condition, a Condition that:
        i. is life-threatening, degenerative, potentially disabling, or congenital; and
        ii. requires specialized medical care over a prolonged period of time.
2. institutional or inpatient care,
3. a scheduled non-elective surgery including postoperative care.
4. pregnancy; or
5. a terminal illness.

Such patients will have up to 90 days of continued coverage at the In-Network Cost Share to allow for a transition of care to an In-Network Provider.

Assignment of Benefits to Providers

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

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

We specifically reserve the right to honor an assignment of benefits or payment by you to a Provider who: (1) is an In-Network Provider under your plan of coverage; (2) is a PPC Provider; (3) is a Traditional Program Provider; (4) is a BlueCard PPO Program Provider; (5) is a BlueCard Traditional Program Provider; or (6) when applicable honor an assignment of your right to receive payment for Covered Services to an Out-of-Network Provider in accordance with Section 627.638(2) Florida Statutes or other applicable statute then in effect. A written attestation of the assignment of benefits may be required.

BLUECARD® PROGRAM

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access Health Care Services outside Florida, the claim for those Services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of Florida, you will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Nonparticipating Providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental care benefits except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by us to provide the specific Service or Services.

BlueCard Program

Under the BlueCard Program, when you receive Covered Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling its contractual obligations to you. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

When you receive Covered Services outside of Florida and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to us

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with your Provider or Provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

Special Cases: Value-Based Programs

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to us through average pricing or fee schedule adjustments. Additional information is available upon request.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to your accounts. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Nonparticipating Providers Outside Florida

When Covered Services are provided outside of Florida by Nonparticipating Providers, our payment will be based on the Allowance or Allowed Amount, as defined in the DEFINITIONS section of the Benefit Booklet.

Blue Cross Blue Shield Global® Core Program

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard Service Area"), they may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing Covered Services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard Service Area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists you with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard Service Area, you will typically have to pay the Providers and submit the claims yourself to obtain reimbursement for these Services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard Service Area, you should call the Blue Cross Blue Shield Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for inpatient Covered Services, except for your Cost Share amounts. In such cases, the hospital will submit your claims to the Blue Cross Blue Shield Global Core Service Center to begin claims processing. However, if you paid in full at the time of Service, you must submit a claim to receive reimbursement for Covered Services. **You must notify us of any non-emergency inpatient Services.**

Outpatient Services

Physicians, Urgent Care Centers and other outpatient Providers located outside the BlueCard Service Area will typically require you to pay in full at the time of Service. You must submit a claim to obtain reimbursement for Covered Services.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for Covered Services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

BLUEPRINT FOR HEALTH PROGRAMS

Introduction

We have established (and from time to time establish) various customer-focused health education and information programs and benefit utilization management and utilization review programs. Under the terms of the ASA between Florida Blue and Diocese of Palm Beach Health Plan Trust, we have agreed to make these programs available to you. We call all these programs Blueprint for Health Programs. The Blueprint for Health Programs are designed to: (1) provide you with information that will help you make more informed decisions about your health; (2) help us facilitate the management and review of coverage and benefits provided under this Booklet; and (3) present opportunities, as explained below, for mutually agreed upon alternative benefits or payments for cost-effective medically appropriate Health Care Services. Some Blueprint for Health Programs may not be available outside the state of Florida.

Admission Notification

Our admission notification rules vary depending on whether you are admitted to a Hospital, Psychiatric, Substance Abuse or Long Term Acute Care (LTAC) Facility which is In-Network or Out-of-Network.

To find out if a Provider is in our network, refer to the current BlueChoice Provider directory on our website at www.floridablue.com or call the customer service phone number on your ID Card.

In-Network

We must be notified of all inpatient admissions (i.e., elective, planned, urgent or emergency) to In-Network Hospital, Psychiatric, Substance Abuse and LTAC Facilities. In-Network Providers located in Florida have agreed to notify us of your admission; however, you should ask the facility if we have been notified of your admission. For an admission outside Florida, you or the facility should notify us of the admission. Making sure that we are notified of your admission will enable us to provide you information about the Blueprint for Health Programs available to you. You or the facility may notify us of your admission by calling the customer service phone number on your ID Card.

Out-of-Network

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

Inpatient Facility Program

We may review Hospital stays, Hospice, LTAC and Skilled Nursing Facility (SNF) Services, and other Health Care Services rendered during the course of an inpatient stay or treatment program. We may conduct this review while you are inpatient, after your discharge, or as part of a review of an episode of care when you are transferred from one level of inpatient care to another for ongoing treatment. The review is conducted solely to determine whether a particular admission or Health Care Services rendered during that admission are covered under this Booklet. Using our established criteria then in effect, a concurrent review of the inpatient stay may occur at regular intervals, including before a transfer from one inpatient facility to another. We will let your Physician know when inpatient coverage criteria are no longer met. As a part of this program, we may review specific medical facts or information and assess, among other things, the appropriateness of the Services being rendered, health care setting and/or the level of care of an inpatient admission or other health care treatment program. Any such reviews by us, and any reviews or assessments of specific medical facts or information which we conduct, are solely for purposes of making coverage or payment decisions under this Benefit Booklet and not for the purpose of recommending or providing medical care.

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

Prior Coverage Authorization/ Pre-Service Notification Programs

It is important for you to understand our prior coverage authorization programs and how the Provider you select and the type of Service you receive affects these requirements and ultimately how much you will have to pay under this Booklet.

You or your Physician will be required to obtain prior coverage authorization from us for Covered Services listed below. You are solely responsible for getting any required authorization before Services are rendered regardless of whether the Service is being rendered by an In-Network Provider or Out-of-Network Provider.

For details on how to obtain prior coverage authorization for these Services, please call the customer service phone number on your ID Card.

Services that Require Prior Authorization

Advanced Diagnostic Imaging Services

You must obtain an authorization for advanced diagnostic imaging Services such as CT scans, MRIs, MRA and nuclear imaging, when rendered or referred by a Provider **before** the advanced diagnostic imaging Services are provided. **If you do not obtain prior coverage authorization this plan will deny coverage for the Services and not make any payment for such Services**.

Applied Behavioral Analysis

You must obtain an authorization for Applied Behavioral Analysis for Autism Spectrum Disorder or Down Syndrome, **before** the Services are provided. **If you do not obtain prior coverage authorization this plan will not make any payment for such Services**.

Approved Clinical Trials

You must obtain an authorization for Services rendered in connection with Approved Clinical Trials, when rendered or referred by a Provider **before** you obtain routine patient care provided in connection with an Approved Clinical Trial. **If you do not obtain prior coverage authorization this plan will not make any payment for such Services**.

Prescription Drugs

In the case of Prescription Drugs, it is your sole responsibility to obtain prior coverage authorization **before** the drug is purchased or administered. **If you do not obtain prior coverage authorization, this plan will deny coverage for the Prescription Drug and not make any payment for the drug or any Service related to the drug or its administration.**

All Prescription Drugs covered under the Medical Pharmacy category in the WHAT IS COVERED? section, require prior authorization. For a list of other medications that require prior coverage authorization and details on how to get an authorization, please refer to the Medication Guide.

Other Health Care Services

In the case of other Health Care Services under a prior coverage authorization or pre-service notification program, you must obtain an authorization or comply with any pre-service notification requirements when rendered or referred by a Provider, **before** the Services are provided.

We will inform you of any Health Care Service that is or will become subject to a prior coverage authorization or pre-service notification program, including how you can obtain prior coverage authorization and/or provide the pre-service notification for such Service. This information will be provided to you upon enrollment, or at least 30 days prior to such Services becoming subject to a prior coverage authorization or pre-service notification program. Such information may be provided to you electronically, if you have elected the delivery of notifications from us in that manner. Changes to the list of other Health Care Services that require prior authorization shall occur no more frequently than twice in a Calendar Year.

Additional Information

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

If you do not obtain authorization or provide pre-service notification, we may:

1. deny payment of the claim; or
2. apply a benefit penalty when the claim is presented to us for payment consisting of one of the following:
   a) $500
   b) 20% of the total Allowed Amount of the claim; or
   c) The lesser of $500 or 20% of the total Amount of the claim.

The decision to apply a penalty or deny the claim will be made uniformly and the applicable denial/penalty will be identified in the notice describing the prior coverage authorization and pre-service notification programs.

Note:

1. Prior coverage authorization is not required when Emergency Services are rendered for the treatment of an Emergency Medical Condition.
2. Prior coverage authorizations expire on the earlier of, but not to exceed 12 months:
   a) the termination date of your plan, or
   b) the period authorized by us, as indicated in the letter you receive from us.

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

See the CLAIMS PROCESSING section for information on what you can do if prior coverage authorization is denied.

Member Focused Programs

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

Personal Case Management Program

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

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

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

Health Information, Promotion, Prevention and Illness Management Programs

These Blueprint for Health Programs may include health information that supports member education and choices for health care issues. These programs focus on keeping you well, help to identify early preventive measures of treatment and help members with chronic problems to enjoy lives that are as productive and healthy as possible. These programs may include illness management programs for Conditions such as diabetes, cancer and heart disease. The programs are voluntary and are designed to enhance your ability to make informed choices and decisions for your unique health care needs. You may call the customer service phone number on your ID Card for more information. Your participation in these programs is completely voluntary.

IMPORTANT INFORMATION RELATING TO OUR BLUEPRINT FOR HEALTH PROGRAMS

All decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical Services, are solely your responsibility and the responsibility of your health care Providers. You and your Providers are responsible for deciding what medical care should be rendered or received, and when and how that care should be provided. Diocese of Palm Beach Health Plan Trust is solely responsible for determining whether expenses, which have been or will be incurred for medical care are, or will be, covered under this Booklet. In fulfilling this responsibility, neither Florida Blue nor Diocese of Palm Beach Health Plan Trust will be deemed to participate in or override the medical decisions of your health care Provider.

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

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

Coverage Protocol Exemption Request

In some cases Services under this Booklet require you to complete use of another Prescription Drug, medical procedure, or course of treatment other than the one requested by your treating Physician before coverage will be authorized/granted. Florida Statute 627.42393 permits you to request a protocol

exemption in order to receive coverage without completing our coverage protocol for the Prescription Drug, medical procedure, or course of treatment. If we deny the coverage protocol exemption request, we will provide you with a written explanation of the reason for the denial, the clinical rationale that supports the denial, and the procedure for appealing the denial. In some instances, the process for appealing a denied coverage protocol exemption request will be your formal appeal of an Adverse Benefit Determination process as outlined in the CLAIMS PROCESSING section of this Booklet.

Information on how to request a coverage protocol exemption or to appeal a denial of a request for exemption can be found on our website at https://www.floridablue.com/docview/coverage-protocol-exemption-request/.

ELIGIBILITY FOR COVERAGE

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

Covered Plan Participant Eligibility

If you are a lay employee, you and your dependents may be eligible to receive benefits under this Plan after completing the Waiting Period of 30 days from the date of hire.

To be eligible, you must be:

1. A full-time lay employee working at least 30 hours a week and following the standard work schedule for your position.
2. An active full-time lay employee, who was enrolled in the plan prior to January 1, 1994 working at least 20 or more hours a week.
3. A retired lay employee at least 55 years of age and eligible for current benefits under the Diocesan Pension Plan.
4. meet any additional eligibility requirements required by the Group.

Dependent Eligibility

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

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

Note: If a Covered Dependent child who has reached the end of the Calendar Year in which he or she becomes 26 obtains a dependent of their own (e.g., through birth or Adoption) such newborn child will not be eligible for this coverage and the Covered Dependent child will also lose his or her eligibility for this coverage. You are solely responsible, as the Covered Plan Participant, to establish that a child meets the eligibility rules. Eligibility will end when the child no longer meets the eligibility rules required to be an Eligible Dependent described above.

This eligibility shall terminate on the last day of the Calendar Year in which the dependent child reaches age 26.

Extension of Eligibility for Dependent Children

A Covered Dependent child may continue coverage beyond the end of the Calendar Year in which he or she reaches age 26, provided he or she is:

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

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

Children with Disabilities

In the case of a dependent child with an intellectual or physical disability, such child is eligible to continue coverage as a Covered Dependent, beyond the age of 26, if the child is:

1. otherwise eligible for coverage under the Group Health Plan;
2. incapable of self-sustaining employment by reason of intellectual or physical disability; and
3. chiefly dependent upon the Covered Plan Participant for support and maintenance provided that the symptoms or causes of the child's intellectual or physical disability existed prior to the child's 26th birthday.

This eligibility will end on the last day of the month in which the dependent child no longer meets these requirements.

Exception for Students on Medical Leave of Absence from School

A Covered Dependent child who is a full-time or part-time student at an accredited post-secondary institution, who takes a Physician certified medically necessary leave of absence from school, will still be considered a student for eligibility purposes under this Booklet for the earlier of 12 months from the first day of the leave of absence or the date the Covered Dependent would otherwise no longer be eligible for coverage under this Booklet.

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

Note: You are solely responsible, as the Covered Plan Participant, to establish that a child meets the eligibility rules. Eligibility will end when the child no longer meets the eligibility rules required to be an Eligible Dependent described above.

Other Rules Regarding Eligibility

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

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Eligible Employees and Eligible Dependents may enroll for coverage as described in this section. Any Eligible Employee or Eligible Dependent who is not properly enrolled will not be covered under this Booklet. Neither Florida Blue nor the Group shall have any obligation whatsoever to any individual who is not properly enrolled.

General Rules for Enrollment

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

How to Apply for Coverage

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

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

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

Coverage Type	Provides Coverage for:
Employee Only	the Eligible Employee only
Employee / One Dependent	the Eligible Employee and One Eligible Dependent
Employee / Family	the Eligible Employee and Eligible Dependents

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

Enrollment Periods

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

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

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

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

Initial Enrollment Period

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

Annual Open Enrollment Period

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

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

Special Enrollment Period

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

If you declined coverage when it was first offered under this Plan and you stated in writing, that coverage under another group health plan or health insurance coverage was the reason for declining enrollment, you may apply for coverage if one of the following special enrollment events occurs and you complete an Enrollment Form and submit it to Diocese of Palm Beach Health Plan Trust within time periods indicated in the chart that follows.

Special Enrollment Events

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

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

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

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

Dependent Enrollment

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

Newborn Child – To enroll a newborn child who is an Eligible Dependent, the Covered Plan Participant must complete an Enrollment Form and submit it to the Group. The Effective Date of coverage for a newborn child is usually the date of birth as long as you have enrolled the newborn child in time (as indicated below). The Group must be notified, in writing, when you are adding a newborn and the rules for Effective Date and contribution amounts charged for the newborn vary depending on when this written notification is received. The chart below indicates these differences:

Newborn Enrollment

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

If the written notice is received more than 60 days after the birth of the newborn child the child may not be added until the Group's next Open Enrollment Period.

Additional Rules for Adopted Newborn Children

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

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

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

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

Adopted Children

For all children covered as Adopted children, if the final decree of Adoption is not issued, coverage shall not be continued for such Adopted Child. It is your responsibility, as the Covered Plan Participant, to notify Diocese of Palm Beach Health Plan Trust in writing if the Adoption does not take place. Upon receipt of this written notification, we will terminate the coverage of the child as of the Effective Date of the Adopted child.

Foster Children

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

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

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

Other Provisions

Rehired Employees

Individuals who are rehired as employees of the Group are considered newly-hired employees for purposes of this section, unless the employer has indicated that the employee qualifies for the exception as described in the federal regulations. The provisions of the Group Health Plan (which includes this Booklet) applicable to newly-hired employees and their Eligible Dependents (e.g., enrollment, Effective Dates of coverage and Waiting Period) are applicable to rehired employees and their Eligible Dependents if the employee does not qualify for the federal exception.

TERMINATION OF COVERAGE

Covered Plan Participant

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

1. on the date the ASA between Florida Blue and Diocese of Palm Beach Health Plan Trust terminates;
2. on the date the Covered Plan Participant becomes covered under an alternative health benefits plan which is offered through or in connection with the Group;
3. on the last day of the month that the Covered Plan Participant no longer meets the definition of a Full-Time Employee or on July 31st for teachers who complete their contract year and leave the employment of the Diocese of Palm Beach;
4. on the date the Covered Plan Participant's coverage is terminated for cause; or
5. on the date specified by the Group.

Covered Dependent

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

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

   Note: as further clarification, a Covered Dependent child who has reached the end of the Calendar Year in which he or she becomes 26, but who has not reached the end of the Calendar Year in which the Covered Dependent child becomes 30 will lose coverage if the Covered Dependent child incurs any of the following:

   i. marriage;

   ii. no longer resides in Florida or is no longer a full-time or part-time student;

   iii. obtains a dependent (e.g. through birth or adoption); or

   iv. obtains other coverage.
4. on the date the Covered Dependent's coverage is terminated for cause; or
5. on the date specified by the Group.

If you as the Covered Plan Participant wish to delete a Covered Dependent from coverage, you must complete an Enrollment Form and submit it to the Group prior to the termination date requested.

If you wish to terminate your spouse from coverage, in the case of divorce for example, the Enrollment Form must be submitted before the termination date you are requesting, or within 10 days of the date the divorce is final, whichever is applicable.

Termination for Cause

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

1. fraud, material misrepresentation, or omission in applying for coverage or benefits; or
2. you intentionally misrepresent, omit or give false information on Enrollment Form, or other forms completed by you or on your behalf; or
3. misuse of the ID Card.

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

Rescission of Coverage

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

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

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

Rescission of coverage is considered an Adverse Benefit Determination and is subject to the Adverse Benefit Determination review standards described in the CLAIMS PROCESSING section.

Notice of Termination

It is Diocese of Palm Beach Health Plan Trust’s responsibility to immediately notify you of termination of the Group Health Plan for any reason.

Group Health Plan Responsibilities Upon Termination of Your Coverage

Upon termination of coverage for you or your Covered Dependents for any reason, Florida Blue and the Group will have no further liability or responsibility with respect to such individual, except as otherwise specifically set forth in this Booklet.

CONTINUING COVERAGE

Continuation of Coverage

If you are an employee, spouse or dependent and are currently covered by the Diocese of Palm Beach Health Plan Trust Health you can extend your coverage for up to 6 months after the date you ceased to be eligible for coverage if you:

1. are no longer eligible for coverage under the Diocese of Palm Beach Health Plan Trust;
2. are not enrolled in Medicare or any other governmental health plan; and
3. are not enrolled in coverage under another group health plan or individual health plan.

For example, if a Covered Employee: 1) is no longer eligible for coverage as of June 30, 2000, due to termination of employment, and 2) the employee is not enrolled in any other health plan, the employee would be eligible for the Continuation of Group Health Coverage Plan until December 31, 2000 (assuming all conditions described in this section are maintained).

Special Continuation of Group Health Coverage exception for Medicare enrollees

Effective August 1, 2003, the medical plan document is amended to include the following language.

If you are a spouse or dependent currently covered by the Diocese of Palm Beach Health Plan Trust Health Plan and you are also enrolled, or entitled to Medicare, you may elect to continue coverage for a period of up to 3 months, at your cost, if you:

1. lost your eligibility for the Diocese of Palm Beach Health Plan Trust Health Plan due to the unforeseen death of the employee; and
2. are not enrolled in coverage under another group health plan or individual health plan.

Election of Continuation of Group Health Coverage

In situations where coverage is lost due to divorce, legal separation or a child losing dependent status under the plan, the employee or family member must notify the Diocese of Palm Beach Health Plan Trust Health Plan office within 30 days of the event. The eligible spouse or dependent(s) will then have 60 days from the date of the event to apply for coverage under the Continuation of Group Health Coverage Plan. If you do not provide this notice within 60 days of the event, you will not be approved for coverage under the Continuation of Group Health Coverage Plan.

For example, if the Covered Dependent of a Covered Employee loses dependent status under the plan on May 12, 2003, the employee or family member must notify the Diocese of Palm Beach Health Plan Trust Health Plan of the loss of eligibility by June 12, 2003. The Covered Dependent would then have until July 12, 2003 to apply for coverage under the Continuation of Group Health Coverage Plan.

If you lose coverage due to termination of employment or reduction of work hours, a notice of your rights and a Continuation of Group Health Coverage Election Form will be sent to your last known address. This Election Form and the appropriate contribution must be sent to the address provided on the form within 60 days from the date you were no longer eligible for coverage under the Diocese of Palm Beach Health Plan Trust Health Plan. You may elect coverage for all qualified beneficiaries or your eligible spouse and dependent(s) can elect coverage separately. If you do not provide the completed Election Form and contribution payment by the date specified on the form, you will not be approved for coverage under the Continuation of Group Health Coverage Plan.

For example, if the Covered Employee is no longer eligible for coverage as of June 30, 2003, due to termination of employment, the employee and all other Covered Dependents would then have until August 30, 2003 to apply for coverage under the Continuation of Group Health Coverage Plan.

Contribution Remittance

You will be offered the same plan coverage that is currently offered by the Diocese of Palm Beach Health Plan Trust and will be responsible for payment of the contribution for your continuation of coverage. The contribution payment includes a 2% administration fee. The Diocese reserves the right to change or alter coverage benefits or contributions at their sole discretion.

All contribution payments are due on the first of the month and must be paid no later than 30 days after the due date to ensure continuation of coverage. Failure to pay the contribution within the 30-day period will result in loss of coverage effective the last day of the month that the contribution was paid. You will also be responsible for reimbursement of any benefits received by you or your family for the period where the contribution was not paid.

Termination of Continuation Coverage Prior to Maximum Coverage Period

The continued coverage may be terminated for any of the following reasons:

1. Coverage will terminate on the first day of the month for which the qualified beneficiary's Continuation of Health Coverage contribution is not timely paid.
2. Coverage will terminate on the date Diocese of Palm Beach Health Plan Trust ceases to maintain any group health plan for its employees.
3. Coverage will terminate for cause on the same basis coverage is terminated for cause with respect to similarly situated beneficiaries under the plan with respect to whom a qualified event has not occurred.
4. Coverage will terminate when the qualified beneficiary becomes entitled to Medicare or any other Governmental Health Plan during Continuation of Health Plan Coverage period.
5. Coverage will terminate when qualified beneficiary becomes covered by another group health or individual health plan.

The Diocese of Palm Beach Health Plan Trust reserves the right to amend or terminate its health plan, including any continuation of coverage described above, for any reason at any time.

Newborn Child or Child Placed for Adoption During the Period of Continuation Coverage

If, during the period of continuation coverage, a child is born to you or is placed for adoption with you, the child is considered a qualified beneficiary. You (or a guardian) have the right to elect continuation coverage for the child, provided the child satisfies the otherwise applicable plan eligibility requirements (for example, age). You or a family member must notify the Diocese of Palm Beach Health Plan Trust Health Plan within 30 days of the birth or placement to enroll the child in the Continuation of Health Coverage Plan. (The 30-day period is the Plan's normal enrollment window for newborn or adopted children). If you or a family member fails to notify the Diocese of Palm Beach Health Plan Trust Health Plan office in a timely fashion, the Covered Employee will NOT be offered the option to elect Continuation of Health Plan Coverage for the newborn or adopted child.

Participant Is Enrolled in Another Health Plan While on Continuation of Coverage

You must notify the Diocese of Palm Beach Health Plan Trust Plan within 60 days after you have become covered under Medicare, a governmental health plan, a group health plan or an individual health plan. If you notify the Diocese of Palm Beach Health Plan Trust Health Plan that you are covered under another health plan within 60 days from your enrollment date, premium payments applied for coverage during that 60 day period will be refunded. Your coverage under the Continuation of Coverage Plan will terminate effective the last day of the month that you became covered under your new health plan. **Failure to notify the Diocese of Palm Beach Health Plan Trust Health Plan of your enrollment in other health coverage within 60 days, will result in forfeiture of any contribution payment. The Diocese of Palm Beach Health Plan Trust Health Plan has a right to reimbursement of any benefits received by a**

plan beneficiary who has become covered under another health plan. The Diocese of Palm Beach Health Plan Trust Health Plan shall be entitled to assert such rights.

Changes to Continuation of Group Health Coverage Plan

You may terminate coverage under this plan at any time by notifying the Diocese of Palm Beach Health Plan Trust Benefits Office or the Continuation of Coverage Administrator. In the situation where there is a marriage, birth of a child or adoption of a child, you may add dependent(s) to your Continuation of Group Health Coverage Plan for any reason other than as specified in this notice.

If you have any questions about this notice or the Diocese of Palm Beach Health Plan Trust Health Plan, please contact the Diocese of Palm Beach Health Plan Trust Benefits Office at 561-775-9525.

If you have any questions regarding the Continuation of Group Health Coverage Plan, please contact the Continuation of Coverage Administrator at the phone number provided by the Diocese of Palm Beach Health Plan Trust Benefits Office.

Note: The Continuation of Coverage provided under this section is neither required by, nor subject to, the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended, or any State law.

USERRA

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”), you have the right to continue coverage under the Plan if you leave your job to perform qualifying military service.

Those rights are similar to your Continuation of Coverage rights described above, with the following exceptions:

- If eligible, your period of USERRA coverage can last for up to 24 months.
- Your Eligible Dependents do not have an independent right to elect USERRA coverage.
- Even if you do not elect to continue coverage during your period of military service, you have the right to be reinstated in the Plan when you are reemployed, generally without any waiting periods or exclusions (such as pre-existing condition exclusions) except for service-connected Illnesses or Injuries.
- You must provide the Diocese of Palm Beach Health Plan Trust Benefits Department, with the documentation of such a leave at the onset of such a leave. This will insure proper continuation of benefits.

For more information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.

CLAIMS PROCESSING

Introduction

This section is intended to:

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

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

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

Types of Claims

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

Post-Service Claims

How to File a Post-Service Claim

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

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

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

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

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

Note: Special claims processing rules may apply for Health Care Services you receive outside the state of Florida under the BlueCard Program.

Processing Post-Service Claims

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

Payment for Post-Service Claims

When payment is due under the terms of this Booklet, we will use our best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, we will use our best efforts to pay (in whole or in part) for paper Post-Service Claims within 40 days of receipt, however all claims subject to the No Surprises Act will be paid or denied within 30 days as stated in the Surprise Billing subsection of the YOUR SHARE OF HEALTH CARE EXPENSES section of this Booklet. You may receive notice of payment for paper claims within 30 days of receipt. If we are unable to determine whether the claim or a portion of the claim is payable because we need more information, we may contest or deny the claim within the timeframes set forth below.

Contested Post-Service Claims

In the event we contest an electronically submitted Post-Service Claim, or a portion of such a claim, we will use our best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is contested. In the event we contest a paper Post-Service Claim, or a portion of such claim, we will use our best efforts to provide notice, within 30 days of receipt, that the claim or a portion of the claim is contested. The notice may identify: (1) the contested portion or portions of the claim; (2) the reasons for contesting the claim or a portion of the claim; and (3) the date that we reasonably expect to notify you of the decision. The notice may also indicate whether more information is needed in order to complete processing of the claim. If we request additional information, we must receive it within 45 days of the request for the information. **If we do not receive the requested information, the claim will be processed based on the information in our possession at the time and may be denied.** Upon receipt of the requested information, we will use our best efforts to complete the processing of the Post-Service Claim within 15 days of receipt of the information.

Denial of Post-Service Claims

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

A Post-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Benefit Determination standards described in this section.

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

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

Pre-Service Claims

How to File A Pre-Service Claim

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

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

Benefit Determinations on Pre-Service Claims Involving Urgent Care

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

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

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

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

A Pre-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Benefit Determination standards described in this section.

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Services

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

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

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

Requests for Extension of Services

Your Provider may request an extension of coverage or benefits for a Service beyond the approved period of time or number of approved Services. If the request for an extension is for a Claim Involving Urgent Care, we will use our best efforts to notify you of the approval or denial of such requested extension within 24 hours after receipt of the request, provided it is received at least 24 hours prior to the expiration of the previously approved number or length of coverage for such Services. We will use our best efforts to notify you within 24 hours if: (1) we need additional information; or (2) you or your representative did not follow proper procedures in the request for an extension. If we request additional information, you will have 48 hours to provide the requested information. We may notify you orally or in writing, unless you or your representative specifically request that it be in writing. A denial of a request for an extension of Services is considered an Adverse Benefit Determination and is subject to the procedures described below.

Adverse Benefit Determinations

Manner and Content of a Notification of an Adverse Benefit Determination

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

1. the date the Service or supply was provided;
2. the Provider's name;
3. the dollar amount of the claim, if applicable;
4. the diagnosis codes included on the claim (e.g., ICD-9, ICD-10, DSM-IV), and upon request, a description of such codes;
5. the standardized procedure code included on the claim (e.g., Current Procedural Terminology), including a description of such codes;
6. the specific reason or reasons for the Adverse Benefit Determination, including any applicable denial code;

7. a description of the specific Booklet provisions upon which the Adverse Benefit Determination is based, as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;
8. a description of any additional information that might change the determination and why that information is necessary;
9. a description of the Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and
10. if the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational exclusions, a statement telling you how to obtain the specific explanation of the scientific or clinical judgment for the determination.

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

How to Appeal an Adverse Benefit Determination

Except as described below, you, or a representative designated by you in writing, have the right to appeal an Adverse Benefit Determination. An appeal of an Adverse Benefit Determination will be reviewed using the process described below. Your appeal must be submitted in writing to us for an internal appeal, within 365 days of the original Adverse Benefit Determination, except in the case of Concurrent Care Decisions which may, depending upon the circumstances, require you to file within a shorter period of time from notice of the denial. The following guidelines are applicable to reviews of Adverse Benefit Determinations:

1. You must cooperate fully with us in our effort to promptly review and resolve an appeal. In the event you do not fully cooperate with us, you will be deemed to have waived your right to have the appeal processed within the time frames set forth in this section.
2. You, or a Provider or a person acting on your behalf, must specifically request an expedited review. The expedited appeal process only applies to Pre-Service Claims or requests for extension of concurrent care Services made within 24 hours before the authorization for such Services expires. An expedited appeal will not be accepted for an Adverse Benefit Determination on a Post-Service Claim.
3. We must receive your appeal of an Adverse Benefit Determination in person or in writing.
4. You may review pertinent documents, upon request and free of charge, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing.
5. If any new or additional information is received from anyone other than you, a copy must be provided to you free of charge and as soon as possible and sufficiently in advance of the date on which the final adverse notice is to be provided to give you a reasonable opportunity to respond prior to that date.
6. If the Adverse Benefit Determination is based on the lack of Medical Necessity of a particular Service or the Experimental or Investigational exclusion, you may request an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of the Booklet to your medical circumstances. This information is provided free of charge.
7. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination.
8. We may consult with appropriate Physicians in the same or similar specialty as typically manages the Condition, procedure, or treatment under review, as necessary.
9. Any independent medical consultant who reviews your Adverse Benefit Determination on our behalf will be identified upon request.

10. If the claim is a Claim Involving Urgent Care, you may request an expedited review orally or in writing in which case all necessary information on review may be transmitted between you and us by telephone, facsimile or other available expeditious method.
11. If your request for expedited review arises out of a concurrent review determination by us that a continued hospitalization is not Medically Necessary, coverage for the hospitalization will continue until you have been notified of the determination.
12. We will review the appeal and may make a decision based on medical records, additional information and input from health care professionals in the same or similar specialty as typically manages the Condition, procedure or treatment under review.
13. We will advise you of all appeal decisions in writing, as outlined in the Timing of Our Appeal Review on Adverse Benefit Determinations subsection.
14. If you wish to give someone else permission to appeal an Adverse Benefit Determination on your behalf, we must receive a completed Appointment of Representative form signed by you indicating the name of the person who will represent you with respect to the appeal. An Appointment of Representative form is not required if your Physician is appealing an Adverse Benefit Determination relating to a Claim Involving Urgent Care. Appointment of Representative forms are available at www.floridablue.com or by calling the number on your ID card.
15. If you are not satisfied with our decision, you have the right to an independent external review through an external review organization for certain appeals, as described in the How to Request External Review of Our Appeal Decision subsection below.

Appeals must be sent to the address below:

Florida Blue
Attention: Member Appeals
P.O. Box 44197
Jacksonville, Florida 32231-4197

Timing of Our Appeal Review on Adverse Benefit Determinations

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

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

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

Exhaustion of Internal Appeals Process

Generally, you must complete all appeal processes outlined in this Benefit Booklet before you can obtain independent external review or bring an action in litigation. However, if we do not strictly adhere to all claim determination and appeal requirements under applicable law, you are considered to have exhausted our appeal requirements (“Deemed Exhaustion”) and may proceed with independent external review unless a minor exception applies. Minor exceptions are allowed when failure to adhere was non-prejudicial; attributable to good cause or matters beyond our control; in the context of on-going good-faith exchange of information; and not reflective of a pattern or practice of non-compliance.

Your Rights under Florida Statute 627.6141

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

External Review

You have a right to independent external review if we have denied your request for payment of a claim (in whole or in part) in the following circumstances:

1. Our decision involves a medical judgment, including, but not limited to, a decision based on Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the Health Care Service or treatment you requested or a determination that the treatment is Experimental or Investigational;
2. Whether or not a Covered Service is subject to the federal No Surprises Act (H.R. 133, P.L. 116-260); and/or
3. The calculation of your Cost Sharing associated with a Covered Service that is subject to the federal No Surprises Act (H.R. 133, P.L. 116-260).

Your request will be reviewed by an independent third party with clinical and legal expertise ("External Reviewer") who has no association with us. If you have any questions or concerns during the external review process, please contact us at the phone number listed on your ID card or visit www.floridablue.com. You may submit additional written comments to External Reviewer. A letter with the mailing address will be sent to you when you file an external review. Please note that if you provide any additional information during the external review process it will be shared with us in order to give us the opportunity to reconsider the denial. Submit your request in writing on the External Review Request form within four months after receipt of your denial to the below address:

Florida Blue
Attention: Member External Reviews DCC9-5
Post Office Box 44197
Jacksonville, FL 32231-4197

If you have a medical Condition where the timeframe for completion of a standard external review would seriously jeopardize your life, health or ability to regain maximum function, you may file a request for an expedited external review. Generally, an urgent situation is one in which your health may be in serious jeopardy, or in the opinion of your Physician, you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. Moreover expedited external reviews may be requested for an admission, availability of care, continued stay or Health Care Service for which you received Emergency Services, but have not been discharged from a facility. Please be sure your treating Physician completes the appropriate form to initiate this request type. If you have any questions or concerns during the external review process, please contact us at the phone number listed on your ID card or visit www.floridablue.com. You may submit additional written comments to the External Reviewer. A letter with the mailing address will be sent to you when you file an external review. Please note that if you provide any additional information during the external review process it will be shared with us in order to give us the opportunity to reconsider the denial. If you believe your situation is urgent, you may request an expedited review by sending your request to the address above or by fax to 904-565-6637.

If the External Reviewer decides to overturn our decision, we will provide coverage or payment for your health care item or Service.

You or someone you name to act for you may file a request for external review. To appoint someone to act on your behalf, please complete an Appointment of Representative form.

You are entitled to receive, upon written request and free of charge, reasonable access to, and copies of all documents relevant to your appeal including a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.

You may request and we will provide the diagnosis and treatment codes, as well as their corresponding meanings, applicable to this notice, if available.

Additional Claims Processing Provisions

Release of Information/Cooperation

In order to process claims, we may need certain information, including information regarding other health care coverage you may have and/or medical information from Providers who render Services to you. You must cooperate with our effort to obtain this information, including signing any release of information form at our request. If you do not fully cooperate with us, we may deny the claim and we will have no liability for such claim.

Physical Examination and Autopsy

In order to make coverage and benefit decisions, we may, at our expense, require you to be examined by a Provider of our choice as often as is reasonably necessary while a claim is pending. We also reserve the right, if the law permits, to have an autopsy performed on you in case of death. If you do not fully cooperate with such examination, we may deny the claim and we shall have no liability for such claim.

Legal Actions

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

Fraud, Misrepresentation or Omission in Applying for Benefits

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

Communication of Claims Decisions

All claims decisions, including denial and claims review decisions, will be communicated to you in writing, such as through your monthly member health statement. This written correspondence may indicate:

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

Circumstances Beyond Our Control

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

COORDINATION OF BENEFITS

Coordination of Benefits

Coordination of Benefits is a limitation of coverage and/or benefits to be provided under this Booklet. It is designed to avoid duplication of payment for Covered Services and/or supplies. We shall coordinate payment of Covered Services to the maximum extent allowed by law.

It is the Covered Employee's responsibility to provide Florida Blue and Diocese of Palm Beach Health Plan Trust information concerning any duplication of coverage under any other health plan, program, or policy the Covered Employee or Covered Dependents may have. This means the Covered Employee must notify Florida Blue and Diocese of Palm Beach Health Plan Trust in writing if any Covered Plan Participant has other applicable coverage or if there is no other coverage. The Covered Employee may be requested to provide this information at initial enrollment, by written correspondence annually thereafter, or in connection with specific Health Care Services received. If the information is not received, claims may be denied and the Covered Plan Participant will be responsible for payment of any expenses related to denied claims.

Contracts which may be subject to Coordination of Benefits include, but are not limited to, the following which will be referred to as "plan(s)" for purposes of this section:

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

The amount of payment is based on whether or not the benefits under this Booklet are primary. When primary, the Plan will pay for Covered Services without regard to coverage under other plans. When this Plan is not primary, payment may be reduced so that total benefits under all plans will not exceed 100 percent of the total reasonable expenses actually incurred for Covered Services. In the event the Covered Services were rendered by an In-Network Provider, total reasonable expenses, for purposes of this section, shall mean the total amount required to be paid to such In-Network Provider based on the Provider's contract. In the event that the primary payer's payment exceeds the Allowed Amount, no payment will be made for such Services.

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

1. This plan always pays secondary to any medical payment, personal injury protection (PIP) coverage or no-fault coverage under any automobile policy available to you.
2. When this Plan covers you as a dependent and the other plan covers you as other than a dependent, this Plan will be secondary.
3. When this Plan covers you as a dependent child and your parents are married (not separated or divorced):
    a) the plan of the parent whose birthday, month and day, falls earlier in the year will be primary;
    b) if both parents have the same birthday, month and day, and the other plan has covered one of the parents longer than us, this Plan will be secondary.

4. When this Plan covers a dependent child whose parents are not married, or are separated or divorced:
   a) the plan of the parent with custody is primary;
   b) the plan of the remarried parent with custody is primary regardless of whether the remarried parent is the employee or a dependent under the step-parent's plan; the step-parent's plan is secondary;
   c) and the plan of the parent without custody pays last;
   d) regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is always primary.
5. When an employee or the employee's dependent and you are covered under a plan that covers you as a laid off or retired employee or as the employee's dependent and the other plan covers you as a dependent:
   a) the plan that covers you by virtue of active employment, e.g. as the dependent spouse of an active employee, is primary;
   b) if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.
6. If you have continuation of coverage under Florida Health Insurance Coverage Continuation Act (FHICCA), and also under another group plan, the following order of benefits applies:
   a) first, the plan covering the person as an employee, or as the employee's dependent; and
   b) second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's dependent provided according to the provisions of FHICCA.
7. When rules 1 through 6 above do not establish an order of benefits, the plan which has covered the Covered Person the longest shall be primary.
8. If the other plan does not have rules that establish the same order of benefits as under this Booklet, the benefits under the other plan will be determined primary to the benefits under this Booklet.

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

Medicare Secondary Payer Provisions

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

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

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

Individuals With End Stage Renal Disease

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

1. the month in which you became entitled to Medicare Part A ESRD benefits; or

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

If Medicare was already primary before ESRD, Medicare will remain primary. Also, if your Group Health Plan coverage was primary before ESRD entitlement, the Group Health Plan will remain primary for the ESRD coordination period. If you are eligible for Medicare due to ESRD, your Group Health Plan coverage is primary for 30 months.

Disabled Active Individuals

The Group Health Plan coverage is primary, if:

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

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

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

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

Miscellaneous

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

We will not be liable to Diocese of Palm Beach Health Plan Trust or anyone covered under the Group Health Plan due to any non-payment of primary benefits that result from any failure of the Group's performance or obligations set forth in this section.

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

Non-Duplication of Government Programs

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

GENERAL PROVISIONS

Access to Information

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

Compliance with State and Federal Laws and Regulations

The terms of coverage and benefits to be provided under this Booklet shall be deemed to have been modified by the parties, and shall be interpreted, so as to comply with applicable state or federal laws and regulations dealing with rates, benefits, eligibility, enrollment, termination, conversion, or other rights and duties of you, the Group, or us.

Confidentiality

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

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

Cooperation Required of Covered Persons

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

Customer Rewards Program

From time to time, we may offer programs to you that reward you for following the terms of the program. This includes shared savings incentive programs as defined under Florida law. We will tell you about any available rewards programs in general mailings, newsletters and/or on our website. Your participation in these programs is always completely voluntary and will in no way affect the coverage available to you under this Booklet. We reserve the right to offer rewards in excess of $100 per year as well as the right to discontinue or modify any reward program features or promotional offers at any time without your consent.

Employer as Plan Administrator

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

Evidence of Coverage

You have been provided with this Booklet and an ID Card as evidence of coverage under Diocese of Palm Beach Health Plan Trust's Group Health Plan.

Florida Agency for Health Care Administration (AHCA) Performance Data

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

Identification Cards

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

Modification of Provider Network

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

Non-Waiver of Defaults

Any failure by us or Diocese of Palm Beach Health Plan Trust at any time, or from time to time, to enforce or to require the strict adherence to any of the terms or conditions set forth herein, shall in no event constitute a waiver of any such terms or conditions. Further, it shall not affect our or Diocese of Palm Beach Health Plan Trust's right at any time to enforce or avail ourselves of any such remedies to which we may be entitled under applicable law or this Booklet.

Notices

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

<u>If to us:</u>

To the address printed on the ID Card.

<u>If to you:</u>

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

You must notify us immediately of any address change.

<u>If to the Group:</u>

To the address indicated by the Group.

Our Obligations Upon Termination

Upon termination of your coverage for any reason, we shall have no further liability or responsibility under the Group Health Plan with respect to you, except as specifically set forth herein.

Promissory Estoppel

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

Relationships Between the Parties

Florida Blue and Health Care Providers

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

Florida Blue and the Group

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

Medical Treatment Decisions

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

Right of Recovery

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

Right to Receive and Release Necessary Information

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

Subrogation and Right of Recovery

The provisions of this subsection apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the Plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult Covered Person without the prior express written consent of the Plan.

The Plan's right of subrogation or reimbursement, as set forth below, extend to all insurance coverage available to you due to an injury, illness or Condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

Your Group Health Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Group Health Plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the Plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or Condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an injury, illness or Condition, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or Condition, up to and including the full amount of your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any Provider) you agree that if you receive any payment as a result of an injury, illness or Condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Group Health Plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or Condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or Condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Assignment

In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the Plan, you acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before you receive any recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or Condition. You and your agents agree to provide the Plan or its representative's notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Group Health Plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the injury, illness or Condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

Third Party Beneficiary

The terms and provisions of the Group Health Plan shall be binding solely upon, and inure solely to the benefit of the Group, and no other person shall have any rights, interest or claims thereunder, or under this Booklet or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. Diocese of Palm Beach Health Plan Trust hereby specifically expresses its intent that health care Providers that have not entered into contracts with Florida Blue to participate in our networks shall not be third-party beneficiaries under the terms of the Group Health Plan or this Booklet.

Your Rights and Responsibilities

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

Rights

1. To be provided with information about our services, coverage and benefits, the In-Network Providers delivering care and members' rights and responsibilities.
2. To receive medical care and treatment from In-Network Providers who have met our credentialing standards.
3. To expect In-Network Providers to:
    a) discuss appropriate or Medically Necessary treatment options for your Condition, regardless of cost or benefit coverage;
    b) permit you to participate in the major decisions about your health care, consistent with legal, ethical, and relevant patient-Provider relationship requirements.
    c) advise whether your medical care or treatment is part of a research experiment, and to give you the opportunity to refuse any experimental treatments; and
    d) inform you about any medications you are told to take, how to take them, and their possible side effects

4. To expect courteous service from us and considerate care from our In-Network Providers with respect and concern for your dignity and privacy.
5. To voice your complaints and/or appeal unfavorable medical or administrative decisions by following the established appeal procedures found in this Booklet.
6. To inform In-Network Providers that you refuse treatment, and to expect them to honor your decision, if you choose to accept the responsibility and the consequences of your decision. In the event, members are encouraged (but not required) to:
   a) complete an advance directive, such as a living will and provide it to In-Network Providers; and
   b) have someone help make decisions, or to give another person the legal responsibility to make decisions about medical care on a member's behalf.
7. To have access to your medical records and to be assured that the confidentiality of your medical records is maintained in accordance with applicable law.
8. To call or write to us any time with helpful comments, questions and observations whether concerning something you like about our plan or something you feel is a problem area. You also may make recommendations regarding our rights and responsibilities policies. Please call the phone number on your ID Card or write to us at the address on your ID Card.

Responsibilities

1. To cooperate with anyone providing your care and treatment.
2. To be respectful of the rights, property, comfort, environment and privacy of other patients and not be disruptive.
3. To take responsibility for understanding your health problems and participate in developing mutually agreed upon treatment goals, to the extent possible, then following the plans and instructions about your care and to ask questions if you do not understand or need an explanation.
4. To provide accurate and complete information concerning your health problems and medical history and to answer all questions truthfully and completely.
5. To pay your Cost Share amounts and be financially responsible for non-covered Services and to provide current information concerning your coverage status to any In-Network Provider.
6. To follow the process for filing an appeal about medical or administrative decisions that you feel were made in error.
7. To request your medical records in accordance with our rules and procedures and in accordance with applicable law.
8. To review information regarding Covered Services, policies and procedures as stated in this Booklet.

DEFINITIONS

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

A

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

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

Acupuncture means the insertion of acupuncture needles to specific areas of the human body.

Acupuncturist means a person who is licensed per Florida Statutes Chapter 457 or a similar applicable law of another state.

Administrative Services Agreement or **ASA** means an agreement between Diocese of Palm Beach Health Plan Trust and Florida Blue. Under the Administrative Services Agreement, we provide claims processing and payment services, customer service, utilization review services, and access to our network of independent contracting Providers.

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

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

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

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

1. In the case of an In-Network Provider located in Florida, this amount will be established in accordance with the applicable agreement between that Provider and Florida Blue.
2. In the case of an In-Network Provider located outside of Florida, this amount will generally be established in accordance with the negotiated price that the on-site Blue Cross and/or Blue Shield Plan (“Host Blue”) passes on to us, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the BLUECARD PROGRAM section for more details.

3. In the case of Out-of-Network Providers located in Florida who participate in the Traditional Program, this amount will be established in accordance with the applicable agreement between that Provider and Florida Blue.
4. In the case of Out-of-Network Providers located outside of Florida who participate in the BlueCard Traditional Program, this amount will generally be established in accordance with the negotiated price that the Host Blue passes on to us, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the BLUECARD PROGRAM section for more details.
5. In the case of an Out-of-Network Provider that has not entered into an agreement with Florida Blue to provide access to a discount from the billed amount of that Provider for the specific Covered Services provided to you, the allowed amount will be the lesser of that Provider's actual billed amount for the specific Covered Services or an amount established by Florida Blue that may be based on several factors, including (but not limited to): (i) payment for such Covered Services under the Medicare and/or Medicaid programs; (ii) payment often accepted for such Covered Services by that Out-of-Network Provider and/or by other Providers, either in Florida or in other comparable market(s), that we determine are comparable to the Out-of-Network Provider that rendered the specific Covered Services (which may include payment accepted by such Out-of-Network Provider and/or by other Providers as participating Providers in other Provider networks of third-party payers which may include, for example, other insurance companies and/or health maintenance organizations); (iii) payment amounts which are consistent, as determined by us, with our Provider network strategies (e.g., does not result in payment that encourages Providers participating in a Florida Blue network to become non-participating); and/or, (iv) the cost of providing the specific Covered Services. In the case of an Out-of-Network Provider that has not entered into an agreement with another Blue Cross and/or Blue Shield organization to provide access to discounts from the billed amount for the specific Covered Services under the BlueCard Program, the allowed amount for the specific Covered Services provided to you may be based upon the amount provided to Florida Blue by the other Blue Cross and/or Blue Shield organization where the Services were provided at the amount such organization would pay non-participating Providers in its geographic area for such Services.
6. In the case of Covered Services rendered by an Out-of-Network Provider where the Services are subject to either the federal No Surprises Act (H.R. 133, P.L. 116-260) or 627.64194(4) F.S., then the allowed amount will be calculated in accordance with the applicable statute. For clarity, if the Provider is located in Florida and 627.64194(4) F.S. applies, then the allowed amount calculated under 5. above is presumed to meet the requirements 627.64194(4) F.S.

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

If a particular Covered Service is not available from any PPC Provider, as determined by us, the allowed amount, whenever Florida Statute 627.6471 applies, means the usual and customary charge(s) of similar Providers in a geographical area established by us.

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

Please specifically note that, in the case of an Out-of-Network Provider that has not entered into an agreement with Florida Blue to provide access to a discount from the billed amount of that Provider, the allowed amount for particular Services is often substantially below the amount billed by such Out-of-Network Provider for such Services. You will be responsible for any difference between our allowed amount and the amount billed for Covered Services by any such Out-of-Network Provider.

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

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

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

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

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

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

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

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

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

Autism Spectrum Disorder means any of the following disorders as defined in the diagnostic categories of the International Classification of Diseases, (ICD-9 CM or ICD-10 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders:

1. Autistic disorder;
2. Asperger's syndrome;
3. Pervasive developmental disorder not otherwise specified; and
4. Childhood Disintegrative Disorder.

B

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

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

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

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

BlueCard PPO Program Provider means a Provider designated as a BlueCard PPO Program Provider by the Host Blue.

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

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

BlueCard Traditional Program Provider means a Provider designated as a BlueCard Traditional Program Provider by the Host Blue.

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

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

C

Calendar Year begins January 1st and ends December 31st of the same year..

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

Care Coordination means organized, information-driven patient care activities intended to facilitate the appropriate responses to a Covered Person's health care needs across the continuum of care.

Care Coordinator Fee means a fixed amount paid by a Blue Cross and/or Blue Shield Licensee, to Providers periodically for Care Coordination under a Value-Based Program.

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

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

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

Coinsurance means the sharing of health care expenses for Covered Services between you and the Plan. After your Deductible is met, the Plan will pay a percentage of the Allowed Amount for Covered Services, as listed in the Schedule of Benefits. The percentage you are responsible for is your coinsurance.

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

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

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

Continuing Care Patient means a patient who is undergoing a course of treatment for:

1. a serious or complex Condition,
    a) in the case of an acute illness, a Condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or
    b) in the case of a chronic illness or Condition, a Condition that:
        i. is life-threatening, degenerative, potentially disabling, or congenital; and
        ii. requires specialized medical care over a prolonged period of time.
2. institutional or inpatient care;
3. a scheduled non-elective surgery including postoperative care;

4. pregnancy; or
5. a terminal illness.

Convenience Kits are prepackaged kits which may contain not only medication(s), but also non-Drug items including, but not limited to, alcohol prep pads, cotton balls, band aids, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages and gauze. We may provide coverage for the medication(s), but not other items included in the kit.

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

Copayment or **Copay** means, when applicable, the dollar amount established solely by us which you must pay to a health care Provider at the time Covered Services are rendered by that Provider.

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

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

Covered Person means a Covered Plan Participant or Covered Dependent.

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

Covered Plan Participant's Spouse means the person to whom the Covered Plan Participant is civilly married under a marriage covenant between a man and a woman as described in Canon 1055 of the Code of Canon Law (Codex Iuris Canonici) for the Latin Rite of the Catholic Church.

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

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

D

Deductible means the amount of charges, up to the Allowed Amount, for Covered Services that you must actually pay each Benefit Period to an appropriate licensed health care Provider, who is recognized for payment under this Booklet, before payment for Covered Services under the Group Health Plan begins.

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

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

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

Dietitian means a person who is properly licensed pursuant to Florida law or a similar applicable law of another state to provide nutrition counseling for diabetes outpatient self-management Services and appropriate behavioral health Conditions covered under this plan.

Down Syndrome means a chromosomal disorder caused by an error in cell division which results in the presence of an extra whole or partial copy of chromosome 21.

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

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

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

E

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

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

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

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

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

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

Employer means Diocese of Palm Beach Health Plan Trust which has established this plan for thepurpose of providing coverage and/or benefits to Covered Plan Participants.

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

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

Enrollment Form(s) means those forms, electronic or paper, used to maintain accurate enrollment files under the Group Health Plan.

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

1. such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the FDA or the Florida Department of Health and approval for marketing has not, in fact, been given at the time such is furnished to you;
2. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device;
3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations;
4. reliable evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
5. reliable evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
6. reliable evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently published Medical Literature using generally accepted scientific, medical, or public health methodologies or statistical practices;
7. there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or
8. such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

"Reliable evidence" shall mean (as determined by us or Diocese of Palm Beach Health Plan Trust):

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

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

F

FDA means the United States Food and Drug Administration.

Florida Blue is a trade name of Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

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

Full-Time Employee means an employee actively working at least 30 hours per week or on an approved leave of absence for up to a total of six (6) months in any twelve month period.

G

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

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

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

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

H

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

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

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

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

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

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

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

I

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

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

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

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

In-Network Provider means any health care Provider who, at the time Covered Services are rendered to you, is under contract with us to participate in our PPC network.

For payment purposes under this Booklet only, the term In-Network Provider also refers, when applicable, to any health care Provider located outside the state of Florida who or which, at the time Health Care Services are rendered to you, participates as a BlueCard PPO Program Provider under the Blue Cross and Blue Shield Association’s BlueCard Program.

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

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

L

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

M

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

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

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

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

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

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

alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness, injury, disease or symptoms.

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

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

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

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

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

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

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

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

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

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

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

Mental and Nervous Disorder means any disorder listed in the diagnostic categories of the International Classification of Diseases, (ICD-9 CM or ICD-10 CM), or their equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

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

N

New Prescription Drug(s) means an FDA approved Prescription Drug or a new dosage form of a previously FDA approved Prescription Drug that has not yet been reviewed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee). Coverage for all New Prescription Drugs will be delayed until a review is completed by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, our Medical Policy Committee), resulting in a final coverage determination. The new Prescription Drug coverage delay begins on the date the Prescription Drug, or new dosage form, is approved by the FDA and ends on the earlier of the following dates:

1. The date the Prescription Drug is assigned to a tier by our Pharmacy and Therapeutics Committee (or, in the case of medical benefits, the date our Medical Policy Committee makes a final coverage determination for the Prescription Drug);

   or

2. December 31st of the following Calendar Year.

O

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

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

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

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

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

1. does not have a contract with us to participate in PPC but is participating in our Traditional Program; or
2. does not have a contract with a Host Blue to participate in its local PPO Program for purposes of the BlueCard PPO Program but is participating, for purposes of the BlueCard Program, as a BlueCard Traditional Program Provider; or
3. does not have a contract with us to participate in PPC or our Traditional Program; or
4. does not have a contract with a Host Blue to participate for purposes of the BlueCard Program as a BlueCard Traditional Program Provider.

Outpatient Rehabilitation Facility means an entity which renders, through Providers properly licensed pursuant to Florida law or a similar applicable law of another state: outpatient Physical Therapy; Speech Therapy; Occupational Therapy; Cardiac Therapy and Massage for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition. Further, such an entity must meet our

criteria for eligibility as an outpatient rehabilitation facility. The term outpatient rehabilitation facility, as used herein, shall not include any Hospital including a general acute care Hospital, or any separately organized unit of a Hospital, which provides comprehensive medical rehabilitation inpatient Services, or rehabilitation outpatient Services, including, but not limited to, a Class III "specialty rehabilitation hospital" described in Chapter 59-A, Florida Administrative Code or a similar applicable law of another state.

P

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

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

Per Admission Deductible (PAD) means the amount of charges, up to the Allowed Amount, for inpatient Covered Services, which you must actually pay, for each Hospital admission to an appropriately licensed Hospital recognized for payment under this Booklet, before the Plan's payment for any inpatient Covered Services begins. The Hospital PAD applies, when indicated in the Schedule of Benefits, regardless of the reason for the admission and is in addition to the Deductible requirement, if applicable.

Per Visit Deductible (PVD) means the amount of charges, up to the Allowed Amount, for Covered Services rendered in an outpatient facility, which you must actually pay, for each visit to an appropriately licensed outpatient facility recognized for payment under this Booklet, before the Plan's payment begins. The PVD applies, when indicated in the Schedule of Benefits, regardless of the reason for the visit and is in addition to the Deductible requirement, if applicable.

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

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

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

Physician Assistant means a person properly licensed pursuant to Chapter 458 of the Florida Statutes, or a similar applicable law of another state to perform surgical first assisting Services.

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

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

Preferred Patient Care[sm] or PPC means, or refers to, the preferred provider network established and so designated by us that is available to BlueChoice members under this Booklet. Please note that our NetworkBlue preferred provider and BlueSelect networks are not available to BlueChoice members under this Booklet.

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

Prescription Drug means any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound which can only be dispensed with a Prescription and/or which is required by state law to bear the following statement or similar statement on the label: "Caution: Federal law prohibits dispensing without a Prescription".

Pre-Service Claim means any request or application for coverage or benefits for a Service that has not yet been provided to you and with respect to which the terms of this Booklet condition payment for the Service (in whole or in part) on approval of coverage or benefits for the Service before you receive it. A pre-service claim may be a Claim Involving Urgent Care. As defined herein, a pre-service claim shall not include a request for a decision or opinion by us regarding coverage, benefits, or payment for a Service that has not actually been rendered to you if the terms of this Booklet do not require (or condition payment upon) approval by us of coverage or benefits for the Service before it is received.

Preventive Services Guide means the guide then in effect issued by us that contains a listing of Preventive Health Services covered under your plan. **Note**: The preventive services guide is subject to change. Please refer to our website at www.floridablue.com/healthresources for the most current guide.

Primary Care Provider or **Primary Care Physician (PCP)** means a Provider who, at the time Covered Services are rendered, was under a primary care Provider contract with us. A primary care Provider may specialize in internal medicine, family practice, general practice, or pediatrics. Also, a gynecologist or obstetrician/ gynecologist, or APRN may elect to contract with us as a primary care Provider.

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

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

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

Provider Incentive means an additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of Covered Persons.

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

Psychologist means a person properly licensed pursuant to Chapter 490 of the Florida Statutes, or a similar applicable law of another state to practice psychology.

R

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

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

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

Rehabilitative Therapies means therapies with the primary purpose of restoring or improving a bodily or mental function impaired or eliminated by a Condition, and include, but are not limited to, Physical Therapy, Speech Therapy, Pain Management, pulmonary therapy or Cardiac Therapy.

Rescission or **Rescind** refers to Florida Blue's or Diocese of Palm Beach Health Plan Trust's action to retroactively cancel or discontinue coverage under the Group Health Plan. Rescission does not include a cancellation or discontinuance of coverage with only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively due to non-payment of premium.

Residential Treatment Facility means a facility properly licensed under Florida law or a similar applicable law of another state, to provide care and treatment of Mental and Nervous Disorders and Substance Dependency and meets all of the following requirements:

- has Mental Health Professionals on-site 24 hours per day and 7 days per week;
- provides access to necessary medical Services 24 hours per day and 7 days per week;
- provides access to at least weekly sessions with a behavioral health professional fully licensed for independent practice for individual psychotherapy;
- has individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- provides a level of skilled intervention consistent with patient risk;
- is not a wilderness treatment program or any such related or similar program, school and/or education service.

With regard to Substance Dependency treatment, in addition to the above, must meet the following:

- if Detoxification Services are necessary, provides access to necessary on-site medical Services 24 hours per day and 7 days per week, which must be actively supervised by an attending Physician;
- ability to assess and recognize withdrawal complications that threaten life or bodily function and to obtain needed Services either on site or externally;
- is supervised by an on-site Physician 24 hours per day and 7 days per week with evidence of close and frequent observation.

Residential Treatment Services means treatment in which an individual is admitted by a Physician overnight to a Hospital, Psychiatric Hospital or Residential Treatment Facility and receives daily face to face treatment by a Mental Health Professional for at least 8 hours per day, each day. The Physician must perform the admission evaluation with documentation and treatment orders within 48 hours and provide evaluations at least weekly with documentation. A multidisciplinary treatment plan must be developed within 3 days of admission and must be updated weekly.

S

Self-Administered Prescription Drug means an FDA-approved Prescription Drug that you may administer to yourself, as recommended by a Physician.

Skilled Nursing Facility means a facility or part thereof which is properly licensed as a skilled nursing facility under Florida law, or a similar applicable law of another state, to provide care and treatment of medical Conditions and meets all of the following requirements:

1. is accredited as a skilled nursing facility by The Joint Commission or recognized as a skilled nursing facility by the Secretary of Health and Human Services of the United States under Medicare, unless such accreditation or recognition requirement has been waived by us;
2. has nursing staff on-site 24 hours per day and 7 days per week;

3. provides access to necessary medical Services 24 hours per day and 7 days per week;
4. provides appropriate access to any Physician-ordered Services required for treatment of your Condition on at least a daily basis (and likely multiple times per day). These Services may consist of skilled nursing Services, (e.g., intravenous fluids and medication administration, wound care, etc.) and therapy Services (i.e., physical, occupational and speech);
5. has individualized active treatment plan (e.g., skilled nursing and therapy Services) directed toward the management and improvement of the Condition that caused the admission; and
6. provides a level of skilled care consistent with your Condition and care needs.

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

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

Specialty Pharmacy means a pharmacy that has signed a participating pharmacy provider agreement with us to provide specific Prescription Drug products, as determined by us. In-Network specialty pharmacies are listed in the Medication Guide. The fact that a pharmacy is a participating pharmacy does not mean that it is a specialty pharmacy.

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

Speech Therapy means Health Care Services provided for the treatment of speech and language disorders by a Physician, Speech Therapist, or licensed audiologist, including language assessment and language restorative therapy Services.

Stabilize shall have the same meaning with regard to Emergency Services as the term is defined in Section 1867 of the Social Security Act.

Standard Reference Compendium means: (a) The United States Pharmacopoeia Drug Information; (b) The American Medical Association Drug Evaluation; or (c) The American Hospital Formulary Service Hospital Drug Information.

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

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

T

Traditional Program means, or refers to, Florida Blue's Provider contracting programs called Payment for Professional Services (PPS) and Payment for Hospital Services (PHS).

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

U

Urgent Care Center means a properly licensed facility that: (1) is available to provide Services to patients at least 60 hours per week with at least 25 of those available hours after 5:00 p.m. on weekdays or on Saturday or Sunday; (2) posts instructions for individuals seeking Health Care Services, in a conspicuous public place, as to where to obtain such Services when the urgent care center is closed; (3) employs or contracts with at least one or more board certified or board eligible Physician and Registered Nurse (RN) who are physically present during all hours of operation. (Physicians, RNs, and other medical professional staff must have appropriate training and skills for the care of adults and children); and (4) maintains and operates basic diagnostic radiology and laboratory equipment in compliance with applicable state and/or federal laws and regulations. For purposes of this Booklet, an urgent care center is not a Hospital, Psychiatric Facility, Substance Abuse Facility, Skilled Nursing Facility or Outpatient Rehabilitation Facility.

V

Value-Based Program means an outcome-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

Virtual Care Provider means (1) an In-Network Provider that offers Virtual Visits at the time Services are rendered; or (2) a licensed Provider that is designated by us and has a contract with us to provide Virtual Visits at the time Services are rendered, unless otherwise designated by us or the Group as ineligible to provide Virtual Visits.

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

W

Waiting Period means the period of time specified by the Group, if any, which must be met by an individual before that individual is eligible to enroll for coverage under the Group Health Plan.

Z

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

BlueChoice ASO Values

Group Name	Diocese of Palm Beach Health Plan Trust
Document Type	
Effective Date	2190101
Effective Year	24
Sequence	00001
Grandfathered	N
HSA	N
PEP	Y
Generation	3
Responsible Steps	N
Government	N

Pharmacy Options

RXDiscount	N
Open Formulary	N
Closed Formulary	N
Generic Choices	N
RXCarveout	N
Mediscript	N
Generic Only	N
Integrated Condition Care	N
Integrated RX	N
Overage Dependent	26
OON Rider	N
Adult Wellness (BCH Only)	N

Domestic Partner

Same	N
Opposite	N
Both	N
SameWDep	N
OppositeWDep	N
BothWDep	N