UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

JEAN MCCULLOUGH,
an individual, on behalf of herself
and all those similarly situated,

Plaintiff,

v. Case No. _____

BLUE CROSS AND BLUE SHIELD
OF FLORIDA, INC.,
a Florida Corporation.

Defendant.
_____/

DEFENDANT'S NOTICE OF REMOVAL

Defendant, Blue Cross and Blue Shield of Florida, Inc. ("Florida Blue"), pursuant to 28 U.S.C. §§ 1441 and 1446, hereby removes to this Court the action styled *Jean McCullough v. Blue Cross and Blue Shield of Florida, Inc.*, Case No. 16-2019-CA-2057, pending in the Circuit Court for the Fourth Judicial Circuit, in and for Duval County, Florida. In support, Florida Blue states as follows:

1. Florida Blue removes this case pursuant to 28 U.S.C. § 1441 as an action over which this Court has original federal question jurisdiction under 28 U.S.C. § 1331. The Amended Complaint in this case raises federal questions, and thus is removable, because the claims at issue therein are completely preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq*. ("ERISA").

2. On March 19, 2019, Plaintiff commenced this action in the Circuit Court, Fourth Judicial Circuit, in and for Duval County, Florida, under Case No. 16-2019-CA-2057 (the "State

Court Action"). Copies of all documents filed in the State Court Action are attached hereto as **Exhibit "1(A)-(C)."**

3. Plaintiff's initial Complaint asserted two counts—Count 1 for Declaratory Relief, and Count 2 for Breach of Contract—arising out of Plaintiff's contention that Florida Blue made a Voluntary Predetermination for Select Services ("VPSS") that a proposed surgery to implant the LINX Gastroesophageal Management System (the "LINX system") to treat her condition of Gastroesophageal Reflux Disease was not covered under Plaintiff's policy of insurance then in effect. At the time of Plaintiff's request for the VPSS she was insured under an individual policy.[1] At the time this action was commenced, Plaintiff had not received the surgery for which she sought the VPSS, and her initial Complaint was based on Florida Blue's VPSS determination. (Compl. ¶¶ 16-20).

4. Notably, the VPSS by its terms is a voluntary courtesy service provided by Florida Blue, and is not required. The individual policy in effect when Plaintiff requested a VPSS provided, among other things:

> We will determine whether Services are Covered Services under this Contract after you have obtained the Services and we have received a claim for the Services. In some circumstances we may determine whether Services might be Covered Services under this Contract before such Services are rendered. For example, we may determine whether a proposed transplant would be a Covered Service under this Contract before the transplant is provided. We are not obligated to determine, in advance, whether any Service not yet provided to you would be a Covered Service unless we have specifically designated that a Service is subject to a prior authorization requirement as described in the "Blueprint for Health Programs" section. We are also not obligated to cover or pay for any Service that has not actually been rendered to you.

[1] The policy in effect at the time Plaintiff sought the VPSS is attached to the Declaration of Juanisha Jones ("Jones Declaration") as Exhibit A. The Jones Declaration is attached to this Notice of Removal as **Exhibit 2**.

(Jones Declaration at Ex. A at 2-1). The policy made clear that there could be no claim for benefits and/or for breach of the policy in the absence of services actually being rendered and a health care claim being submitted to Florida Blue while the insured's coverage was in force and effect. (Jones Declaration, Ex. A at 2-1) (providing that one of the requirements for expenses for health care services to be covered under the policy is that the services "are actually rendered to you (not just proposed or recommended) by an appropriately licensed health care Provider . . . .").

5. Because the Plaintiff's initial Complaint sought relief under an individual policy this action was not removable to this Court. On June 22, 2020, however, Plaintiff filed a Motion for Leave to File First Amended Complaint ("Motion for Leave"). As required by Fla. R. Civ. P. 1.190, the proposed Amended Complaint was attached to the Motion for Leave. In the proposed Amended Complaint, Plaintiff alleged that she "had surgery on June 8, 2020 to install the LINX system" and sought damages allegedly incurred as a direct result of the surgery. (Proposed Amended Complaint at ¶ 22) ("Because BCBS failed to pay for Mrs. McCullough's medically necessary surgery, Mrs. McCullough was forced to pay for her treatment out of her own pocket.").

6. Although Plaintiff had an individual policy of insurance at the time the initial Complaint was filed, as of February 1, 2020, she became insured under a group policy issued to Twin City Petroleum and Prop. This group policy is governed by ERISA. Therefore, at the time of Plaintiff's surgery on June 8, 2020, she was covered under a group insurance policy governed by ERISA. (Jones Declaration at ¶ 5 - 6). A copy of the ERISA policy in effect when Plaintiff received her surgery on June 8, 2020 is attached as Exhibit B to the Jones Declaration. Therefore, Plaintiff's proposed Amended Complaint sought relief that would be governed by ERISA.

7. Case law in this District, however, holds that a proposed Amended Complaint is not removable. *Barwick v. Eslinger*, No. 6:12-CV-635-J-37DAB, 2012 WL 1656736, at *2 (M.D.

Fla. May 10, 2012) ("Although Plaintiffs' proposed Fourth Amended Complaint may have contained federal causes of action at the time of removal, those causes of actions remain nothing more than ***proposed*** causes of action until the state court judge allows Plaintiffs to file their newest complaint." (emphasis in original)). As numerous courts have explained, *proposed* amended pleadings are not removable until leave to amend is granted:

> Until the state judge grant[s] the motion to amend, there [is] no basis for removal. Until then, the complaint [does] not state a federal claim. It might never state a claim, since the state judge might deny the motion. The statutory language . . . [of § 1446(b)] speaks of a motion or other paper that discloses **that the case is or has become removable, not that it may sometime in the future become removable if something happens, in this case the granting of a motion by the state judge**.

Sullivan v. Conway, 157 F.3d 1092, 1094 (7th Cir. 1998); *see also Miami Beach Cosmetic & Plastic Surgery Ctr., Inc. v. UnitedHealthcare Ins. Co.*, No. 1:15-CV-24041-UU, 2016 WL 8607846, at *3 (S.D. Fla. Jan. 8, 2016) ("[R]egardless of whether removal is based on federal question or diversity jurisdiction a *proposed* amended complaint will not suffice to furnish a basis for removal jurisdiction . . . And a proposed amended complaint remains proposed until plaintiff obtains written consent from the adverse party or the Court grants the motion to amend.") (citations omitted) (emphasis in original); *Long v. FIA Card Servs., N.A.*, No. 2:12-CV-14-FTM-UA, 2012 WL 2370218, at *3 (M.D. Fla. Apr. 11, 2012) ("Starting the clock ticking for removal purposes prior to the Amended Complaint actually being filed with the State Court is not logical since there is no actual pleading to remove.").

8. Florida Blue opposed Plaintiff's Motion for Leave, which also reframed the action as a putative class, and filed a written opposition. In its opposition to Plaintiff's Motion for Leave, Florida Blue alerted Plaintiff to the fact that on the date of her surgery she had insurance coverage through a group insurance policy governed by ERISA:

> On the date of the alleged surgery at issue – June 8, 2020 – Plaintiff had coverage through an entirely different policy. ***Although Plaintiff had an individual policy***

> ***of insurance at the time suit was filed, as of February 5, 2020, she became insured under a group policy issued to Twin City Petroleum and Prop, a policy for which her husband is the administrator.*** Attached hereto as Exhibit "A" is a copy of the Twin City Petroleum and Prop policy.

(Defendant's Opposition to Plaintiff's Motion for Leave at 3) (emphasis added).

9. On September 18, 2020, the state court entered an Order granting Plaintiff's Motion for Leave to Amend, and permitting Plaintiff to file the proposed Amended Complaint. The state court did not permit Plaintiff to make any revisions or modifications to the proposed Amended Complaint, except to change the word "treatment" to "coverage" in the class definition:

> MR. CONNER: Your Honor, I'd like to have 30 days. I have a lot things on my plate right now. So are we -- are you deeming the proposed amended complaint filed as of today? How are you doing that?
>
> THE COURT: Why don't we give Ms. Crowley ten days to file it, and I'll grant her leave based upon what's attached. So let her fix that little flaw there, treatment versus coverage. I always like to have the complaint in the docket area standing apart from the motion. You know what I mean? So a lot of times the amended complaint you're looking for, it's under a motion for leave. So with that little glitch issue as well, so the order should grant Ms. Crowley leave to amend and say that she shall file that first amended complaint within ten days. And, Mr. Conner, you would have 30 days after service to respond.

(Transcript from Sept. 3, 2020 hearing at 30-32, **Exhibit 4**).

10. Rather than file the proposed Amended Complaint that the Court granted Plaintiff leave to file, however, Plaintiff—now on notice of the ERISA issue—impermissibly revised her Amended Complaint in an effort to avoid ERISA preemption. Specifically, Plaintiff deleted the allegations regarding the date of the surgery at issue and the out-of-pocket expenses incurred related to the surgery from the proposed Amended Complaint which the state court had allowed to be filed. This sleight-of-hand was clearly designed to attempt an end-run around the application of ERISA. Preemption under ERISA, however, is not so easily defeated.

11. Plaintiff's impermissibly revised Amended Complaint removed the following allegations from the proposed pleading:

> 21. Mrs. McCullough had surgery on June 8, 2020 to install the LINX system.
>
> 22. Because BCBS failed to pay for Mrs. McCullough's medically necessary surgery, Mrs. McCullough was forced to pay for her treatment out of her own pocket.

Compare (Proposed Amended Complaint ¶¶ 21-22), *with* (Amended Complaint). Plaintiff's effort to avoid ERISA does not change the fact that she had the LINX system surgery on June 8, 2020, and that her Amended Complaint seeks relief under an ERISA policy. In the "wherefore" clause of Count I of the Amended Complaint Plaintiff requests that the court "enter judgment declaring that BCBS is required to *provide coverage and benefits* to Mrs. McCullough … ." (emphasis supplied). The coverage and benefits sought are clearly for the surgery. In the "wherefore" clause of Count II of the Amended Complaint Plaintiff requests that the court "enter judgment and *award damages* associated with BCBS's breach of contract … ." (emphasis supplied). The only damages available would be compensatory damages for not paying the costs of the surgery. The claims asserted in the Amended Complaint are preempted by ERISA, and this case is properly removable. Indeed, the anesthesiologist and assistant anesthesiologist have recently submitted health care claims to Florida Blue related to the June 8, 2020 surgery, and those claims indicate that Plaintiff provided an assignment of benefits under the ERISA plan (Jones Declaration, para. 6, Exhibit C).

12. Employer-sponsored or employer-provided health care plans are governed exclusively by ERISA. This federal act "comprehensively regulates employee pension and welfare plans." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732, 105 S.Ct. 2380, 85 L. Ed. 2d 728 (1985).

13. An "employee welfare benefit plan" is defined at §1002(1) of Title 29 of ERISA as follows:

> Any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer … to the extent that such plan, fund, or program was established or is maintained for the purpose of

> providing for its participants or their beneficiaries, for the purchase of insurance or otherwise (A) **Medical, Surgical, or Hospital Care or Benefits in the event of sickness, accident, disability, death, or unemployment … .**

14. In *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58, 63-64, 95 L. Ed. 2d 55, 107 S.Ct. 1542, 1546-47 (1987), the Supreme Court held that a defendant may remove a state cause of action to federal court if ERISA completely pre-empts the state claims. Here, Plaintiff's claim for benefits is governed by an ERISA plan. As the Eleventh Circuit noted in *Garren v. John Hancock Mutual Life Insurance Company*, 114 F.3d 186, 187 (11th Cir. 1997), "[a] party's state law claim 'relates to' an ERISA benefit plan for purposes of ERISA pre-emption whenever the alleged conduct at issue is intertwined with the refusal to pay benefits."

15. Plaintiff's claims are pre-empted by ERISA. *Mullénix v. Aetna Life & Cas. Co.*, 912 F.2d 1406 (11th Cir. 1990) (finding breach of contract action for failure to pay insurance benefits was pre-empted by ERISA); *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272, 1276 (6th Cir. 1991) (noting that "[i]t is not the label placed on a state law claim that determines whether it is pre-empted, but whether in essence such a claim is for the recovery of an ERISA plan benefit"); *HCA Health Srvs. of Georgia, Inc. v. Employer's Health Ins. Co.*, 22 F. Supp. 2d 1390 (N.D.Ga. 1998), *aff'd.*, 240 F.3d 982 (11th Cir. 2001) (finding provider's claims for quantum meruit, open account, and stated account under Georgia common law pre-empted by ERISA).

16. ERISA was designed to establish pension and welfare plan regulation "as exclusively a federal concern." *Alessi v. Raybestos – Manhattan, Inc.*, 451 U.S. 504, 523, 101 S. Ct. 1895, 68 L. Ed. 2d 402 (1981). Congress' intent is evidenced in the statutory provision of ERISA which provides that ERISA shall supersede all state laws that "relate to" any employee benefit plans described in the statute. 29 U.S.C. §1144(a). The United States Supreme Court has described ERISA's pre-emption clause as "deliberately expansive," noting that Congress "intended

to insure that plans … would be subject to a uniform body of benefit law" with the goal of minimizing "the administrative and financial burden of complying with conflicting directives among States." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142, 111 S.Ct. 478, 112 L. Ed. 2d 474 (1990).

17. The United States Supreme Court reaffirmed ERISA's strong preemptive force in *Aetna Health Inc. v. Davila*, 124 S.Ct. 2488 (2004). In *Davila*, two individuals sued their Health Maintenance Organizations under a Texas medical malpractice statute for payment for benefits not provided under the individuals' health care plans. The individuals argued that the Texas statute was an independent state law claim unrelated to ERISA. They further argued that they did not seek reimbursement for benefits denied them but rather tort damages from breach of a statutorily imposed duty of ordinary care. 124 S.Ct. at 2493-94. The Fifth Circuit Court of Appeals had held that the claims were outside the scope of ERISA's preemptive reach, and thus the cases should be remanded to state court. The Supreme Court rejected this reasoning, and held that the individuals' causes of action, "brought to remedy only the denial of benefits under ERISA-regulated benefit plans, fell within the scope of, and are completely pre-empted by, ERISA § 502(a)(1)(B), and thus removable to federal district court." 124 S.Ct. at 2502. In its analysis, the *Davila* Court held that the preemptive force of ERISA is stronger than only preempting a state law cause of action that "duplicates, supplements, or supplants the ERISA civil enforcement remedy." 124 S.Ct. at 2495. ERISA preempts state law claims even if the remedies provided under those state laws are different or more extensive or if the state law claims are not duplicative of ERISA. 124 S.Ct. at 2499.

18. The *Davila* Court disapproved of the circuit court's reasoning, that the individuals were asserting "tort" claims rather than "breach of contract" claims based on ERISA. 124 S.Ct. 498. "[D]istinguishing between pre-empted and non-preempted claims based on the

particular label affixed to them would 'elevate form over substance and allow parties to evade' the pre-emptive scope of ERISA simply 'by relabeling their contract claims as claims for tortious breach of contract.'" 124 S.Ct. 2498. Thus, the Court held that where the suit is brought to rectify a wrongful denial of benefits under an ERISA plan, the "relates to" requirement is satisfied regardless of the label placed on the claim, and therefore ERISA completely preempted the state law claims. 124 S.Ct. 2502.

19. There can be no doubt that a suit to recover benefits from an ERISA governed plan falls directly under 29 U.S.C. § 1132, which provides for an exclusive federal scheme of civil enforcement of ERISA disputes. *Ingersoll-Rand Co. v. McClendon, supra*; *Belasco v. WKP Wilson & Sons, Inc.*, 833 F.2d 277, 282 (11th Cir. 1987); *Amos v. Blue Cross and Blue Shield of Alabama*, 868 F.2d 430, 432 (11th Cir. 1989); *Brown v. Connecticut Gen. Life Ins. Co.*, 934 F. 2d 1193, 1195-96 (11th Cir. 1991).

20. In *Brown v. Connecticut General Life Insurance Co.*, the Eleventh Circuit discussed the fact that the well-pleaded complaint rule does not apply when there is ERISA "super pre-emption" and stated as follows:

> An exception to this rule is when Congress "so completely pre-empts" a particular area that any civil complaint raising the select group of claims is necessarily federal in character. The effect of this exception is to convert what would ordinarily be a state claim into a claim arising under the laws of the United States. This conversion of what would otherwise be state law claims into federal claims can be labeled "super pre-emption" to distinguish it from ordinary pre-emption, which does not have that effect.
>
> The Supreme Court has determined that ERISA "completely pre-empts" the area of employee benefit plans and thus converts the state law claims into federal claims when the state law is pre-empted by ERISA and also falls within the scope of the civil enforcement section of ERISA, Section 502 (a), 29 U.S.C. §1132 (a).

934 F.2d at 1196 (citations omitted).

21. Plaintiff's Amended Complaint seeks insurance benefits under an ERISA plan. In the Amended Complaint, Plaintiff complains that Florida Blue has refused to pay for Plaintiff's LINX system surgery. Plaintiff had that surgery on June 8, 2020, more than a year after she filed the initial Complaint. At the time that Plaintiff had the surgery, she was covered under a group policy issued to Twin City Petroleum and Prop. which is governed by ERISA. Plaintiff's Amended Complaint asks the Court to "award damages associated with BCBS's breach of contract." (Am. Compl. at 7). On the same day Plaintiff filed her Motion for Leave, she served interrogatory answers making clear that she is seeking to recover the costs of the surgery:

> 5. Please itemize with particularity all damages You claim to have suffered within Your Complaint, and all other fines, fees, or penalties which you claim in this lawsuit, and with respect to each such component, please:
>
> a. State how that particular component of damages was calculated;
>
> b. Identify all Documents which reflect, support, and/or establish each component of damages; and
>
> c. Identify all Persons who have knowledge relating to each component of damages, and the basis for their knowledge.
>
> d. Identify all statutory provisions upon which your claim of damages are based.
>
> ANSWER:
>
> McCullough just had surgery approximately a couple of weeks ago and as such has not received final invoices. McCullough will attend any follow-up appointments as necessary. Preliminary payments are being produced in response to Defendant's Request for Production. Discovery has only recently commenced and is ongoing, and Plaintiff reserves the right to supplement this response as this case proceeds.

(Plaintiff's Unverified Answers and Objections to Defendant's First Set of Interrogatories at 5, **Exhibit 3**).

22. Ultimately, any liability to pay Plaintiff arises solely from the terms and conditions of the ERISA plan in effect when she had the surgery on June 8, 2020. There can be no claim for benefits and/or breach of the policy without services actually being rendered while Plaintiff's

coverage is in effect, and a health care claim being timely submitted to Florida Blue. (Jones Declaration, Ex. B "Section 2: What is Covered?" at INC-1).

23. Any recovery in this case would be based on the benefit allegedly available, i.e., the June 8, 2020, surgery Plaintiff had while she was covered by an ERISA policy. In the "wherefore" clause of Count I of the Amended Complaint Plaintiff requests that the court "enter judgment declaring that BCBS is required to *provide coverage and benefits* to Mrs. McCullough … ." (emphasis supplied). The coverage and benefits sought are clearly for the surgery. In the "wherefore" clause of Count II of the Amended Complaint Plaintiff requests that the court "enter judgment and *award damages* associated with BCBS's breach of contract … ." (emphasis supplied). The only damages available would be compensatory damages for not paying the costs of the surgery. Plaintiff's claims fall squarely within the ambit of ERISA, and removal of the state action is appropriate.

24. This removal is timely because it is being effectuated within thirty (30) days of receipt by Florida Blue of Plaintiff's Amended Complaint filed on September 14, 2020, which, under this District's case law, was required to be filed before Florida Blue could remove the case.

25. Pursuant to 28 U.S.C. § 1441(a), the United States District Court for the Middle District of Florida, Jacksonville Division is the district court of the United States and division embracing the place where the state court action is pending.

26. There are no other named defendants in this action.

27. In compliance with 28 U.S.C. § 1446(d), Defendant will promptly give written notice of this removal to all adverse parties and will file a copy of this Notice of Removal with the clerk of the state court.

Respectfully submitted this 14th day of October, 2020.

HOLLAND & KNIGHT LLP

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy hereof has been furnished by electronic mail this 14th day of October, 2020 to:

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Attorneys for Plaintiff

/s Timothy J. Conner
Attorney

Exhibit 1A

IN THE CIRCUIT COURT, FOURTH
JUDICIAL CIRCUIT, IN AND FOR
DUVAL COUNTY, FLORIDA

CASE NO.:
DIVISION:

JEAN MCCULLOUGH,
an individual, on behalf of herself
and all those similarly situated

Plaintiff, **CLASS REPRESENTATION**

v.

BLUE CROSS AND BLUE SHIELD
OF FLORIDA, INC.,
a Florida corporation.

Defendant.
_____/

FIRST AMENDED CLASS ACTION COMPLAINT FOR DECLARATORY RELIEF AND DAMAGES

Plaintiff Jean McCullough, individually and on behalf of all those similarly situated hereby files this Complaint for declaratory relief and damages against Defendant Blue Cross and Blue Shield of Florida, Inc. In support hereof, Plaintiff states as follows:

JURISDICTION AND VENUE

1. This is an action involving damages in excess of $30,000.00.

2. Venue is proper pursuant to Section 47.051 of the Florida Statutes, because Defendant Blue Cross and Blue Shield of Florida ("BCBS") is a Florida corporation which keeps an office for transaction of its customary business in Duval County, Florida.

3. Venue is additionally proper as Duval County, Florida is the county where the cause of action accrued.

PARTIES

4. Jean McCullough is an individual residing in Duval County, Florida.

5. BCBS is a Florida corporation with its principal address at 4800 Deerwood Campus Parkway, Jacksonville, FL 32246.

6. BCBS is an independent licensee of the Blue Cross and Blue Shield Association.

GENERAL ALLEGATIONS

7. Jean McCullough is an adult female diagnosed with Gastroesophageal Reflux Disease (GERD).

8. GERD is a digestive disorder that affects the lower esophageal sphincter, causing the reflux of gastric contents into the esophagus. Sufferers of GERD may experience heartburn or acid indigestion. In more serious cases, GERD can lead to pathological changes in the esophagus, or esophageal cancer.

9. As such, many diagnosed with GERD are advised to have surgery to minimize acid reflux.

10. Mrs. McCullough suffers from severe GERD and was advised by her licensed physician that surgery to minimize acid reflux was medically necessary.

11. Mrs. McCullough's physician recommended Mrs. McCullough undergo a surgery to receive a magnetic sphincter augmentation device, specifically, the LINX Gastroesophageal Management System (the "LINX system").

12. The LINX system is composed of miniature titanium beads, each with a magnetic core, connected together to form a ring shape. It is implanted at the lower esophageal sphincter and prevents the backward flow of stomach acid or contents.

13. The LINX system is approved by the United States Food and Drug Administration.

14. The LINX system is rated a Category I CPT code by the American Medical Association, meaning that it is consistent with contemporary medical practice, is widely performed, and is documented in medical literature.

15. Mrs. McCullough sought insurance coverage for the LINX system procedure pursuant to her BCBS of Florida Policy, Policy Form Number 19458 0800 CA, which is attached hereto as Exhibit "A."

16. BCBS denied coverage for the LINX procedure, calling it "experimental or investigative" pursuant to the Policy. The Policy defines "experimental or investigative" as follows:

> **Experimental or Investigational** means any evaluation, treatment, therapy, or device which involves the application, administration or use, of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined solely by BCBSF:
>
> 1. Such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the Florida Department of Health and approval for marketing has not, in fact, been given at the time such is furnished to the Insured;
>
> 2. Such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device;
>
> 3. Such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations;
>
> 4. Reliable evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations or 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;

> 5. 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 in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices;
>
> 6. There is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or
>
> 7. 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.

17. Mrs. McCullough appealed this decision, and BCBS asked a Family Medicine Hospice & Palliative Care physician to review the file. This physician confirmed BCBS's finding that the LINX procedure was "experimental and investigative" pursuant to the Policy.

18. Mrs. McCullough then sought copies of all records reviewed by this physician to make their determination.

19. BCBS responded to this request by producing a handful of papers, allegedly reviewed by the physician in coming to their decision. The documents are BCBS internal documents stating that the LINX procedure is "experimental and investigative."

20. In other words, BCBS assigned a physician to review Mrs. McCullough's appeal and the only records they reviewed were internal BCBS documents providing the conclusion that the procedure was excluded under the Policy. There is no evidence of independent investigation or of review of any documents which are not self-serving, internal documents.

21. Mrs. McCullough complied with all conditions precedent to bringing this action.

CLASS REPRESENTATION ALLEGATIONS

22. Mrs. McCullough brings this action on behalf of all those insured by BCBS who were denied coverage of the LINX procedure on the basis that such procedure is "experimental and investigative" (the "Class").

23. Mrs. McCullough reserves the right to amend the Class definition as discovery proceeds.

24. Based upon information and belief, the number of Class members is so numerous that separate joinder of each Class member is impractical.

25. The exact number of Class members is unknown and cannot be known absent Class discovery, but Mrs. McCullough believes the number to be in excess of 40.

26. Mrs. McCullough's claim that she was wrongfully denied the LINX procedure on the basis that the LINX procedure was "experimental and investigative," is the exact same claim as each proposed member of the class.

27. Mrs. McCullough has retained the undersigned attorneys who are experienced in handling class actions and are qualified to adequately protect the interests of the Class.

28. Mrs. McCullough brings this action pursuant to Florida Rule of Civil Procedure 1.220(b)(1), because individual suits by all class members could produce varying and inconsistent results which may establish incompatible guidelines for BCBS.

29. Mrs. McCullough brings this action pursuant to Florida Rule of Civil Procedure 1.220(b)(2), because BCBS's actions are generally applicable to all class members, making relief concerning the class as a whole appropriate.

30. Finally, the question of law and/or fact raised by Mrs. McCullough on behalf of the Class – i.e. whether BCBS wrongfully denies claims for the LINX procedure as being "experimental and investigative" – predominates over any question of law or fact affecting any

individual Class member, such that class representation is a superior method for the fair and efficient adjudication of this controversy, in accordance with Florida Rule of Civil Procedure 1.220(b)(3).

COUNT I – DECLARATORY RELIEF

31. Mrs. McCullough hereby realleges and incorporates the allegations set forth in paragraphs 1-32, inclusive, as though fully set forth herein.

32. Based upon the LINX system's general acceptance in the medical field, Mrs. McCullough believes the procedure is not "experimental or investigational" as that term is defined under the Policy, attached hereto as Exhibit A.

33. A bona fide, actual, and present controversy exists between Mrs. McCullough, the Class, and BCBS with respect to the Policy and BCBS's obligations and duties to Mrs. McCullough and the Class to cover the LINX system procedure.

34. A declaration pursuant to Chapter 86, Florida Statutes is necessary and appropriate to determine BCBS's duties and obligations in this regard.

35. Accordingly, Mrs. McCullough seeks a judicial declaration that BCBS has a duty to provide benefits to Mrs. McCullough and the Class.

WHEREFORE, Plaintiff Jean McCullough, individually and on behalf of the Class, respectfully requests this Court (i) enter an order certifying that this action is properly maintained under Florida Rule of Civil Procedure 1.220(b)(1),(2), and/or (3); (ii) exercise jurisdiction over this cause and determine the rights, duties, and obligations of the parties under the subject Policy; (iii) enter judgment declaring that BCBS is required to provide coverage and benefits to Mrs. McCullough and the Class; and (iv) enter judgment for costs and attorney fees pursuant to Section 627.428, Florida Statutes.

COUNT II – BREACH OF CONTRACT

36. Mrs. McCullough hereby realleges and incorporates the allegations set forth in paragraphs 1-32, inclusive, as though fully set forth herein.

37. A valid contract exists, as shown by the Policy attached hereto as Exhibit A.

38. BCBS breached the policy by denying coverage to Mrs. McCullough and the Class for the LINX system procedure, which is a generally accepted, non-experimental, medical practice.

39. Due to BCBS's breach, Mrs. McCullough and the Class suffered injury.

WHEREFORE, Plaintiff Jean McCullough, individually and on behalf of the Class, respectfully requests this Court: (i) enter an order certifying that this action is properly maintained under Florida Rule of Civil Procedure 1.220(b)(1),(2), and/or (3); (ii) exercise jurisdiction over this cause; (iii) enter judgment and award damages associated with BCBS's breach of contract; and (iv) enter judgment for costs and attorney fees pursuant to Section 627.428, Florida Statutes.

DEMAND FOR JURY TRIAL

Plaintiff hereby demands a trial by jury on all issues in this matter so triable.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that the foregoing was filed via the eFiling Portal this 14th day of September 2020 and furnished electronically to: *Counsel for Defendant,* **Timothy J. Conner, Esq.**, Holland & Knight, LLP, 50 North Laura Street, Suite 3900, Jacksonville, Florida, 32202, (timothy.conner@hklaw.com; camille.winn@hklaw.com).

ORR | COOK

/s/ Kathleen H. Crowley

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EXHIBIT A

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Home Office
4800 Deerwood Campus Parkway
Jacksonville, Fl 32246

Thank you for selecting Blue Cross and Blue Shield of Florida's (BCBSF) **BlueChoice for Individuals Under 65 Non-Group Contract (BlueChoice).**

BlueChoice gives you access to two of BCBSF's provider networks - BCBSF's statewide network of preferred providers and BCBSF's network of traditional providers. With **BlueChoice**, you have the freedom to select any provider you wish to see. However, you may be able to lower your out-of-pocket expenses by receiving care from participating PPO Providers. To find out about a health care provider's participation status, you may review the PPO Provider Directory then in effect, call the provider's office, access our web-site at www.bcbsfl.com and/or call the customer service phone number on the front cover of this Contract or on your Identification Card. You should also carefully review the Schedule of Benefits which is a part of this Contract for a detailed list of your financial responsibilities. This is important because with **BlueChoice** your financial responsibilities, including any applicable Copayments, Deductibles, and Coinsurance responsibilities, **may vary** depending upon the Providers you choose.

If you did not receive, or cannot find, the Schedule of Benefits, which is a part of your Contract, it is important that you call the number on the front cover of this Contract or on your Identification Card and we will mail you another one.

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

M. Cascone, Jr.
President

SCHEDULE OF BENEFITS

Insureds should carefully review this Schedule of Benefits. If the Insured did not receive, or cannot find the Contract, of which this Schedule of Benefits is a part, contact BCBSF to obtain a copy of the Contract issued to the Contractholder. This plan provides coverage for certain Physician office services, without having to satisfy a Calendar Year Deductible requirement, when obtained from a PPO Family Physician. This plan also provides coverage for adult wellness services without having to satisfy a Calendar Year Deductible requirement.

A. INSURED'S FINANCIAL RESPONSIBILITIES FOR COVERED SERVICES

1. Deductible:

a. Individual Calendar Year Deductible..... $1,000
   (1) The Individual Calendar Year Deductible will be waived by BCBSF for Health Care Services rendered by any Independent Clinical Laboratory.

b. Hospital Per Admission Deductible
   (1) PPO Hospitals..... $0
   (2) Hospitals Not Participating In PPO..... $500

NOTE:
The Hospital Per Admission Deductible is in addition to the Calendar Year Deductible.

2. Coinsurance Percentage Payable by BCBSF:

a. PPO Providers - Allowed Amount..... 80%

b. Providers Not Participating In PPO - Allowance..... 60%
   (1) Ambulance Services - Allowance..... 80%
   (2) Prescription Drugs
      a) Generic..... 80%
      b) Brand..... 60%

3. Coinsurance Responsibility Per Calendar Year:

a. Individual Coinsurance Limit..... $3,000

b. Family Coinsurance Limit..... $6,000

NOTE:
Coinsurance Responsibility Limits do not include the Calendar Year Deductible amount, the Hospital Per Admission Deductible amount, the Copayment, any benefit penalty reduction, non-covered charges, charges in excess of the Allowed Amount, or charges for services rendered by Providers not Participating in PPO (except for prescription drugs and ambulance services).

4. Office Services

a. Office services rendered by a PPO Family Physician (i.e., a PPO Family Physician practicing in the following areas: Family Practice, General Practice, Internal Medicine, or Pediatrics) are subject only to the Copayment requirement:

(1) Office services by a PPO Family Physician (Copayment Only) $20

a) Durable Medical Equipment, Prosthetics, and Orthotics are not subject to the Copayment requirement, but are subject to Individual Calendar Year Deductible and Coinsurance.

(2) Allergy Injections (Copayment Only) $5

b. Office services (including services for Durable Medical Equipment, Prosthetics, and Orthotics) rendered by any Provider, other than a PPO Family Physician are subject to the Calendar Year Deductible requirement and Coinsurance responsibility.

NOTE:
To verify a Provider's specialty or participation status, the Insured may contact the local BCBSF office, contact the Provider's office, or review the most recent Provider Directory. It is the Insured's sole responsibility to select and verify a health care Provider's participating status at the time Health Care Services are rendered.

B. BENEFIT MAXIMUMS

1. Calendar Year Maximums Per Insured

a. Mental Health Services Benefit Maximum:

(1) Inpatient Hospital/Physician or combination of inpatient and Partial Hospitalization $2,000

(2) Outpatient $600

b. Home Health Care Benefit Maximum $2,500

c. Skilled Nursing Facility Days Benefit Maximum 60

d. Low Protein Food Products Benefit Maximum $2,500

e. Combined Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations Benefit Maximum $1,500

NOTE:
Refer to the Contract for Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations reimbursement guidelines.

2. Lifetime Maximums Per Insured

a. Total Lifetime Maximum Benefit $2,000,000
b. Mental Health Services $10,000
c. Substance Dependency Care and Treatment Benefit Maximum (inpatient, outpatient, or any combination) $2,000
d. Hospice Benefit Maximum $5,200

Benefit Maximum Carryover

If immediately before the Effective Date of coverage, under this Contract, an Insured was covered under a prior individual insurance policy issued by BCBSF, amounts applied to an Insured's Calendar Year benefit maximums and lifetime maximums under the prior BCBSF individual insurance policy will be applied toward the Insured's Calendar Year benefit maximums and lifetime maximums under the Contract.

NOTE:
Financial responsibilities, including any applicable Copayments, Deductibles, and Coinsurance responsibilities, **may vary**depending upon the Providers chosen by the Insured.

C. ADDITIONAL BENEFITS AND FEATURES

Adult Wellness

1. Adult Wellness Benefit Maximum Per Insured Per Calendar Year $150

Covered Services for an adult (i.e., age 17 and older), includes the following:

a. annual physical or gynecological exam;
b. related wellness services (e.g., pap smears, Prostate Specific Antigen PSA, x-rays, laboratory services, and immunizations). Routine vision and hearing examinations and screenings are not covered. The adult wellness services above are not subject to the Individual Calendar Year Deductible, but are subject to the Copayment requirement, or applicable Coinsurance responsibility depending on the location of service and the Provider's participating status.

2. Accident Care

Covered Services in connection with an Accident are not subject to the Individual Calendar Year Deductible. All other Insured's financial responsibilities, including the Hospital Per Admission Deductible, Coinsurance, and Copayment (if applicable) will continue to apply.

D. ADMISSION CERTIFICATION REQUIREMENTS

All Hospital admissions in the State of Florida must be certified. The following penalties will apply for admissions within the State of Florida which are not certified.

1. Admissions to a Hospital that is a BCBSF PPC Provider - No penalty for the Insured. It is the responsibility of the PPC Hospital Physician to obtain admission certification.
2. Hospitals that are not BCBSF Providers - any non certified admissions in the State of Florida are subject to a 25% benefit penalty reduction. The Insured is responsible for obtaining certification for the admission from BCBSF and for any applicable benefit reductions for failure to obtain such certification.

TABLE OF CONTENTS

INTRODUCTION TO THE CONTRACT

This Contract, which includes the Schedule of Benefits, sets forth the Insured's rights and obligations and those of BCBSF. It is important that each Insured read the Contract carefully and become familiar with its terms, including its coverage, benefits, exclusions and limitations.

Set out below are highlights from the Contract and information on where to look for relevant information.

The **Schedule of Benefits** includes information about the limitations and maximums of coverage and explains any financial obligations.

The **Insured's Financial Obligations Section** sets forth requirements and responsibilities that apply to Insureds under this Contract. Refer to the Schedule of Benefits for additional information concerning these requirements and financial responsibilities.

The **Health Care Provider Alternatives Section** sets forth BCBSF's payment rules for Covered Services depending on the health care Provider selected by an Insured to provide Health Care Services.

The **Covered Services Section** describes the Health Care Services which may be covered, and highlights specific exclusions and limitations that apply to particular types of Health Care Services.

The **General Exclusions Section** lists other exclusions and limitations in addition to those specifically listed in the Covered Services Section.

The **Eligibility Section** describes who is eligible for coverage and how and when this coverage begins.

The **Glossary of Terms Section** will define many of the words and phrases used throughout the Contract. 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 this section or where used in the Contract.

Other sections contained in this Contract explain when benefits may change; how and when coverage stops; how to obtain coverage if coverage ends; how BCBSF will coordinate benefits with other policies or plans; BCBSF's subrogation rights; and BCBSF's right of reimbursement. These sections also explain how to file a claim when services are received from a Provider who does not participate in BCBSF's PPO or traditional networks.

INSURED'S FINANCIAL OBLIGATIONS

This section sets out an Insured's financial obligations under this Contract. Important information concerning these financial obligations is set forth in the Schedule of Benefits. If an Insured did not receive, or cannot find, the Schedule of Benefits, which is a part of this Contract, it is important that the Insured call the customer service number on the front cover of this Contract or on the Identification Card and BCBSF will mail another one.

Calendar Year Deductible Requirement

Individual Calendar Year Deductible Requirement

This requirement, when applicable, must be satisfied by each Insured each Calendar Year, as determined by BCBSF, before any payment will be made by BCBSF for any claim. Only those charges indicated on claims received by BCBSF for Covered Services will be credited by BCBSF toward the Individual Calendar Year Deductible requirement and only up to the applicable Allowed Amount.

Hospital Per Admission Deductible

The Hospital Per Admission Deductible must be satisfied by each Insured, for each Hospital admission, before any payment will be made by BCBSF for any claim for inpatient Health Care Services. The Hospital Per Admission Deductible applies regardless of the reason for the admission, is in addition to the Calendar Year Deductible requirement, and applies to Hospital admissions in or outside the State of Florida.

Coinsurance Responsibility

After the Insured has satisfied the applicable Deductible responsibility, BCBSF will pay claims for Covered Services at the Coinsurance percentage of the applicable Allowed Amount as set forth in the Schedule of Benefits. The unpaid percentage of the Allowed Amount is the Insured's Coinsurance Responsibility.

Coinsurance Responsibility Limit/Maximum Out-of-Pocket Coinsurance Amount

1. Individual Coinsurance Responsibility Limit

   Once an Insured has reached the Individual Coinsurance Responsibility Limit amount as set forth in the Schedule of Benefits, the Insured will have no additional Coinsurance Responsibility for the remainder of the Calendar Year and BCBSF will pay for Covered Services at 100 percent of the Allowed Amount.

2. Family Coinsurance Responsibility Limit

   Once the Contractholder's family has reached the Family Coinsurance Responsibility Limit amount as set forth in the Schedule of Benefits, no Insured in the Contractholder's family will have any additional Coinsurance Responsibility for the remainder of that Calendar Year and BCBSF will pay for Covered Services at 100

percent of the Allowed Amount. The maximum amount any Insured can contribute toward the Family Coinsurance Responsibility Limit is the amount applied toward the Individual Coinsurance Responsibility Limit amount.

NOTE: Coinsurance Responsibility Limits do not include the Calendar Year Deductible, Hospital Per Admission Deductible, any Copayment, any benefit penalty reduction, non-covered charges or any charges in excess of the Allowed Amount.

Benefit Maximum Carryover

If immediately before the Effective Date of the coverage, under this Contract, an Insured was covered under a prior individual insurance policy issued by BCBSF, amounts applied to an Insured's Calendar Year benefit maximums and lifetime maximums under the prior BCBSF individual insurance policy will be applied toward the Insured's Calendar Year benefit maximums and lifetime maximums under this Contract.

Additional Financial Responsibilities

In addition to the financial obligations set forth above, Insureds are also responsible for:

1. any applicable Copayments;
2. expenses incurred for non-Covered Services;
3. charges in excess of any maximum benefit limitation set forth in the Schedule of Benefits (e.g., the lifetime maximum and Calendar Year maximums);
4. charges in excess of the applicable Allowed Amount; and
5. any benefit reduction (e.g., benefit penalties resulting from an Insured's failure to comply with any Individual Benefit Utilization Management/Utilization Review Program requirements).

Additional Information

Covered Physician Health Care Services (except for Durable Medical Equipment, Prosthetics, and Orthotics) rendered in the PPO Physician's office are only subject to the Copayment amount set forth on the Schedule of Benefits, when the PPO Physician practices in the following: Family Practice, General Practice, Internal Medicine, or Pediatrics.

HEALTH CARE PROVIDER ALTERNATIVES AND REIMBURSEMENT RULES

Introduction

BlueChoice gives Insureds access to BCBSF's statewide network of PPO Providers and also access to BCBSF's statewide program of Traditional Insurance Providers.

Insureds are free to obtain services from any health care Provider of their choice, including PPO Providers, Traditional Insurance Providers, or health care Providers who do not participate in any of BCBSF's Provider contracting programs. BCBSF's reimbursement rules for Covered Services varies, as explained below, depending on the health care Provider selected by an Insured to provide Health Care Services. To find out about a health care Provider's participation status, an Insured can review the PPO Provider Directory then in effect, call the Provider's office, access BCBSF's web-site at www.bcbsfl.com and/or call the customer service phone number on the front cover of this Contract or on the Insured's Identification Card.

It is the Insured's sole responsibility to select a Provider when obtaining Health Care Services and to verify such Provider's participation status, if any, at the time the Health Care Services are rendered.

Reimbursement Rules for BCBSF PPC Providers

A **"BCBSF PPC℠ Provider"** is a PPO Provider in the State of Florida, or in certain counties outside of Florida, that is also a **"Preferred Patient Care℠"** or **"PPC℠"** Provider (or in a BCBSF Provider network program that replaces, in whole or part, such PPC℠ program). To find out about a health care Provider's participation status, an Insured can review the PPO Provider Directory then in effect, call the Provider's office, access BCBSF's web-site at www.bcbsfl.com and/or call the customer service phone number on the front cover of this Contract or on the Insured's Identification Card. BCBSF PPC℠ Providers have agreed to file claims for the services they render. They have also agreed not to bill or otherwise collect from an Insured any amounts in excess of BCBSF's PPO Schedule Amount, except as otherwise permitted under the terms of their Provider contracts and this Contract. **BCBSF's payment for Covered Services rendered by a BCBSF PPC℠ Provider, if any, will always be made directly to the BCBSF PPC℠ Provider.** For a list of the type of Providers that are currently eligible to participate as BCBSF PPC℠ Providers, see the Eligible Providers subsection of this section.

When an Insured receives Health Care Services from a BCBSF PPC℠ Provider, BCBSF's payment of expenses for those services which are Covered Services (as defined in this Contract) will be at the Coinsurance percentage set forth in the Schedule of Benefits based on BCBSF's Allowed Amount for such services. The Insured's financial responsibility includes:

1. the payment of any applicable Copayments, Deductible(s) and/or Coinsurance requirements;

2. the payment of expenses which are not covered, limited, or excluded;

3. the payment of any expenses in excess of any benefit maximum limitations; and

4. the payment of any applicable benefit reductions or penalties.

Note: For additional reimbursement rules for certain out-of-state PPO Providers, see the BlueCard® Program Section of this Contract.

Rules For Providers Who Do Not Participate in BCBSF's PPC Network

1. Traditional Insurance Providers

Traditional Insurance Providers are those health care Providers who are not BCBSF PPC℠ Providers, but who have entered into a contract, then in effect, to participate in BCBSF's traditional programs (these programs are also known as Payment for Physician Services "PPS" and Payment for Hospital Services "PHS"), as applicable, in Florida or in certain counties outside of Florida, when such programs exist. These Providers have agreed to accept BCBSF's Allowance as payment for Covered Services and to file claims for the services they render. They have also agreed not to bill or otherwise collect from an Insured any amounts in excess of BCBSF's Allowance, except as otherwise permitted under the terms of this Contract and their Provider contract. **BCBSF's payment for Covered Services rendered by a Traditional Insurance Provider, if any, will always be made directly to the Provider.** For a list of the type of Providers that are currently eligible to participate as Traditional Insurance Providers, see the Eligible Providers subsection of this section or call the customer service number listed on the Insured's Identification Card.

BCBSF's payment of expenses for Covered Services (as defined in this Contract) will be at the Coinsurance percentage set forth in the Schedule of Benefits based on BCBSF's Allowance for such services.

The Insured's financial responsibility for services rendered by Traditional Insurance Providers includes, but is not limited to:

1. the payment of any applicable Copayments, Deductible(s) and/or Coinsurance requirements;

2. the payment of expenses which are not covered, limited, or excluded;

3. the payment of any expenses in excess of any benefit maximum limitations; and

4. the payment of any applicable benefit reductions or penalties.

2. Reimbursement Rules For Providers Who Are Eligible To Participate As BCBSF Traditional Insurance Providers But Who Have Not Entered Into A Traditional Insurance Provider Contract

Certain Providers who are eligible to participate as Traditional Insurance Providers, but who have not entered into a Traditional Insurance Provider contract with BCBSF, may

not accept BCBSF's Allowance as payment for Covered Services. Insureds receiving Health Care Services from such Providers are responsible for filing claims in connection with those services and payment for those services. BCBSF's payment of expenses for Covered Services (as defined in this Contract) will be at the Coinsurance percentage set forth in the Schedule of Benefits based on BCBSF's Allowance for such services.

BCBSF's payment, if any, will always be made directly to the Insured and not the Provider. The Insured's financial responsibility includes:

1. the payment of any applicable Copayments, Deductible(s) and/or Coinsurance requirements;

2. the payment of expenses which are not covered, limited, or excluded;

3. the payment of any expenses in excess of any benefit maximum limitations;

4. the payment of any applicable benefit reductions or penalties; and

5. the payment of the difference between BCBSF's Allowance and the Provider's charges.

3. Reimbursement Rules for Providers Not Eligible To Participate In Any Of BCBSF's Provider Programs

Certain categories of health care Providers are not eligible to participate as BCBSF PPC℠ Providers or as Traditional Insurance Providers. To determine which categories of health care Providers are eligible to participate as BCBSF PPC℠ Providers or as Traditional Insurance Providers, an Insured can review the PPO Provider Directory then in effect, call the Provider's office, access BCBSF's web-site at www.bcbsfl.com and/or call the customer service phone number on the front cover of this Contract or on the Insured's Identification Card. The Insured is responsible for filing claims for Health Care Services rendered by these Providers. **BCBSF's payment for Covered Services rendered by these Providers, if any, will be made to the Insured, unless the Insured has properly assigned the benefits to the Provider.** BCBSF's payment, if any, for Covered Services rendered by these Providers will be at the Coinsurance percentage as set forth in the Schedule of Benefits based on BCBSF's Allowance for such services. The Insured's financial responsibility includes:

1. the payment of any applicable Copayments, Deductible(s) and/or Coinsurance requirements;

2. the payment of expenses which are not covered, limited, or excluded;

3. the payment of any expenses in excess of any benefit maximum limitations;

4. the payment of any applicable benefit reductions or penalties; and

5. the payment of the difference between BCBSF's Allowance and the Provider's charges.

Assignment of Benefits to Providers

BCBSF is not required to honor any assignment to a Provider who does not participate in any of BCBSF's Provider contracting programs including, without limitation, any of the following: an assignment of the benefits due the Insured under this Contract; an assignment of the right to receive payments due under this Contract; or an assignment of a claim for damages resulting from a breach, or an alleged breach, of the Contract.

Note: For additional reimbursement rules for certain out-of-state PPO Providers, see the BlueCard® Program Section of this Contract.

Eligible Providers

The following categories of Providers are eligible to participate as BCBSF PPC Providers and/or Traditional Insurance Providers:

1. Acute Care General Hospitals/Osteopathic Hospitals
2. Ambulatory Surgical Centers
3. Dialysis Centers
4. Doctors of Chiropractic (D.C.)
5. Doctors of Dental Medicine (D.M.D.)
6. Doctors of Dental Science (D.D.S.)
7. Doctors of Dental Surgery (D.D.S.)
8. Doctors of Medicine (M.D.)
9. Doctors of Optometry (O.D.)
10. Doctors of Osteopathy (D.O.)
11. Doctors of Podiatric Medicine (D.P.M.)
12. Durable Medical Equipment Providers
13. Home Health Agencies
14. Independent Clinical Laboratories
15. Mental Health Professionals
16. Physical Therapist Providers

17. Prosthetists/Orthotists

18. Psychiatric Facilities

19. Psychologists

20. Substance Abuse Facilities

BLUECARD® PROGRAM

Providers Outside The State of Florida

When amounts are paid or payable by BCBSF under this Contract to a Provider outside the State of Florida who is not in BCBSF's network, reimbursement to the out-of-state Provider may be determined based on the Provider arrangements, if any, the Blue Cross and/or Blue Shield plan has with the Provider in the area where services are provided. Also, the Insured's financial responsibilities (e.g. coinsurance requirement limits) may be determined using the same Provider arrangements. In those instances the Blue Cross and/or Blue Shield plan in that area is called a "Host Plan." BCBSF will coordinate with the appropriate Host Plan when reimbursement and financial responsibilities are to be so handled. This is done by use of a special national program of the Blue Cross and Blue Shield Association called the BlueCard® Program. Participation in this program allows BCBSF to make available coverage for out-of-area services using favorable Allowed Amounts that would generally not be available had BCBSF paid the Provider directly.

Insureds have access to a Host Plan's BlueCard® PPO Provider network where available. Payment for Covered Services rendered by an applicable Host Plan's PPO Providers will be at the Coinsurance percentage which is highest under this Contract, as set forth in the Schedule of Benefits, using the applicable Allowed Amount under the BlueCard® Program. Certain categories of Providers may not be eligible to participate in a specific Host Plan's PPO network. Further, only certain Providers will participate in any specific Host Plan PPO network. Under the BlueCard® Program, however, certain additional Providers may also participate. Payment for Covered Services rendered by such non-PPO Providers will be at the Coinsurance percentage which is lowest under this Contract, using the applicable Allowed Amount under the BlueCard® Program, as set forth on the Schedule of Benefits.

An Insured's financial responsibilities may vary depending upon the Provider chosen under the BlueCard® Program. For information on the BlueCard® participation status of Providers, call the BlueCard® access number on the Insured's Identification Card when listed or call the customer service number on the Insured's Identification Card for further assistance.

Under the BlueCard® Program, Host Plans may charge BCBSF a fee (called an access fee) for making their negotiated payment rates available on claims incurred. The access fee may be up to 10 percent (but not to exceed $2,000 for any claim) of the discount the Host Plan has obtained from its Providers. The access fee may be charged only if the Host Plan's arrangement with the Provider prohibits billing Insureds for amounts in excess of the negotiated payment rate. However, Providers may bill for Deductibles, Coinsurance and/or Copayments if applicable.

When BCBSF is charged an access fee, BCBSF will include the access fee amount when calculating the Insured's claims expenses. If BCBSF receives an access fee credit in such situations, BCBSF will include such credit when calculating the Insured's claims expenses. Access fees are considered a claims expense in such situations because they represent claim dollars BCBSF was unable to, or in the case of a credit was able to, avoid. Further,

while additional administrative charges will be paid by BCBSF for each claim processed under the BlueCard® Program, such charges will not be passed along as a claims expense.

Instances may occur in which BCBSF does not pay a claim (or pays only a small amount) because the amounts eligible for payment were applied to the Deductible, Coinsurance or Copayment if applicable. In such instances the Host Plan's arrangement with its Provider may allow the negotiated payment rate to apply when the amount is fully or mostly an Insured's obligation. If so, BCBSF will pay the Host Plan's access fee.

The Allowed Amount paid by BCBSF to the Host Plan under the BlueCard® Program for Health Care Services will be arrived at using one of the following three methods. The first method uses the actual price paid on the claim. In limited circumstances this price may be greater than charges (e.g. sometimes payment under a "DRG" Diagnostic Related Grouping payment system will be greater than charges). The second method uses an estimated price. This price reflects an adjusted aggregate payment expected to result from past or future settlements or other non-claims transactions with all of the Host Plan's health care Providers or one or more particular Providers. The third method uses a discount from billed charges. This price is obtained by applying an average savings factor representing the Host Plan's expected savings for all of its Providers or for a specified group of Providers. Estimated and average pricing used under options two and three may be prospectively adjusted. This helps correct for either over or under estimation of past prices.

The calculation of Coinsurance and other Insured liability for Covered Services will be at the lower of the Provider's billed charges or the Allowed Amount BCBSF pays the Host Plan under the BlueCard® Program. Also note that statutes in a small number of states require local Blue Cross and/or Blue Shield plans to use a basis for calculating Insured's liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim. When an Insured receives Covered Services in these states, liability for these services will be calculated using these states' statutory methods.

Under the BlueCard® Program, the Insured's financial responsibility includes:

1. the payment of any applicable Copayments, Deductible(s) and/or Coinsurance requirements;

2. the payment of expenses which are not covered, limited, or excluded;

3. the payment of any expenses in excess of any benefit maximum limitations; and

4. the payment of any applicable benefit reductions or penalties.

PRE-EXISTING CONDITIONS EXCLUSION PERIOD

There is no coverage for Health Care Services to treat a Pre-existing Condition or Conditions directly or indirectly caused by a Pre-existing Condition, until the Insured has been continuously covered for a 24-month period. This 24-month Pre-existing Condition exclusionary period begins on the Insured's Effective Date of coverage. This exclusionary period also applies to any Prescription Drug that is prescribed in connection with a Pre-existing Condition.

A Pre-existing Condition means any Condition that manifests itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care or treatment was recommended or received during the 24-month period immediately preceding the Insured's Effective Date of coverage under this Contract.

A Pre-existing Condition does not include:

1. Genetic Information in the absence of a diagnosis of the Condition;

2. Routine follow-up care for breast cancer after the person was determined to be free of breast cancer for a period of at least two years to the date of application for this Contract; or

3. Conditions resulting from domestic violence.

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

Covered Dependents enrolled subsequent to the Effective Date will be subject to the Pre-existing Conditions exclusionary period, except for newborn or Adopted dependents who are properly and timely enrolled. However, credit will be given for the time an Insured was covered under previous Creditable Coverage if the previous Creditable Coverage was continuous to a date not more than 62 days prior to the Insured's Effective Date of coverage.

If there was a break in coverage of 62 days or more, no credit will be given for prior Creditable Coverage. Prior health insurers and/or group health plan are required to provide a certification of Creditable Coverage to the Insured upon termination of his or her coverage.

Important Note: This Contract does not provide coverage or benefits for maternity/obstetrical care unless the Contractholder purchased such coverage under the Optional Maternity/Obstetrical Care Benefits Endorsement.

INDIVIDUAL BENEFIT UTILIZATION MANAGEMENT/UTILIZATION REVIEW PROGRAMS

Introduction

BCBSF has established various Benefit Utilization Management/Utilization Review Programs ("UM/UR Programs"), including Admission Certification, Concurrent Review, Discharge Planning and Case Management. These programs help BCBSF facilitate the management and review of coverage and benefits provided under BCBSF's policies and, under certain limited circumstances, present opportunities, as explained below, to agree upon alternative benefits or payment alternatives for cost-effective Health Care Services.

IMPORTANT INFORMATION RELATING TO BCBSF's UM/UR PROGRAMS

All decisions that require or pertain to independent professional medical/clinical judgement or training, or the need for medical services, are solely the responsibility of the Insured and the Insured's treating Physicians and health care Providers together with the Insured. Insureds and their Physicians are responsible for deciding what medical care should be rendered or received, and when and how that care should be provided. BCBSF is solely responsible for determining whether expenses incurred, or to be incurred, for medical care are, or would be, covered under this Contract. In fulfilling this responsibility, BCBSF shall not be deemed to participate in or override the medical decisions of any Insured's health care Provider.

Admission Certification Program

The Admission Certification Program helps BCBSF determine, for coverage and payment purposes only, whether an admission is Medically Necessary as defined by BCBSF. In administering the Admission Certification Program, BCBSF may review specific medical facts or information and assess, among other things, the appropriateness, health care setting and/or the level of care of a Hospital admission. The coverage and/or benefit determinations made by BCBSF, and any reviews or assessments of specific medical facts or information which it conducts, are solely for purposes of making such coverage or payment decisions under this Contract and not for the purpose of recommending or providing medical care. As explained below, the Admission Certification Program requirements vary depending on whether or not the Hospital utilized is a BCBSF PPC℠ Provider. A BCBSF PPC℠ Provider is a PPO Provider in the State of Florida, or in certain counties outside of Florida, that is also a "Preferred Patient Care℠" or "PPC℠" Provider (or in a BCBSF Provider network program that replaces, in whole or part, such PPC℠ program). To find out about a health care Provider's participation status, the Insured can review the PPO Provider Directory then in effect, call the Provider's office, access our web site at www.bcbsfl.com and/or call the customer service phone number on the front cover of this Contract or on the Insured's Identification Card.

1. **Admission Certification Requirements For Inpatient Admissions To Hospitals that are BCBSF PPC Providers**

Under the Admission Certification Program, ALL inpatient admissions (i.e., elective, planned, urgent or emergency) must be certified by BCBSF in order for the Insured to receive full benefits for an inpatient admission to a Hospital that is a BCBSF PPC℠ Provider.

The Admission Certification Program requirements for admissions to such Hospitals are the Hospital's sole responsibility. Insureds are not responsible for satisfying such requirement, or for any potential benefit reductions for failure to obtain certification, when the Insured is admitted to any such Hospital.

Once BCBSF has the necessary medical information, BCBSF will review the information and make a certification decision, for coverage and payment purposes, based upon the Admission Certification Program's established criteria then in effect.

For admissions to such Hospitals which are not certified under this program, payment to the Hospital will be reduced by the amount specified in that Hospital's PPC℠ contract with BCBSF.

2. **Insureds' Admission Certification Requirements For Admissions To Florida Hospitals That Are Not BCBSF PPC Providers**

The Admission Certification Program also requires Insureds to obtain from BCBSF certification for ANY admission (e.g., elective, planned, urgent, or emergency) to a Hospital in the State of Florida that is not a BCBSF PPC℠ Provider. If the Insured fails to obtain certification from BCBSF for the admission, the Allowance for such admission will be reduced by 25 percent as a penalty. This penalty is the Insured's responsibility and is in addition to all applicable obligations and limitations under this Contract (e.g., the Deductible and Coinsurance requirements). This penalty amount will not be applied towards the Coinsurance requirement limits (e.g., the Individual Coinsurance requirement limit).

a. Obtaining Certification from BCBSF

1). Planned Admissions

For all planned admissions (i.e., an inpatient Hospital admission which is not an emergency or urgent as determined by BCBSF) to a Hospital in the State of Florida that is not then a PPC Provider, the Insured must obtain a "Request For Admission Certification" form, or other applicable form, from BCBSF (**Note:** the Insured may want to ask his/her Provider to assist) and deliver such form to the Insured's Physician requesting the admission. The Physician must complete the form and submit it to BCBSF in advance of the planned admission so that BCBSF receives the form at least two working days prior to the planned admission.

2). Unplanned Admissions

For all unplanned admissions (i.e., an inpatient Hospital admission that is an emergency or is urgent or cannot be scheduled in advance) to a Hospital in the State of Florida that is not then a BCBSF PPC℠ Provider, the Insured must

ensure that the Physician or the Hospital contacts BCBSF by telephone within 24 hours of the admission or the first business day following a weekend or holiday admission. In the event the Insured's Condition makes it impossible for the Insured to ensure that BCBSF is so notified within the applicable time frame, the Insured must ensure that BCBSF is so notified as soon as possible.

3). BCBSF's Certification Decision

Once BCBSF has received the necessary information, in conformity with paragraphs 1 and 2 above, BCBSF will review the information and make a certification decision, for coverage and payment purposes only, based upon the Admission Certification program's criteria then in effect. BCBSF will notify the Insured, the Physician and the Hospital of the certification decision as soon as possible.

In the event the admission is not certified under this program, BCBSF will, as noted above, reduce the Allowance for such admission by 25 percent as a penalty. The Insured may obtain Covered Services on an outpatient basis without a reduction in the applicable Allowance.

Concurrent Review Program

The Concurrent Review Program is completely voluntary for BCBSF and Insureds. Under this UM/UR program, BCBSF may (but shall not be required to) review Hospital stays and other health care treatment programs during the course of such stay or treatment program. Any such review is conducted solely to determine whether BCBSF should continue coverage and/or payment for a particular admission. Using established criteria then in effect, concurrent review of the Hospital stay may occur at regular intervals. In those instances where BCBSF administers the program, BCBSF will provide the Insured's Physician with notification when BCBSF's criteria under this program for coverage and payment for continued inpatient care are no longer met. In administering the Concurrent Review Program, BCBSF may review specific medical facts or information and assess, among other things, the appropriateness, health care setting and/or the level of care, of a Hospital admission or other health care treatment programs. Such coverage and/or payment determinations made by BCBSF, and any reviews or assessments of specific medical facts or information which it conducts, are solely for purposes of making such coverage or payment decisions under this Contract and not for the purpose of recommending or providing medical care.

Discharge Planning

The Discharge Planning Program is completely voluntary for BCBSF and Insureds. Under this UM/UR program, BCBSF may (but shall not be required to) assist the Insured and the Insured's Physician identify health care resources which may be available in the Insured's community following hospitalization. BCBSF will, upon request, answer questions the Insured's Physician has regarding the Insured's coverage or benefits under this Contract following discharge from the Hospital.

Case Management Program

This program may be made available by BCBSF, in its sole discretion, for those Insureds who have a catastrophic or chronic Condition. Under this voluntary program, BCBSF may elect to (but is not required to) offer alternative benefits or payment for cost-effective Health Care Services. These alternative benefits or payments may be made available by BCBSF on a case-by-case basis to Insureds who meets BCBSF's criteria then in effect. Such alternative benefits or payments, if any, will be made available in accordance with a treatment plan with which the Insured, or a representative of the Insured acceptable to BCBSF, and the Insured's Physician agree to in writing.

BCBSF's offering to provide or providing of any alternative benefits or payments in no way obligates BCBSF to continue to provide such alternative benefit payments, or to provide alternative benefits or payments to the Insured or any other person insured by BCBSF at any time. Nothing contained in this section shall be deemed a waiver of BCBSF's right to enforce this Contract in strict accordance with its terms. The terms of this Contract will continue to apply, except as specifically modified in writing by BCBSF, when alternative benefits or payments under this program are made available.

Appeal Process

The Insured, a treating Physician or a Hospital may request that BCBSF review a UM/UR Program coverage/or payment decision, provided such request is received by BCBSF in writing within 90 days of the date of the decision. The review request must include all information deemed relevant or necessary by BCBSF. BCBSF will review the decision in light of such information and notify the Insured or the Insured's representative, the Hospital and/or the Physician of the review decision.

MEDICAL NECESSITY

In order for Health Care Services to be covered under this Contract, such services must be: 1) not otherwise limited or excluded under this Contract; 2) rendered while coverage is in force; 3) within the service categories set forth in the Covered Services Section; and 4) Medically Necessary, as defined by BCBSF.

It is important to remember that any review of Medical Necessity by BCBSF is solely for the purposes of determining coverage or benefits under this Contract and not for the purpose of recommending or providing medical care. In this respect, BCBSF may review specific medical facts or information pertaining to an Insured. Any such review, however, is strictly for the purpose of determining, among other things, whether a Health Care Service provided or proposed meets BCBSF's coverage and payment guidelines then in effect.

All decisions that require or pertain to independent professional medical/clinical judgement or training, or the need for medical services, are solely the responsibility of the Insured and the Insured's treating Physicians and health care Providers. Insureds and their Physicians are responsible for deciding what medical care should be rendered or received and when that care should be provided. BCBSF is solely responsible for determining whether expenses incurred, or to be incurred, for medical care are, or would be, covered under this Contract. In making coverage decisions, BCBSF shall not be deemed to participate in or override the medical decisions of an Insured or an Insured's health care Providers.

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

1. continued hospitalization 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 the treatment plan;

3. hospitalization because supervision in the home, or care in the home, is inconvenient; or hospitalization for any service which could have been provided adequately in an alternate setting (e.g., Hospital outpatient department); or

4. inpatient admissions to a Hospital, Skilled Nursing Facility, or any other facility for the purpose of Custodial Care, convalescent care, or any other service primarily for the convenience of the patient and/or his/her family members or the Provider.

NOTE: Whether or not a Health Care Service is specifically listed as an exclusion, the fact that a Provider may prescribe, recommend, approve, or furnish a Health Care Service does not mean that the service is Medically Necessary (as defined by BCBSF) or a Covered Service. Please refer to the Glossary of Terms for the definitions of "Medically Necessary" or "Medical Necessity".

COVERED SERVICES

Introduction

The following subsections describe the Health Care Services which may be Covered Services under this Contract. All benefits for Covered Services are subject to the Insured's applicable financial responsibilities, benefit maximums (e.g., Calendar Year Deductible and Lifetime Maximum), the applicable Allowed Amount, limitations, exclusions, and all other provisions contained in this Contract (including the Schedule of Benefits) in accordance with BCBSF's Medical Necessity criteria and guidelines then in effect.

Expenses for the Health Care Services listed below will be covered under this Contract only if the services are:

1. within the services categories set forth in this Covered Services Section;
2. rendered by an appropriate licensed health care Provider who is recognized for payment by BCBSF;
3. Medically Necessary, as defined in this Contract and determined by BCBSF;
4. rendered while an Insured's coverage is in force; and
5. not specifically or generally limited (e.g., Pre-existing Condition exclusionary period) or excluded under this Contract.

Note: More than one limitation or exclusion may apply to a specific Health Care Service or a particular situation.

Under most circumstances, BCBSF will determine whether Health Care Services are Covered Services under this Contract when processing an Insured's claim after the Insured has obtained such services and a claim has been received by BCBSF for such services. In some circumstances, BCBSF may, but is not required to, determine whether Health Care Services are Covered Services under this Contract before the Insured is provided the service. For example, BCBSF may determine whether a proposed transplant is a Covered Service under this Contract before such transplant is provided.

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

BCBSF's Benefit Guidelines

In providing benefits for Covered Services, BCBSF may apply the benefit guidelines set forth below as well as any other applicable reimbursement rules specific to particular categories of Health Care Services:

1. BCBSF's reimbursement for certain Health Care Services is included within the Allowed Amount for the primary procedure, and therefore no additional amount is payable by BCBSF for any such services and/or supplies.

2. BCBSF's reimbursement is based on the Allowed Amount for the actual service rendered (i.e., not based on the Allowed Amount for a service which is more complex than the service actually rendered), and is not based on the method utilized to perform the service nor the day of the week nor the time of day the procedure is performed.

3. BCBSF's reimbursement for a service includes all components of the service when such service can be described by a single procedure code, or when the service is an essential or integral part of the associated therapeutic/diagnostic service.

Covered Services Categories

The Health Care Services listed below may be Covered Services under this Contract. For ease of reference, limitations and exclusions which apply to specific services have been included in this section. Any specific limitations and/or exclusions included in this section are in addition to any other limitations and/or exclusions listed in this Contract including those listed in the General Exclusions Section.

- **Accident Care**

  Health Care Services to treat an injury resulting from an Accident not related to an Insured's job or employment.

  Exclusion
  Health Care Services to treat an injury resulting from an Accident related to an Insured's job or employment are excluded except for 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.

- **Adult Wellness** services for an adult (i.e., age 17 and older), includes the following:

  1. annual physical or gynecological exam;

  2. related wellness services (e.g., pap smears, Prostate Specific Antigen PSA, x-rays, laboratory services, and immunizations). Routine vision and hearing examinations and screenings are not covered.

  The adult wellness services above are not subject to the Individual Calendar Year Deductible, but are subject to the Copayment requirement, or applicable Coinsurance Responsibility depending on the location of service and the Provider participating status.

  Benefits for Adult Wellness services are limited as set forth in the Schedule of Benefits.

Exclusion
Preventive care or routine screening services, except as specified in the Covered Services Section of this Contract and the Schedule of Benefits, are not covered.

- **Allergy Testing and Treatments**

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

- **Ambulance Services**

Ambulance services to transport an Insured from:

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

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

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

- **Ambulatory Surgical Centers**

Health Care Services rendered at an Ambulatory Surgical Center including:

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

8. transfusion supplies and equipment;

9. diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG); and

10. chemotherapy treatment for proven malignant disease.

- **Anesthesia Administration Services**

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

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

- **Breast Reconstructive Surgery**

Breast Reconstructive Surgery and implanted prostheses incident to Mastectomy. In order to be covered, such surgery must be provided in a manner chosen by the Insured's Physician, consistent with prevailing medical standards, and in consultation with the Insured.

- **Child Cleft Lip and Cleft Palate Treatment**

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

- **Child Health Supervision Services:**

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

1. periodic examinations, which include a history, a physical examination, and a developmental assessment and anticipatory guidance necessary to monitor the normal growth and development of a child;

2. oral and/or injectable immunizations; and

3. laboratory tests normally performed for a well child.

In order to be covered, services shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

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

- **Complications of Pregnancy**

Health Care Services provided to an Insured for the treatment of complications of pregnancy may be Covered Services. Coverage for complications of pregnancy is limited to Covered Services to treat the Condition caused by the complication. Coverage of maternity care is not included in care of the Condition unless delivery is required to resolve the Condition. Additionally, coverage for complications of pregnancy are subject to any Pre-existing Condition limitations. For purposes of this section, the phrase "complications of pregnancy" means a Condition which is diagnosed as a separate Condition from the pregnancy.

Complications of pregnancy include, but are not limited to:

1. acute nephritis;
2. nephrosis;
3. cardiac decompensation;
4. eclampsia (toxemia with convulsions);
5. ectopic pregnancy;
6. uncontrolled vomiting requiring fluid replacement;
7. therapeutic and missed abortion (i.e., termination of pregnancy before the time of fetal viability due to danger to the pregnant woman or when the pregnancy would result in the birth of an infant with grave malformation);
8. Conditions which may require other than a vaginal delivery, such as:
    a. uterine wound separation
    b. premature labor unresponsive to tocolytic therapy;
    c. failed trial labor;
    d. dystocia (i.e., cephalopelvic disproportion, failure to progress, dysfunctional labor);
    e. fetal distress requiring neonatal support/intervention;
    f. breech presentation where external version is unsuccessful;
    g. active clinical herpes at delivery;
    h. placenta previa;
    i. transverse lie where external version is unsuccessful;

j. presence of fetal anomaly;

9. tubal pregnancy;

10. miscarriages; or

11. medical and surgical Conditions of similar severity;

12. Medically Necessary non-elective cesarean section.

Complications of pregnancy do not include:

1. false labor;

2. occasional spotting;

3. bed rest prescribed by a Physician;

4. morning sickness/hyperemesis gravidarum;

5. pre-eclampsia (protein in urine, sudden increase in weight, continual increase in blood pressure without convulsions);

6. similar problems associated with difficult pregnancy; or

7. elective cesarean sections which are not Medically Necessary and are performed primarily for the convenience of the Insured.

Note: This Contract does not provide coverage or benefits for maternity/obstetrical care unless the Contractholder purchased such coverage under the Optional Maternity/Obstetrical Care Benefits Endorsement.

- **Concurrent Physician Care**

Physician medical services, provided: (a) the additional Physician actively participates in the Insured's treatment; (b) the Condition involves more than one body system or is so severe or complex that one Physician cannot provide the care unassisted; and (c) the Physicians have different specialties or have the same specialty with different sub-specialties.

- **Consultations**

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

- **Dental**

Dental Care is limited to the following:

1. Care and treatment initiated within 62 days of an Accidental Dental Injury provided such services are for the treatment of damage to sound natural teeth.

2. Anesthesia services for dental care including general anesthesia and hospitalization services necessary to assure the safe delivery of necessary dental care provided to an Insured in a Hospital or Ambulatory Surgical Center if:

   a. the Insured is under 8 years of age when it is determined by a dentist and the Insured's Physician that dental treatment is necessary due to a dental Condition that is significantly complex, or the Insured has a developmental disability in which patient management in the dental office has proven to be ineffective; or

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

- **Diabetes Outpatient Self-Management**

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

- **Diagnostic Services**

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

1. radiology, ultrasound and nuclear medicine, Magnetic Resonance Imaging (MRI);

2. laboratory and pathology services;

3. services involving bones or joints of the jaw (e.g., services to treat temporomandibular joint TMJ dysfunction) or facial region if, under accepted medical standards, such diagnostic services are necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury;

4. approved machine testing (e.g., electrocardiogram EKG, electroencephalograph EEG, and other electronic diagnostic medical procedures);

5. genetic testing for the purposes of explaining current signs and symptoms of a possible hereditary disease.

- **Dialysis Services**

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

- **Durable Medical Equipment**

  Durable Medical Equipment when provided by a Durable Medical Equipment Provider and when prescribed for an Insured by a Physician, limited to the most cost effective Durable Medical Equipment, which meets the Insured's needs as determined by BCBSF.

  Reimbursement Guidelines for Durable Medical Equipment

  Supplies and services to repair medical equipment may be Covered Services only if the Insured owns the equipment or is purchasing the equipment. BCBSF's reimbursement amount for Durable Medical Equipment will be the lowest of the following: (1) the purchase price; (2) the lease/purchase price; (3) the rental rate; or (4) BCBSF's Allowed Amount. BCBSF's Allowed Amount for such rental equipment will not exceed the total purchase price. Durable Medical Equipment includes, but is not limited to, the following: wheelchairs, crutches, canes, walkers, hospital beds, and oxygen equipment.

  Repair or replacement of Durable Medical Equipment due to growth of a child or due to a change in the Insured's Condition is a Covered Service.

  Exclusion

  Equipment which is primarily for the convenience and/or comfort of the Insured, the Insured's family or caretakers; modifications to motor vehicles and/or homes such as wheelchair lifts or ramps; electric scooters; water therapy devices such as Jacuzzis, hot tubs, swimming pools or whirlpools; exercise and massage equipment; 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 and dehumidifiers.

- **Enteral Formulas (Low Protein Food Products)**

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

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

  Benefits for low protein food products are limited as set forth in the Schedule of Benefits.

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 or disease to an Insured's eyes.

Exclusion

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

Home Health Care

The following Home Health Care Services only when: 1) provided directly by (or indirectly through) a Home Health Agency licensed pursuant to Part IV Chapter 400 of the Florida Statutes or another state's applicable laws; 2) the Insured's Physician submits a written treatment plan to BCBSF; 3) the treatment plan is acceptable to BCBSF for coverage and payment purposes; and 4) the Insured is confined to home and is unable to carry out the basic activities of daily living.

1. part-time or intermittent nursing care by a Registered Nurse or Licensed Practical Nurse;
2. home health aide services;
3. medical social services;
4. nutritional guidance;
5. respiratory, or inhalation therapy (e.g., oxygen);
6. Physical Therapy by a Physical Therapist, Occupational Therapy by a Occupational Therapist, and Speech Therapy by a Speech Therapist.

Benefits for Covered Services for Home Health Care are limited as set forth in the Schedule of Benefits.

Exclusion

1. any Home Health Care service which is not directly provided by (or indirectly provided) through a Home Health Agency;
2. homemaker services;

3. domestic maid services;
4. sitter services;
5. companion services;
6. 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;
7. Custodial Care; or
8. food, housing, and home delivered meals.

- **Hospice Services**

Health Care Services provided to an Insured in connection with a Hospice treatment program may be Covered Services, provided the Hospice treatment program is approved by the Insured's Physician and the Insured is not expected to live more than one year. BCBSF shall have the right to request that an Insured's Physician certify in writing the life expectancy of an Insured.

Benefits for Covered Services for Hospice are limited as set forth in the Schedule of Benefits.

- **Hospital Services**

Hospital services including:

1. room and board in a semi-private room when confined as an inpatient, unless the patient must be isolated from others for documented clinical reasons;
2. intensive care units, including cardiac, progressive and neonatal care;
3. use of operating and recovery rooms;
4. use of emergency rooms;
5. respiratory, pulmonary, or inhalation therapy (e.g., oxygen);
6. drugs and medicines administered (except for take home drugs) by the Hospital;
7. intravenous solutions;
8. administration of, including the cost of, whole blood or blood products;
9. dressings, including ordinary casts;
10. anesthetics and their administration;
11. transfusion supplies and equipment;

12. diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);

13. chemotherapy and radiation treatment for proven malignant disease;

14. Physical, Speech, Occupational, Cardiac therapies; and

15. transplants as set forth in the Transplant Section.

Exclusion

Expenses for the following Hospital Health Care Services are excluded when such services could have been provided without admitting the Insured to the Hospital: 1) room and board provided during the Insured's admission; 2) Physician visits provided while the Insured was an inpatient; or 3) Occupational Therapy, Speech Therapy, Physical Therapy, and Cardiac Therapy.

In addition, expenses for the following are also excluded:

1. gowns and slippers;

2. shampoo, toothpaste, body lotions and hygiene packets;

3. take-home drugs;

4. telephone and television;

5. guest meals or gourmet menus; and

6. admission kits.

Note: This Contract does not provide coverage or benefits for maternity/ obstetrical care unless the Contractholder purchased such coverage under the Optional Maternity/Obstetrical Care Benefits Endorsement.

- **Mammograms**

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

Benefits for Mammograms are not subject to the Calendar Year Deductible, Coinsurance, or Copayment.

- **Mastectomy Services**

Breast cancer treatment including treatment for physical complications relating to a Mastectomy (including lymphedemas), and outpatient post-surgical follow-up care in accordance with prevailing medical standards as determined by the Insured's attending Physician and the Insured. Outpatient post-surgical follow-up care for

Mastectomy services shall be covered when provided by a Provider in accordance with the prevailing medical standards and at the most medically appropriate setting. The setting may be the Hospital, Physician's office, outpatient center, or home of the Insured. The treating Physician, after consultation with the Insured, may choose the appropriate setting.

- **Mental Health Services**

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

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

Benefits for care and treatment of Mental and Nervous Disorders are limited as set forth in the Schedule of Benefits.

Exclusion

1. services rendered in connection with a Condition not classified in the most recently published version of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association;
2. services extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation;
3. services for marriage and juvenile counseling;
4. services for court ordered care or testing, or required as a condition of parole or probation, unless otherwise covered;
5. services for testing of aptitude, ability, intelligence or interest;
6. services for testing and evaluation for the purpose of maintaining employment; or
7. services for cognitive remediation.

- **Newborn Care**

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

Newborn Assessment

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

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

- **Orthotic Devices**

Orthotic Devices including braces and trusses for the leg, arm, neck and back, and special surgical corsets when prescribed by a Physician.

Benefits may be provided for necessary replacement of an Orthotic Device which is owned by the Insured when due to irreparable damage, wear, a change in the Insured's Condition, or when necessitated due to growth of a child.

Reimbursement for splints for the treatment of temporomandibular joint ("TMJ") dysfunction is limited to payment for one splint in a six month period unless determined by BCBSF to be Medically Necessary.

Exclusion Expenses for the following are excluded:

Arch Supports, orthopedic 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.

- **Osteoporosis Screening, Diagnosis, and Treatment**

Screening, diagnosis, and treatment of osteoporosis for high-risk individuals, including, but not limited to, estrogen-deficient individuals who are at clinical risk for osteoporosis, individuals who have vertebral abnormalities, individuals who are receiving long-term glucocorticoid (steroid) therapy, individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis.

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

1. Outpatient therapies listed below when ordered by a Physician or other health care professional licensed to perform such 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. **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.

Reimbursement Guidelines for Physical Therapy
Physical Therapy services are limited to 4 modalities per day not to exceed the benefit maximum set forth on the Schedule of Benefits.

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

Reimbursement Guidelines for Massage Therapy
Massage Therapy services are limited to 4 modalities per day not to exceed the benefit maximum set forth on the Schedule of Benefits.

e. **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.

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

Reimbursement for spinal manipulations
Spinal manipulations are limited to 26 spinal manipulations per Calendar Year, or the combined outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations benefit maximum set forth in the Schedule of Benefits, whichever occurs first.

The Schedule of Benefits sets forth the maximum amount that BCBSF will pay for any combination of the outpatient therapies and spinal manipulation services listed above. The outpatient Cardiac, Occupational, Physical, Massage and Speech Therapy and Spinal Manipulation benefits specified above are in addition to the Cardiac, Occupational, Physical and Speech Therapy benefits listed in the Home Health Care, Hospital, and Skilled Nursing Facility subsections herein.

- **Oxygen**

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

- **Physician Services**

  Medical or surgical Health Care Services provided by a Physician.

  Note: This Contract does not provide coverage or benefits for maternity/ obstetrical care unless the Contractholder purchased such coverage under the Optional Maternity/Obstetrical Care Benefits Endorsement.

- **Prosthetic Devices**

  The following Prosthetic Devices are covered when prescribed by a Physician:

  1. artificial hands, arms, feet, legs and eyes, including permanent implanted lenses following cataract surgery;

  2. appliances needed to effectively use artificial limbs or corrective braces;

  3. penile prosthesis and surgery to insert penile prosthesis when necessary in the treatment of organic impotence resulting from treatment of prostate cancer, diabetes mellitus, peripheral neuropathy, medical endocrine causes of impotence, arteriosclerosis/postoperative bilateral sympathectomy, spinal cord injury, pelvic-perineal injury, post-prostatectomy, post-priapism, epispadias, and exstrophy.

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

  Covered Prosthetic Devices (except cardiac pacemakers and prosthetic devices incident to Mastectomy) are limited to the first such permanent prosthesis prescribed for each specific Condition. The first temporary prosthesis is also covered if it is determined to be Medically Necessary.

- **Skilled Nursing Facilities**

  The following Health Care Services may be Covered Services when: 1) the Insured is an inpatient in a Skilled Nursing Facility; and 2) the Insured's Physician submits a treatment plan that is acceptable to BCBSF for coverage and payment purposes:

  1. room and board;

  2. respiratory, pulmonary, or inhalation therapy (e.g., oxygen);

  3. drugs and medicines administered while an inpatient (except take home drugs);

4. intravenous solutions;

5. administration of, including the cost of, whole blood or blood products;

6. dressings, including ordinary casts;

7. transfusion supplies and equipment;

8. diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);

9. chemotherapy treatment for proven malignant disease; and

10. Physical, Speech, and Occupational Therapy;

Benefits for Covered Services at a Skilled Nursing Facility are limited as set forth in the Schedule of Benefits.

Exclusion
Expenses for an inpatient admission to a Skilled Nursing Facility for purposes of Custodial Care, convalescent care, or any other service primarily for the convenience of the patient and/or his/her family members or the Provider. Expenses for any inpatient days beyond the per Insured per Calendar Year maximum as set forth on the Schedule of Benefits are also excluded.

Note: Cardiac Therapy is not covered in a Skilled Nursing Facility.

- **Substance Dependency Care and Treatment**

Substance Dependency Care and Treatment including:

1. Health Care Services (inpatient and outpatient or any combination thereof) provided to an Insured by a Physician, Psychologist in a program accredited by the Joint Commission of the Accreditation of Healthcare Organizations or approved by the State of Florida for the Detoxification or Substance Dependency Care and Treatment.

2. Physician and Psychologist outpatient visits for the care and treatment of substance dependency.

Benefits for Substance Dependency Care and Treatment are limited as set forth in the Schedule of Benefits.

Exclusion
Expenses for Substance Dependency Care and Treatment in excess of the maximum amount set forth on the Schedule of Benefits for treatment of alcoholism or drug addiction, including prolonged treatment in a specialized inpatient or residential facility.

- **Surgical Assistant Services**

  Services rendered by a Physician, Registered Nurse First Assistant or Physician Assistant when acting as a surgical assistant (provided no intern, resident, or other staff physician is available) when the assistant is necessary. The Allowed Amount for such is limited to 20 percent of the surgical procedure's Allowed Amount.

- **Surgical Procedures**

  Surgical procedures performed by a Physician including the following:

  1. sterilization (tubal ligations and vasectomies), regardless of Medical Necessity;
  2. surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes;
  3. oral surgical procedures for excisions of tumors, cysts, abscesses, and lesions of the mouth;
  4. surgical procedures involving bones or joints of the jaw (e.g., temporomandibular joint TMJ) and facial region if, under accepted medical standards, such surgery is necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury;
  5. surgical procedures performed on an Insured for the treatment of Morbid Obesity (e.g., intestinal bypass, stomach stapling, balloon dilation) and the associated care provided the Insured has not previously undergone the same or similar procedure in their lifetime;

     Exclusion
     Surgical procedures performed to revise, or correct defects related to, a prior intestinal bypass, stomach stapling or balloon dilation not covered under this Contract are also excluded.

  6. services of a Physician for the purpose of rendering a second surgical opinion and related diagnostic services to help determine the need for surgery.

  BCBSF's Reimbursement Guidelines for Surgical Procedures

  a. reimbursement for multiple surgical procedures, performed on the same or different areas of the body, during the same operative session will be limited to 50 percent of the Allowed Amount for the primary procedure. This guideline is applicable to all bilateral procedures and all surgical procedures performed on the same date of service;

  b. reimbursement 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 the opinion of BCBSF, is not clearly identified and/or does not add significant time or complexity to the surgical session. For example, the removal of a normal appendix performed in conjunction with a medically necessary hysterectomy is an Incidental Surgical Procedure (i.e., there is no reimbursement for the removal of the normal appendix in the example); and

c. reimbursement for surgical procedures for fracture care, dislocation treatment, debridement, wound repair, unna boot, and other related Health Care Services, is included in the Allowed Amount of the surgical procedure.

- **Transplant Services**

Limited to the procedures listed below, if coverage has been predetermined by BCBSF and if performed at a facility acceptable to BCBSF, subject to the conditions and limitations described below:

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

1. Bone Marrow Transplant, as defined herein, which is specifically listed in Rule 59B-12.001 of the *Florida Administrative Code* (or any successor rule or regulation) or covered by Medicare as described in the most recently published *Medicare Coverage Issues Manual* issued by the Health Care Financing Administration. BCBSF will cover the cost of donating bone marrow by a donor to an Insured to the same extent such cost would be covered for an Insured and subject to the same limitations and exclusions as would be applicable to an Insured. Coverage for the reasonable costs 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;

8. pancreas transplant performed simultaneously with a kidney transplant; or

9. lung-whole single or whole bilateral transplant.

In order to ensure that a proposed transplant is covered, the Insured should notify or the Insured's Physician should notify BCBSF in advance of the Insured's initial evaluation for the procedure. Corneal and kidney transplants only, do not require prior benefit determination.

BCBSF will make a prior benefit determination concerning the proposed transplant, however, BCBSF must be given the opportunity to evaluate the clinical results of the Insured's initial evaluation for the transplant as well as any applicable protocols. If BCBSF is not given an opportunity to make the prior benefit determination, the transplant may be subject to a reduction in payment in accordance with the rules set forth in the Individual Utilization Management/Utilization Review Section. Once coverage for the transplant is predetermined, BCBSF will advise the Insured or the Insured's Physician of the coverage decision.

For covered transplants, and all related complications, BCBSF will cover:

1. Hospital and Physician expenses provided that such services will be paid in accordance with the same terms and conditions for care and treatment of any other covered Condition.

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

Insureds may call the customer service phone number indicated on the front cover of this Contract or on the Insured's Identification Card in order to determine which Bone Marrow Transplants are covered under this Contract.

Exclusion

The following are excluded:

1. transplant procedures not included in the list above, or otherwise excluded under this Contract (e.g., Experimental or Investigational transplant procedures);

2. transplant procedures involving the transplantation or implantation of any non-human organ or tissue;

3. transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered by BCBSF;

4. transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ;

5. any organ, tissue, marrow, or stem cells which is/are sold rather than donated to the Insured;

6. any Bone Marrow Transplant, as defined herein, which is not specifically listed in Rule 59B-12.001 (or any successor rule or regulation) of the *Florida Administrative Code* or covered by Medicare pursuant to a national coverage decision made by the Health Care Financing Administration 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. The reasonable cost of searching for a donor is covered and will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;

8. any transportation costs for the Insured or the Insured's family to and from the approved facility;

9. any direct, non-medical costs for the Insured to and from the approved facility;

10. any temporary lodging; and

11. any artificial heart devices (if used as a bridge to transplant).

GENERAL EXCLUSIONS

Introduction

The following subsections describe Health Care Services for which expenses are excluded. These exclusions are in addition to any exclusions specified in the Covered Services Section.

General Exclusions include, but are not limited to:

1. any Health Care Service received prior to an Insured's Effective Date or after the date an Insured's coverage terminates;

2. any Health Care Services to treat a Condition excluded under a Rider issued with this Contract;

3. any Health Care Services not specifically listed in the Covered Services Section or in any Endorsement issued with this Contract, unless such services are specifically required to be covered by applicable law;

4. any Health Care Services provided by a Physician or other health care Provider related to the Insured by blood or marriage;

5. any Health Care Service which is not Medically Necessary as defined in this Contract and determined by BCBSF. The ordering of a service by a health care Provider does not in itself make such service Medically Necessary or a Covered Service;

6. any Health Care Service for treatment of non-medical Conditions related to hyperkinetic syndromes, learning disabilities, mental retardation, or inpatient confinement for environmental change;

7. Experimental or Investigational services, except as otherwise covered under the Bone Marrow Transplant provision of the Transplant Services subsection, and except for any drug prescribed for the treatment of cancer that has been approved by the Federal Food and Drug Administration (FDA) for at least one indication, provided the drug is recognized for treatment of the Insured's cancer in a Standard Reference Compendium or recommended for treatment of the Insured's cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded;

8. any Health Care Services to treat a work related Condition to the extent the Insured is covered or required to be covered by Workers' Compensation law. Any Health Care Service to diagnose or treat any Condition resulting from or in connection with an Insured's job or employment will not be covered, 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;

9. any Health Care Services rendered at no charge;

10. any Health Care Service to diagnose or treat any Condition which initially occurred while an Insured was (or which, directly or indirectly, resulted from, or is in connection with, an Insured being) under the influence of alcoholic beverages, any chemical substance set forth in Section 877.111 of the *Florida Statutes*, or any substance controlled under Chapter 893 of the *Florida Statutes* (or, with respect to such statutory provisions, any successor statutory provisions). Notwithstanding, this exclusion shall not apply to the use of any prescription medication by the Insured if such medication is taken on the specific advice of a Physician in a manner consistent with such advice;

11. any Health Care Services to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with:

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

    b. the Insured's participation in, or commission of, any act punishable by law as a felony, or which constitutes riot, or rebellion;

    c. the Insured's engaging in an illegal occupation;

    d. services received at military or government facilities including service in the armed forces, reserves and/or National Guard;

    e. the Insured being under the influence of alcohol or any narcotic, unless taken on the specific advice of a Physician in a manner consistent with such advice; or

    f. an intentionally self-inflicted Condition, suicide or attempted suicide, whether the Insured is sane or insane.

12. court ordered care or treatment, unless otherwise covered;

13. any Health Care Services rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group.

Additional General Exclusions

Expenses for the following Health Care Services are also excluded. These exclusions are in addition to any exclusions specified above and in the Covered Services Section.

Abortion, by choice; not Medically Necessary.

Arch Supports, orthopedic 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.

Autopsy or postmortem examination services, unless specifically requested by BCBSF.

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

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

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

Contraceptive medications, devices, and appliances, 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 subsection), including without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A), and hair implants/transplants.

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

Custodial Care, and any service of a custodial nature, including without limitation: Health Care Services primarily to assist the Insured in the activities of daily living; rest homes; home companions or sitters; home parents; domestic maid services; and respite care.

Dental 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 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, Child Cleft Lip and Cleft Palate Treatment Services.

Drugs:

1. Prescribed for uses other than the 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 the Insured's cancer in a Standard Reference Compendium or recommended for treatment of the Insured's cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.

2. All Drugs dispensed to, or purchased by, an Insured from a Pharmacy, except for Prescription Drugs as defined by, and covered under, the Mediscript® Pharmacy Program Endorsement or as otherwise covered when the Insured is inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility, or outpatient department of a Hospital.

3. Any non-Prescription medicine, remedy, vaccine, biological product (except insulin), pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, over the counter drugs, products, or health foods.

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

Genetic Screening, including the evaluation of genes of an Insured to determine if they are carriers of an abnormal gene that puts them at risk for a disease.

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

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

Maternity/Obstetrical Care including inpatient and outpatient maternity/obstetrical care services of a Midwife or Certified Nurse Midwife and/or Physician including prenatal care, delivery, and all services related to maternity/obstetrical care benefits and services or early termination of pregnancy unless the Contractholder purchased such coverage under the Optional Maternity/Obstetrical Care Benefits Endorsement.

Oral Surgery for the primary purpose of improving the appearance or self-perception of an individual, except as provided under the Covered Services Section.

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

Personal Comfort, Hygiene or Convenience Items and Services deemed to be not Medically Necessary and not directly related to the treatment of the Insured including, but not limited to; beauty and barber services; clothing, including support hose; radio and television; guest meals and accommodations; telephone charges; take-home supplies; travel expenses (other than Medically Necessary Ambulance services); motel/hotel accommodations; air conditioners; air or water purification systems; water softening systems; humidifiers; physical fitness equipment; hand rails and grab bars; and massages except as provided in the Covered Services Section of this Contract.

Private Duty Nursing Care rendered at any location.

Rehabilitative Therapies provided to an Insured on an inpatient or outpatient basis, except as provided in the following categories of the Covered Services Section: 1) Hospital; 2) Skilled Nursing Facility; 3) Home Health Care; and 4) Outpatient Cardiac, Occupational, Physical, Speech, Massage Therapies and Spinal Manipulations.

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

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

Smoking Cessation Programs, including any service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products (e.g., gum, transdermal patches, etc.).

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

Training and Educational Programs, or materials, including, but not limited to programs or materials for pain management and vocational rehabilitation.

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

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

Weight Control Services including any service to lose, gain, or maintain weight, including without limitation: any weight control/loss program; appetite suppressants; dietary regimens; food or food supplements; exercise programs; equipment; whether or not it is part of a treatment plan for a Condition. For coverage concerning treatment of Morbid Obesity, refer to the Surgical Procedures category of the Covered Services Section.

Wigs and/or cranial prosthesis.

Work Related Condition Services to the extent the Insured is covered or required to be covered by Workers' Compensation law. Any Health Care Service to diagnose or treat any Condition resulting from or in connection with an Insured's job or employment will not be covered under this Contract, 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.

Qualified Exclusion for AIDS and ARC

If, in the opinion of a Physician, an Insured either first exhibited objective manifestations of Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) which are not attributable to another cause or tested HIV positive, or was diagnosed as having AIDS or ARC, at any time prior to that Insured's first Anniversary Date, there is no coverage

under this Contract for any expense related, directly or indirectly, to AIDS or ARC. This exclusion is in addition to any other rights BCBSF has, including but not limited to, enforcement of the Pre-Existing Condition limitation provision, and rescission or cancellation of this Contract for fraud or Material Misrepresentation.

This exclusion shall not apply if:

1. BCBSF fails to assert this provision within the first two years of that Insured's coverage under this Contract;

2. BCBSF fails to notify the Insured, in writing, of the applicability of this provision within 90 days of BCBSF's determination that the Insured is subject to this provision.

Conditions Excluded by Rider

This Contract excludes coverage for Health Care Services related to any Condition that BCBSF excluded from coverage by a Rider when an Insured accepted coverage under this Contract.

Riders issued with a Contract are permanent. BCBSF may consider (but is not required to) removal of a Rider after the Insured has been covered under this Contract for at least two years providing that the ridered Condition is not permanent and there have been no symptoms or treatment for the Condition within the previous 24 months, nor does the Condition require periodic medical treatment or evaluation.

In order for BCBSF to consider removal of a Rider, a written request must be submitted along with current medical documentation from the Physician familiar with the Insured's health status, including the Condition that is ridered. Medical documentation must include the Physician's office notes as well as the results of all laboratory or other testing performed within the 24-month period immediately preceding the date of the request and must be provided at the Insured's expense.

ELIGIBILITY FOR COVERAGE

Any individual who meets and continues to meet BCBSF's eligibility requirements described in this Contract, shall be entitled to apply to become an Insured under this Contract. BCBSF may require acceptable documentation that an individual meets and continues to meet its eligibility requirements (e.g., court order naming the Contractholder as a legal guardian; proof of Florida residency; or "Adoption" documentation).

Eligibility Requirements for Contractholders

To be Eligible to be a Contractholder, a person must:

1. be bona fide resident of the State of Florida;
2. apply for and be named on the Individual Application for Health Insurance as a Contractholder;
3. determined by BCBSF to be Medically Acceptable;
4. pay the required Premiums; and
5. be under the age of 65 and not eligible for Medicare on the Effective Date of coverage.

Eligibility Requirements for Dependent(s)

An individual who meets the eligibility criteria for Eligible Dependents specified below is eligible to apply for coverage as an Eligible Dependent only if the individual: 1) was named on the Individual Application for Health Insurance; 2) was determined by BCBSF to be Medically Acceptable; 3) pays the required Premiums; 4) is under the age of 65 and not eligible for Medicare on the Effective Date of coverage:

1. the Contractholder's present spouse;
2. the Contractholder's natural, newborn, Adopted, foster, or step child(ren) (or a child for whom the Contractholder has been court-appointed as legal guardian or legal custodian) until the end of the Calendar Year, in which the child reaches age 19, and who is:
   a. dependent upon the Contractholder for financial support; and
   b. living in the household of the Contractholder; or
   c. a Full-Time Student.

3. the newborn child of an Insured other than the Contractholder or the newborn child of an Insured other than the Contractholder's spouse. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Note: It is the Insured's sole responsibility to establish that a child meets the applicable requirements for eligibility. Eligibility will terminate the end of the Calendar Year in which the child no longer meets the eligibility criteria required to be an Eligible Dependent.

Extension of Eligibility for Dependent Children

Students

A Covered Dependent child(ren) may be covered to the end of the Calendar Year in which the child(ren) reaches the limiting age of 23, if the child meets all of the following requirements:

1. the child is dependent on the Contractholder for support;

2. the child's legal residence is within the household of the Contractholder; and

3. the child is a Full-time Student.

Handicapped Children

A handicapped dependent child is eligible to continue coverage beyond the limiting age as a Covered Dependent if such child is otherwise eligible for coverage under this Contract, incapable of self-sustaining employment by reason of mental retardation or physical handicap, and chiefly dependent upon the Contractholder for support and maintenance provided that the symptoms or causes of such child's handicap existed prior to such child's 19th birthday. This eligibility shall terminate on the last day of the month in which the child does not meet the requirements for extended eligibility as a handicapped child.

Other Requirements/Rules Regarding Eligibility

1. No individual whose coverage with BCBSF has been terminated for cause or any other reason listed in the Termination of an Individual Coverage for Cause subsection of the Termination of an Individual Insureds Coverage Section, shall be eligible for coverage with BCBSF.

2. No person shall be refused enrollment or re-enrollment with BCBSF because of race, color, creed, marital status, sex, or age (except as provided in the Eligibility Requirements for Dependents subsection above).

3. The Contractholder must notify BCBSF as soon as possible when a Covered Dependent is no longer eligible for coverage (e.g., no longer a Full-time Student). If a Covered Dependent fails to continue to meet each of the eligibility requirements under this Contract, and such proper notification is not timely provided by the Contractholder to BCBSF, BCBSF shall have the right to retroactively terminate coverage of such dependent to the date any such eligibility requirement was not met, and to recover an

amount equal to the Allowed Amount for Health Care Services provided following such date less any Premiums and other applicable charges received by BCBSF for such dependent for coverage after such date. Upon BCBSF's request, the Contractholder shall provide proof, which is acceptable to BCBSF, of a Covered Dependent's continued eligibility for coverage.

4. Any applicant proposed for coverage who is found to be not Medically Acceptable to BCBSF will be excluded for coverage under this Contract by a Rider.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Any individual who is not properly enrolled hereunder shall not be covered under this Contract and BCBSF shall have no obligation whatsoever with respect to such individual.

Eligible individuals may enroll for coverage according to the provisions set forth below.

General Rules for Enrollment

1. All factual representations on the enrollment forms must be accurate and complete. Any false, incomplete, or misleading information provided during the enrollment process, or at any other time, may result, in addition to any other legal right(s) BCBSF may have, in disqualification for, termination of, or rescission of coverage.

2. BCBSF shall not be required to provide coverage and/or benefits to any individual who would not have been entitled to enrollment with BCBSF, had accurate and complete information been provided on a timely basis. In such cases, BCBSF may require such individual, or an individual legally responsible for that individual, to reimburse BCBSF for any payments made by BCBSF on behalf of such individual.

3. Eligibility for coverage under this Contract is determined by medical risk classifications applicable to the applicant and his or her dependents. Among the factors used when making an underwriting decision are the medical information requested on the application and, if applicable, results of a paramedical exam and/or medical records obtained from a Physician.

4. Material Misrepresentations, omissions, concealment of facts and incorrect statements made on an application or a medical statement by an applicant, Insured or a Contractholder which is discovered by BCBSF within two years of the issue date of the Contract may prevent payment of benefits under this Contract and may void this Contract for the individual making the misrepresentation, omission, concealment of facts or incorrect statement. Fraudulent misstatements in the application or medical statement discovered by BCBSF at any time, may result in this Contract being voided or claims being denied for the individual making or responsible for the fraudulent misstatement.

5. In the event of fraud or misrepresentation pertaining to, but not limited to, medical information, geographical area, or the sex and/or the age of applicant or his or her dependents made on an application or medical statement by an applicant, Contractholder or Insured, the sole liability of BCBSF shall be the return of any unearned Premium, less benefit payments. However, at our discretion, we may elect to cancel the Contract with 45 days prior written notice or continue this Contract provided that the Contractholder makes payment to us for the full amount of the Premium which would have been in effect had the true facts been stated by the applicant, Contractholder, or Insured.

Enrollment Forms/Electing Coverage

To apply for coverage, an eligible individual must:

1. complete and submit an Individual Application for Health Insurance form to BCBSF;
2. provide any additional information needed to determine eligibility, if requested by BCBSF;
3. pay the required Premium; and
4. complete and submit, the required forms necessary to add Eligible Dependents or delete Covered Dependents.

Dependent Enrollment

An individual may be added upon becoming an Eligible Dependent of a Contractholder.

1. **Newborn Child** To enroll a newborn child who is an Eligible Dependent, the Contractholder must submit a Member Status Change Request form to BCBSF prior to or during the 60-day period immediately following the date of birth. The Effective Date of coverage for a newborn child shall be the date of birth.

   If notice is given within 30 days following the date of birth, no additional Premium will be charged for coverage of the newborn child for the first 30 days of coverage. If notice is received within 31 to 60 days following the date of birth, BCBSF will charge the applicable Premium from the date of birth. Any Pre-existing Condition exclusionary period will not apply to a covered newborn child. A newborn child will be denied enrollment if notice is not given within 60 days following the date of birth of the newborn child.

   However, if notice is not provided within 60 days from the date of birth, the Contractholder may apply for coverage for the newborn child by completing and submitting an Individual Application for Health Insurance which is Medically Acceptable to BCBSF. If accepted, the Effective Date of coverage for the newborn child will be determined by BCBSF. The Contractholder must pay the additional Premium for coverage to be provided to the newborn child.

   NOTE: Coverage for a newborn child of an Insured other than the Contractholder or the Contractholder's spouse will automatically terminate 18 months after the birth of the newborn child.

2. **Adopted Newborn Child** To enroll an Adopted newborn child, the Contractholder must submit a Member Status Change Request form to BCBSF prior to or during the 60-day period immediately following the date of birth and pay the additional Premium, if any. The Effective Date of coverage for an Adopted newborn child, eligible for coverage, shall be the moment of birth, provided that a written agreement to adopt such child has been entered into by the Insured prior to the birth of such child, whether or not such an agreement is enforceable. Any Pre-existing Condition

exclusionary period will not apply. BCBSF may require the Contractholder to provide any information and/or documents which BCBSF deems necessary in order to administer this provision.

If the Adopted newborn child is enrolled within 30 days following the date of birth, Premium will not be charged for the first 30 days of coverage. If the Adopted newborn child is enrolled within 31 to 60 days following the date of birth, Premium will be charged from the moment of birth. An Adopted newborn child will be denied enrollment if notice is not given within 60 days following the date of birth of the Adopted newborn child.

However, if notice is not provided within 60 days from the date of birth, the Contractholder may apply for coverage for the Adopted newborn child by completing and submitting an Individual Application for Health Insurance which is Medically Acceptable to BCBSF. If accepted, the Effective Date of coverage for the newborn child will be determined by BCBSF. The Contractholder must pay the additional Premium for coverage to be provided to the newborn child.

For all children covered as Adopted children, if the final decree of Adoption is not issued, coverage shall not be continued for the proposed Adopted child under this Contract. Proof of final Adoption must be submitted to BCBSF. It is the responsibility of the Contractholder to notify BCBSF if the Adoption does not take place. Upon receipt of this notification, BCBSF will terminate the coverage of the Adopted newborn child on the first billing date following BCBSF's receipt of the written notice.

3. **Adopted/Foster Children** To enroll an Adopted child (other than a newborn) or Foster Child, the Contractholder must submit a Member Status Change Request form to BCBSF prior to or during the 60-day period immediately following the date of Placement and pay the additional Premium, if any. The Effective Date for an Adopted or Foster child (other than an Adopted newborn child) shall be the date such Adopted or Foster child is Placed in the residence of the Insured pursuant to Florida law. If timely notice is given, no additional Premium will be charged for coverage of the Adopted child for the duration of the notice period. Any Pre-existing Condition exclusionary period will not apply to an Adopted child but will apply to a Foster Child. BCBSF may require the Contractholder to provide any information and/or documents deemed necessary by BCBSF in order to properly administer this section.

   If the Adopted or Foster Child is enrolled within 30 days, Premium will not be charged for the first 30 days of coverage. If the Adopted or Foster Child is enrolled within 31 to 60 days, Premium will be charged from the date of Placement. An Adopted or Foster Child will be denied enrollment if notice is not given within 60 days of the date following Placement of the Adopted or Foster Child.

   However, if notice is not provided within 60 days from the date of Placement, the Contractholder may apply for coverage for the Adopted or Foster Child by completing and submitting an Individual Application for Health Insurance which is Medically Acceptable to BCBSF. If accepted, the Effective Date of coverage for the Adopted or Foster Child will be determined by BCBSF. The Contractholder must pay the additional Premium for coverage to be provided to the Adopted or Foster Child.

For all children covered as Adopted children, if the final decree of Adoption is not issued, coverage shall not be continued for the proposed Adopted Child. Proof of final Adoption must be submitted to BCBSF. It is the responsibility of the Contractholder to notify BCBSF if the Adoption does not take place. Upon receipt of this notification, BCBSF will terminate the coverage of the child on the first billing date following receipt of the written notice.

If the Contractholder's status as a foster parent is terminated, coverage shall not be continued for any Foster Child. It is the responsibility of the Contractholder to notify BCBSF that the Foster Child is no longer in the Contractholder's care. Upon receipt of this notification, BCBSF will terminate the coverage of the child on the first billing date following receipt of the written notice.

4. **Other Dependents** - If other Eligible Dependents were not named on the Individual Application for Health Insurance, the Contractholder may still apply for coverage for the Eligible Dependents. Eligible Dependents can become covered when the Contractholder files an Individual Application for Health Insurance form for coverage which is Medically Acceptable to BCBSF and the Contractholder pays an additional Premium for coverage of the new Dependent(s).

5. **Marital Status** A Contractholder may apply for coverage for an Eligible Dependent spouse due to marriage. To apply for coverage, the Eligible Dependent spouse must: 1) complete and submit the Individual Application for Health Insurance; 2) be determined by BCBSF to be Medically Acceptable; 3) pay the required Premium; and 4) be under the age of 65 and not eligible for Medicare on the Effective Date of coverage. The Effective Date of coverage will be determined by BCBSF.

6. **Court Order** A Contractholder may apply for coverage for an Eligible Dependent if a court has ordered coverage to be provided for a minor child by the Contractholder. To apply for coverage, an Individual Application for Health Insurance must be completed for the Eligible Dependent and he or she must be Medically Acceptable to BCBSF. If accepted, the Effective Date of coverage for the Eligible Dependent will be determined by BCBSF. The Contractholder must pay the additional Premium for coverage to be provided to the Eligible Dependent.

All dependents except those listed below who are added to the Contract after the Effective Date of coverage will be subject to the Pre-existing Condition exclusionary period contained in this Contract:

1. Adopted child or Adopted newborn child; and
2. natural newborn child.

Continuing Coverage on Termination of Eligibility

If coverage ceases because of termination of eligibility under this Contract, the Insured shall be entitled to be issued a Contract in his/her name without evidence of insurability, provided that application is made and Premiums are paid within 31 days after termination. There will be continuous coverage during the 31-day period, if such coverage is selected and the Premiums are paid. See also Contractholder's Responsibility for Notice of Insured Termination subsection of the Termination of an Individual Insured's Coverage Section.

TERMINATION OF AN INDIVIDUAL INSURED's COVERAGE

Termination of a Contractholder's Coverage

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

1. for failure to pay required Premium(s);
2. if BCBSF cancels all Contracts with this same form number;
3. on the date the Contractholder's coverage is terminated for cause (see the Termination of an Individual Coverage for Cause subsection); or
4. if the Contractholder ceases to reside for six months or more each Calendar Year in the State of Florida.

Termination of a Covered Dependent's Coverage

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

1. on the date the Contractholder's coverage terminates for any reason;
2. if the Covered Dependent fails to continue to meet any of the applicable eligibility requirements (e.g., a child reaches the limiting age, or a spouse is divorced from the Contractholder); or
3. on the date specified by BCBSF that the Covered Dependent's coverage is terminated by BCBSF for cause.

In the event the Contractholder wishes to delete a Covered Dependent from coverage, a Member Status Change Request form should be forwarded to BCBSF.

In the event the Contractholder wishes to terminate a spouse's coverage, (e.g., in the case of divorce), the Contractholder must submit a Member Status Change Request form to BCBSF.

Termination of an Individual's Coverage for Cause

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

1. fraud, intentional misrepresentation of material fact, or omission in applying for coverage or benefits;
2. the knowing misrepresentation, omission, or the giving of false information on the Individual Application for Health Insurance, Member Status Change Request form, or other forms completed for BCBSF, by or on behalf of the Insured;
3. misuse of the Identification Card;

4. a Covered Dependent reaches the limiting age as specified in the Eligibility for Coverage and Enrollment and Effective Date of Coverage Sections.

NOTE: Relative to a misstatement in the Individual Application for Health Insurance or Member Status Change Request form, after two years from the Insured's Effective Date, only fraudulent misstatements on the application may be used by BCBSF to void coverage or deny any claim for loss incurred or disability starting after the two year period.

Contractholder's Responsibility for Notice of Insured Termination

The Contractholder must notify BCBSF in writing immediately if any Covered Dependent ceases to meet all of the applicable eligibility requirements specified in the Eligibility for Coverage Section of this Contract, but no later than 31 days after the Covered Dependent ceases to be eligible for coverage. If notification of the change is received after the 31-day period from the date the Covered Dependent ceases to be eligible, the change will be made effective as of a current date and no Premiums will be refunded. See also the Continuing Coverage on Termination of Eligibility subsection of the Enrollment and Effective Date of Coverage Section.

Responsibilities of BCBSF Upon Termination of an Insured's Coverage

Upon termination of an Insured's coverage for any reason, BCBSF shall have no further liability or responsibility with respect to such individual, except as otherwise specifically set forth in this Contract.

Prior Carrier Responsibilities under an Extension of Benefits

If an Insured was covered by another health insurance company or plan prior to the coverage under this Contract, the prior health insurance company or plan, if any, may be required to provide certain benefits for Health Care Services which would otherwise be covered by this Contract under an extension of benefits provision. In no event shall BCBSF be responsible for the payment of any claims under this Contract for Health Care Services which are covered under any extension of benefits provision in the prior health insurance company's or plan's policy.

Conditions of Renewal and Termination

This Contract is conditionally renewable. This means that it automatically renews each year on the Anniversary Date unless terminated earlier in accordance with the terms of this Contract. BCBSF may terminate this Contract or refuse to renew it if:

1. Premiums are not paid in accordance with the terms of this Contract or BCBSF has not received timely Premium payments;

2. an Insured perform an act, or engage in any practice, that constitutes fraud or make an intentional misrepresentation of material fact; or

3. an Insured fail to comply with a material provision of the Contract.

If BCBSF decides to terminate the Contract or not renew it, based on one or more of the actions listed above, BCBSF will provide at least 45 days advance written notice.

Certification of Creditable Coverage

In the event coverage terminates for any reason, BCBSF will issue a written Certification of Creditable Coverage to the Insured.

The Certification of Creditable Coverage will indicate the period of time the Insured was enrolled with BCBSF. Creditable Coverage may reduce the length of any Pre-existing condition exclusion period by the length of time the Insured had prior Creditable Coverage.

Insureds may request another Certification of Creditable Coverage within a 24-month period after termination of coverage.

The succeeding carrier, if any, will be responsible for determining if this Contract meets the requirement for qualifying Creditable Coverage (e.g., no more than a 62-day break in coverage, similar coverage, etc.).

TERMINATION AND REINSTATEMENT OF THE ENTIRE CONTRACT

Termination Based on Failure to Return Rider

Failure of an Insured to return any medical exclusionary Rider form(s) issued by BCBSF as a Condition of coverage under this Contract, appropriately signed and dated, within 10 days of receipt, shall render this Contract null and void.

Termination Based on Discontinuation of Form

BCBSF may decide to discontinue this form, but may do so only if:

1. BCBSF provides notice to each Contractholder under this policy form in the individual market of such discontinuation at least 90 days prior to the date of the non-renewal of such coverage;

2. BCBSF offers to each Insured the option to purchase any other individual health care coverage currently being offered by BCBSF for individuals in such market in the State; and

3. in exercising the option to discontinue coverage of the policy form and in offering the option of other individual health care coverage, BCBSF acts uniformly without regard to any health-status-related factor of Insureds or individuals who may become eligible for such coverage.

Termination Based on Discontinuation of all Policies in Individual Market

BCBSF may terminate this Contract if it elects to terminate all of the policies it has issued in the individual market in this state. In that case, BCBSF will provide notice, at least 180 days prior to the date of non-renewal, to the Florida Department of Insurance and Contractholder. If BCBSF terminates coverage pursuant to this provision, any unused Premium will be returned to the Contractholder.

Defaults in Payments

In the event full payment of all Premiums required under this Contract are not paid when due, this Contract will automatically terminate immediately effective at the end of the grace period, as set forth and described in the General Provisions Section. In no event will termination relieve the Contractholder of his/her obligation under this Contract to pay BCBSF any prorated portion of the Premium applicable to the period of time during which BCBSF has provided benefits, or for any amounts otherwise due BCBSF.

Notice of Termination

A written notification of any termination of this entire Contract shall be mailed to the Contractholder. This notification shall state the reason for the termination.

Reinstatement of the Contract

This Contract may be reinstated, at the sole option of BCBSF, upon re-application by the Contractholder, and upon timely payment to BCBSF of the applicable Premiums.

DUPLICATION OF COVERAGE UNDER OTHER HEALTH PLANS/PROGRAMS

Coordination of Benefits

Coordination of Benefits ("COB") is a limitation on the coverage and/or benefits to be provided by BCBSF. COB also determines the manner in which expenses will be paid when an Insured is covered under more than one health plan, program, or policy providing benefits for Health Care Services. COB is designed to avoid the costly duplication of payment for Covered Services. Contracts which may be subject to COB include, but are not limited to, the following which will be referred to as "plan(s)" for purposes of this section:

1. any group 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 PIP insurance policy and/or medical payment coverage;

4. Medicare.

The amount of payment by BCBSF, if any, is based on whether or not BCBSF is the primary payer. When BCBSF is primary, BCBSF will pay for Covered Services without regard to the Insured's coverage under other plans. When BCBSF is other than primary, BCBSF's payment for Covered Services may be reduced so that total benefits under all such plans will not exceed 100 percent of the total reasonable expenses actually incurred for Covered Services. For purposes of this section, in the event an Insured receives Covered Services from a PPO Provider or a Traditional Insurance Provider, "total reasonable expenses" shall mean the amount BCBSF is obligated to pay to that Provider pursuant to the applicable agreement BCBSF has with such Provider. In the event that the primary payer's payment exceeds BCBSF's Allowed Amount for services rendered by such a Provider, no payment will be made under this Contract for such services.

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

1. When BCBSF covers the Insured as a Covered Dependent and the other plan covers the Insured as other than a dependent, BCBSF will be secondary.

2. When BCBSF covers a dependent child whose parents are not separated or divorced:

   a. the plan of the parent whose birthday, excluding year of birth, falls earlier in the year will be primary;

   b. if both parents have the same birthday, excluding year of birth, and the other plan has covered one of the parents longer than BCBSF, BCBSF will be secondary.

3. When BCBSF covers a dependent child whose parents are separated or divorced:

a. if the parent with custody is not remarried, the plan of the parent with custody is primary;

b. if the parent with custody has remarried, the plan of the parent with custody is primary; the step-parent's plan is secondary; and the plan of the parent without custody pays last;

c. regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is primary.

4. When BCBSF covers the Insured as a dependent child and the other plan covers the Insured as a dependent child:

   a. the plan of the parent who is neither laid off nor retired will be primary;

   b. if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.

5. When rules 1, 2, 3, and 4 above do not establish an order of benefits, the plan which has covered the Insured the longest shall be primary.

BCBSF will not coordinate benefits against an indemity-type policy, an excess insurance policy, a policy with coverage limited to specific illnesses or accidents, or a Medicare supplement policy.

Facility of Payment

Whenever payments which are due by BCBSF under this Contract are made by any other person, plan, or organization, BCBSF shall have the right, exercisable alone and in its sole discretion, to pay over to any such person, plan, or organization making such other payments, any amounts BCBSF shall determine to be required in order to satisfy its coverage obligations hereunder. Amounts so paid shall be deemed to be paid under this Contract and, to the extent of such payments, BCBSF shall be fully discharged from liability.

Non-Duplication of Government Programs

The coverage and/or benefits provided by BCBSF hereunder shall not duplicate any benefits to which the Insured is entitled to, eligible to, or eligible for under government programs (e.g., Medicare, Medicaid, Veterans Administration) to the extent that such Insured has been paid under any such programs. In the event BCBSF has duplicated such benefits, all sums paid or payable under such programs shall be paid or payable to BCBSF to the extent of such duplication.

SUBROGATION

Subrogation

If an Insured is injured or becomes ill as a result of another person's or entity's intentional act, negligence, or fault, the Insured must notify BCBSF concerning the circumstances under which the Insured was injured or became ill. The Insured or the Insured's lawyer must notify BCBSF, by certified or registered mail, if the Insured intends to claim damages from someone for injuries or illness. If the Insured recovers money to compensate for the cost/expense of Health Care Services to treat the Insured's illness or injury, BCBSF is legally entitled to recover payments made on the Insured's behalf to the doctors, hospitals, or other providers who treated the Insured. BCBSF's legal right to recover money it has paid in such cases is called "subrogation." BCBSF may recover the amount of any payments it made on the Insured's behalf minus its pro rata share for any costs and attorney fees incurred by the Insured in pursuing and recovering damages. BCBSF may subrogate against all money recovered regardless of the source of the money including but not limited to uninsured motorists coverage. Although BCBSF may, but is not required to, take into consideration any special factors relating to an Insured's specific case in resolving its subrogation claim, BCBSF shall have the first right of recovery out of any recovery or settlement amount the Insured is able to obtain even if the Insured or the Insured's attorney believes that he/she has not been made whole for his/her losses or damages by the amount of the recovery or settlement.

An Insured shall do nothing to prejudice BCBSF's right of subrogation hereunder and no waiver, release of liability, or other documents executed by the Insured, without notice to and written consent of BCBSF, shall be binding upon BCBSF.

RIGHT OF REIMBURSEMENT

Right of Reimbursement

If any payment under this Contract is made to or on behalf of an Insured on account of any injury or illness resulting from the intentional act, negligence, or fault of a third person or entity, BCBSF shall have a right to be reimbursed by the Insured (out of any settlement or judgement proceeds recovered which include payment for medical expenses) one dollar ($1.00) for each dollar paid under the terms of this Contract minus its pro rata share for any costs and attorney fees incurred by the Insured in pursuing and recovering such proceeds.

BCBSF's right of reimbursement shall be in addition to any subrogation right or claim available to BCBSF, and the Insured shall execute and deliver such instruments or papers pertaining to any settlement or claim, settlement negotiations, or litigation as may be requested by BCBSF to exercise its right of reimbursement hereunder. An Insured shall do nothing to prejudice BCBSF's right of reimbursement hereunder and no waiver, release of liability, or other documents executed by the Insured, without notice to and written consent of BCBSF, shall be binding upon BCBSF.

CLAIMS PROCESSING

How to File a Claim for Benefits/Time Requirement

PPO Providers and Traditional Insurance Providers have agreed to file with BCBSF claims for Health Care Services they rendered to Insureds. In the event a Provider who renders services to an Insured does not file a claim for such services, it is the Insured's responsibility to file the claim with BCBSF.

A claim must be received by BCBSF within 90 days of the date the service or supply was rendered, or if it is not reasonably possible to file the claim within such 90 day period, the Insured shall ensure that the claim is filed as soon as possible. In any event, no claim for Health Care Services will be considered for payment if, BCBSF does not receive the claim at the address indicated on the Insured's Identification Card within one year of the date the Health Care Service was rendered unless the Insured was legally incapacitated.

To file a claim, the Insured must obtain an itemized statement from the health care Provider and attach it to a completed BCBSF claim form. The Insured may obtain a BCBSF claim form by contacting the local BCBSF office. The itemized statement must contain the following information:

1. the date the service or supply was provided;
2. a description of the service or supply;
3. the amount actually charged by the Provider;
4. the diagnosis;
5. the Provider's name and address;
6. the patient's name; and
7. the Contractholder's name.

The itemized statement and claim form must be sent to BCBSF at the address indicated on the Insured's Identification Card:

NOTE: Special claims processing rules may apply, when amounts are payable by BCBSF for Health Care Services rendered outside the State of Florida, under the BlueCard® Program. (See the BlueCard® Program Section of this Contract)

The Processing of the Claim

Once BCBSF has received the completed claim, BCBSF will promptly process it. BCBSF will process all claims for which it has all of the necessary information, as determined by BCBSF, within 45 days of receipt of the completed claim for benefits (proof of claim). In the event BCBSF contests or denies the claim or a portion of the claim, or needs

additional information, BCBSF will so notify the Insured (or the Insured's assignee, if any assignment of benefits is required to be honored by BCBSF), within 45 days of receipt of the initial claim. The notice will identify the contested or denied portion of the claim and the reason(s) for contesting or denying the claim or a portion of the claim. It is the Insured's responsibility to ensure that BCBSF receives all information that BCBSF determines is necessary to complete claims processing of the claim. If BCBSF does not receive necessary information, a claim or a portion of a claim may be denied. BCBSF will complete the processing of the claim within 60 days of receipt of the additional information requested by BCBSF. In any event, all claims will be paid or denied 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 processing decision is deposited in the mail by BCBSF or otherwise electronically transmitted. Any claims payment not made by BCBSF within the applicable time frame is subject to the payment of simple interest at the rate of 10 percent per annum.

BCBSF will investigate any claim of improper billing by a Provider, upon written notification by an Insured. If BCBSF determines that the Insured was improperly billed, any payment amount will be adjusted, and if applicable, a refund will be requested. If payment to the Provider is reduced due solely to the notification from the Insured, BCBSF will pay the Insured 20 percent of the amount of the reduction, up to a total of $500.

The Review of Claims which are Denied

In the event BCBSF denies a claim, the Insured may request BCBSF to review the decision to deny the claim. The Insured must request such review within 60 days of receipt of the notice of the claim denial. The Insured should submit to BCBSF any additional information the Insured wants BCBSF to consider during the review. BCBSF will promptly notify the Insured of its review decision. The Insured may designate, in writing, an individual to represent the Insured during the review process.

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

Additional Claims Processing Provision

1. Release of Information/Cooperation

   In order to process claims, BCBSF may need information, including medical information, from the health care Provider who rendered the Health Care Service. Insureds shall cooperate with BCBSF in its effort to obtain such information by, among other ways, signing any release of information form as requested by BCBSF. Failure by an Insured to fully cooperate with BCBSF may result in a denial of the pending claim and BCBSF shall have no liability for such claim.

2. Physical Examination and Autopsy

In order to make coverage and/or benefit decisions, BCBSF may, at its expense, require an Insured to be examined by a health care Provider of BCBSF's choice as often as is reasonably necessary while a claim is pending. BCBSF also reserves the right, if the law permits, to have an autopsy performed on the Insured in case of death. Failure by an Insured to fully cooperate with such examination or the failure of BCBSF to obtain a requested autopsy report shall result in a denial of the pending claim and BCBSF shall have no liability for such claim.

3. Legal Actions

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

4. Fraud, Misrepresentation or Omission in Applying for Benefits

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

5. Explanation of Benefits Form

Claims decisions will be communicated to the Insured in writing in an explanation of benefits form:

This form may indicate:

a. the reason(s) the claim was denied;

b. a reference to the applicable provision upon which the denial is based;

c. a description of additional material or information necessary to make the claim payable and why such material or information is necessary; and

d. an explanation of the steps to be taken if an Insured wants a claim denial decision reviewed.

6. Circumstances Beyond the Control of BCBSF

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

payment of claims for such Covered Services, except that BCBSF shall 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 the control of BCBSF if BCBSF cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

RELATIONSHIPS BETWEEN THE PARTIES

BCBSF and Health Care Providers

Neither BCBSF nor any of its officers, directors or employees provide Health Care Services to Insureds. Rather, BCBSF and such individuals are engaged in making coverage and/or benefit decisions under this Contract. By accepting BCBSF coverage and/or benefits, Insureds agree that making such coverage and/or benefit decisions does not constitute the rendering of Health Care Services and that health care Providers rendering Health Care Services are not the employees or agents of BCBSF. **In this regard, BCBSF hereby expressly disclaims any agency relationship, actual or implied, with any health care Provider.** BCBSF does not, by virtue of making coverage, benefit, and payment decisions, exercise any control or direction over the medical judgement or clinical decisions of any health care Provider. Any decisions made by BCBSF concerning appropriateness of setting, or whether any service is Medically Necessary, shall be deemed to be made solely for purposes of determining whether such services are covered, and not for purposes of recommending any treatment or non-treatment. Neither will BCBSF assume liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

Medical Decisions - Responsibility of an Insured's Physician, Not BCBSF

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

MEMBERSHIP PROVISION

Membership Provision

All holders of insurance policies issued by BCBSF shall be members of the Corporation, except that reinsurance may be effected without membership. Members shall have all the rights, privileges, and obligations provided in the Articles of Incorporation and Bylaws of the Corporation as now in force and as the same may be amended from time to time.

The annual meeting of the members shall be held for the purpose of electing the Board of Directors and transacting such other business as may be properly brought before the meeting.

At all meetings of the members of the Corporation, each member of the Corporation shall be entitled to cast a number of votes equal to the amount of Premiums attributed to such member in the month of record, as determined by BCBSF (e.g., a Premium of $150.00 in that month will be equal to 150 votes). All proxies shall be filed with the Secretary of the Corporation before the meeting at which the proxy is to be voted.

GENERAL PROVISIONS

Access to Information

BCBSF shall have the right to receive, from any health care Provider rendering services to an Insured, information that is reasonably necessary, as determined by BCBSF, in order to administer the coverage and/or benefits it provides, subject to all applicable confidentiality requirements set forth below. By accepting coverage, each Insured authorizes every health care Provider, who renders Health Care Services to an Insured, to disclose to BCBSF or to entities affiliated with BCBSF, upon request, all facts, records, and reports pertaining to such Insured's care, treatment, and physical or mental Condition, and to permit BCBSF to copy any such records and reports so obtained.

Right to Receive Necessary Information

In order to administer coverage and/or benefits, BCBSF may, without the consent of, or notice to, any person, plan, or organization, obtain from any person, plan, or organization any information with respect to any Insured or applicant for enrollment which BCBSF deems to be necessary.

Amendment

The terms of coverage and/or benefits to be provided by BCBSF may be amended annually on this Contract's Anniversary Date, without the consent of any Insured or any other person, upon 45 days prior written notice to the Contractholder. Any such amendment shall be without prejudice to claims filed with BCBSF prior to the date of such amendment. No agent or other person, except a duly authorized officer of BCBSF, has the authority to modify the terms of the Contract, or to bind BCBSF in any manner not expressly set forth herein, including but not limited to the making of any promise or representation, or by giving or receiving any information. The terms of coverage and/or benefits to be provided by BCBSF may not be amended by BCBSF unless such amendment is evidenced in writing and signed by a duly authorized officer of BCBSF. The Contractholder shall immediately notify each Insured of any such amendment.

Assignment and Delegation

The obligations arising hereunder may not be assigned, delegated or otherwise transferred by either party without the written consent of the other party; provided, however, that BCBSF may assign its coverage and/or benefit obligations to its successor in interest or an affiliated entity without the consent of the Contractholder at any time. **Any assignment, delegation, or transfer made in violation of this provision shall be void.**

Payment of Premiums

This Contract will not be in force until the Contractholder's application for coverage has been received by BCBSF, is Medically Acceptable to BCBSF, and BCBSF has received the Contractholder's first Premium payment. All subsequent Premium payments are payable in advance or within the Grace Period. The amount of the Contractholder's initial monthly Premium is indicated on the front cover of this Contract. Failure on BCBSF's part, for whatever reasons, to provide the Contractholder with a notice of payment due does not justify the Contractholder's non-payment of Premiums. It is the Contractholder's responsibility to submit the indicated Premium by the end of the Grace Period or to notify us that a billing was not received.

The Premium will automatically change if the Contractholder changes Risk Classes, or if the number of individuals covered under this Contract changes. For example, the Contractholder's Premium may change if the Contractholder moves to a different geographical area. Additionally, the Premium may increase each year on the Contractholder's Anniversary Date due to the increase in the Contractholder's age and the covered spouse's age.

If BCBSF accepts Premium for coverage for a Covered Dependent for a period extending beyond the date, age, or event specified for termination of such Covered Dependent, then coverage for such a Covered Dependent shall continue during the Grace Period for which an identifiable Premium was accepted, except if such acceptance resulted from a misstatement of age or residence.

Premium payments are payable to:

Blue Cross and Blue Shield of Florida, Inc.
P.O. Box 2913
Jacksonville, Fl 32231

Premium Payment Due Date

The first Premium payment is due before the Effective Date of this Contract. Each following Premium payment is due as indicated on the Contractholder's application unless the Contractholder and BCBSF agree on some other method and/or frequency of Premium payment. The Premium is due and payable on or before the due date of the Premium unless the Contractholder and BCBSF agree to another Premium due date.

Changes in Premium

BCBSF may modify the Rates at any time, without the consent of the Contractholder or any Insured, upon at least 45 days prior notice by BCBSF to the Contractholder. Payments submitted to BCBSF following receipt of any such written notice of modification constitutes acceptance by the Contractholder of any such modification.

Grace Period

This Contract has a 31-day Premium payment Grace Period which begins on the date the Premium payment is due. If any required Premium payment is not received by BCBSF on or before the date it is due, it may be paid during this Grace Period. Coverage will stay in force during the Grace Period. If Premium payments are not received by the end of the Grace Period, coverage shall automatically terminate as of the Premium Due Date.

Misstatement of Medical Condition, Age, Sex, Residence, or Tobacco Use

If any information relevant to determining the Insured's Risk Class has been misstated on the application, the Premium amount owed under this Contract will be what the Premium would have been had the correct information been given on the application. If such misstatement causes BCBSF to accept Premiums for a time period that it would not have accepted Premium for if the correct information had been stated, BCBSF's only liability will be the return of any unearned Premium. BCBSF will not provide any coverage for that time period. This right is in addition to any other rights BCBSF may have under this Contract and applicable laws.

Right to Recovery

Whenever BCBSF has made payments in excess of the maximum provided for under this Contract, BCBSF shall have the right to recover any such payments, to the extent of such excess, from any Insured, person, plan, or other organization that received such payments.

Compliance With State and Federal Laws and Regulations

The terms of coverage and/or benefits to be provided by BCBSF under the Contract 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 an Insured, or BCBSF.

Confidentiality

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

BCBSF's arrangements with Providers may require that BCBSF release certain claims and medical information about Insureds even if the Insured has not sought treatment by or through that Provider. By accepting coverage, each Insured hereby authorizes BCBSF to release to Providers claims information, including related medical information, pertaining to the Insured in order for any such Provider to evaluate the Insured's financial responsibility under this Contract.

Evidence of Coverage

Each Contractholder will be provided with a Contract and an Identification Card for enrolled Insureds as evidence of coverage.

Governing Law

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

Identification Cards

BCBSF will provide the Contractholder with an Identification Card. The Identification Card will be issued in the Contractholder's name and this card may be used by the Contractholder or any of the Covered Dependents.

Modification of Provider Networks and the Participation Status

Provider networks and the participation status of individual Providers, available under this Contract are subject to change at any time without prior notice to, or approval of, BCBSF or any Insured. Additionally, BCBSF may, at any time, terminate or modify the terms of any Provider contract and may enter into additional Provider contracts without prior notice to, or approval of, BCBSF or any Insured. It is the Insured's responsibility to determine whether a health care Provider is participating in any Provider network at the time the Health Care Service is rendered. Under this Contract, an Insured's financial responsibility may vary depending upon a Provider's participation status.

Cooperation Required of Insureds

Each Insured shall cooperate with BCBSF, and shall execute and submit to BCBSF such consents, releases, assignments, and other documents as may be requested by BCBSF in order to administer, and exercise its rights hereunder. Failure to do so shall constitute grounds for termination for cause by BCBSF. (See the Termination of an Individual's Coverage for Cause subsection in the Termination Of An Individual Insured's Coverage Section.)

Non-Waiver of Defaults

Any failure by BCBSF 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 the right of BCBSF at any time to enforce or avail itself of any such remedies as it may be entitled to under applicable law.

Notices

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

If to BCBSF:

> To the address printed on the Individual Application for Health Insurance and/or the Identification Card.

If to an Insured:

> To the latest address provided by the Insured or to the Contractholder's latest address on the Individual Application for Health Insurance or change of address form received by BCBSF.
>
> **The Contractholder shall notify BCBSF immediately of any address change.**

Obligations of BCBSF Upon Termination

Upon termination of an individual's coverage for any reason, BCBSF shall have no further liability or responsibility under the Contract with respect to such individual, 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 Contract.

GLOSSARY OF TERMS

For purposes of this Contract and any Riders or Endorsements, the following terms shall have the meanings set forth below. Additional definitions pertaining to Providers may be found in the Health Care Provider Alternatives and Reimbursement Rules Section of this Contract and any Endorsements issued with this Contract.

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

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

Adoption or Adopt(ed) means the process and act of creating a legal parent/child relationship 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 otherwise defined by *Florida Statutes* or the similar applicable laws of another state.

Allowance means the maximum amount BCBSF will base payment on for a Covered Service rendered by a health care Provider who, at the time the Covered Service was rendered, was not a PPO Provider. This Allowance is determined and established solely by BCBSF and is based upon many factors. Such factors may (but not necessarily will) include: pre-negotiated payment amounts; diagnostic related grouping(s) (DRG); relative value scales; the charge(s) of the Provider; the charge(s) of similar Providers within a particular geographic area established by BCBSF; and/or the cost of providing the Covered Service. The Allowance may be modified by BCBSF at any time without the consent of or notice to the Insured. In no event will the Allowance be less than the Allowed Amount.

Allowed Amount means the maximum amount BCBSF will base payment on for Covered Services. The Allowed Amount is the PPO Schedule Amount when the Provider who rendered the Covered Service(s) was a BCBSF PPC℠ Provider, and the Allowance when the Provider who rendered the Covered Service(s) was not a PPO Provider. Further, under the BlueCard® Program, the Allowed Amount means the maximum amount upon which BCBSF will base payment to the applicable Host Plan for Covered Services provided in the applicable Host Plan's geographic area. Each Allowed Amount is determined and established by BCBSF and is subject to change at any time without notice to or consent of the Insured.

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

Ambulatory Surgical Center means a facility properly licensed pursuant to Chapter 395 of the *Florida Statutes*, or a similar applicable law of another state, the primary purpose of which is to provide elective surgical care to a patient, admitted to, and discharged from such facility within the same working day. As used herein an Ambulatory Surgical Center cannot be a part of a Hospital.

Anniversary Date means the date, one year after the Effective Date, stated on the Individual Application for Health Insurance and subsequent annual anniversaries of that date.

ARC means AIDS-related complex.

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.

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

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

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

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

Calendar Year begins January 1st and ends December 31st in any given Calendar 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.

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

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

Coinsurance means the sharing of health care expenses for Covered Services between BCBSF and the Insured. After the Insured's Deductible requirement is met, BCBSF will pay a percentage of the Allowed Amount for Covered Services, as set forth in the Schedule of Benefits.

Condition means a disease, illness, ailment, injury, bodily malfunction, or pregnancy of an Insured.

Conditional Receipt is a process by which the proposed Insured/applicant signs and receives a copy of a receipt for Premium collected and is assigned an Effective Date of coverage contingent upon the proposed Insured/applicant being Medically Acceptable to BCBSF.

Contract includes this document, the application for coverage signed by the Contractholder, the Identification Card(s) issued to the Contractholder, and any Rider(s), and Endorsement(s).

Contractholder means an individual who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the Contract other than as a Covered Dependent. (See the Eligibility Requirements for Contractholders subsection of the Eligibility of Coverage Section.)

Copayment (if applicable) means the dollar amount established solely by BCBSF which is required to be paid to a health care Provider by an Insured at the time certain Covered Services are rendered by that Provider. While this amount may vary depending on, among other things, the contracting status of the health care Provider rendering the service and the type of service being rendered, in no event will such amount exceed the amount specified in the Schedule of Benefits for the service. Except as otherwise established solely by BCBSF, if more than one Covered Service is rendered by a health care Provider during a single office visit, the Copayment shall not exceed the highest Copayment specified in the Schedule of Benefits for any of the services rendered during such office visit, regardless of the number of services rendered during such office visit.

Covered Dependent means an Eligible Dependent who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, other than as a Contractholder. (See the Eligibility Requirements for Dependent(s) subsection of the Eligibility for Coverage Section.)

Covered Services means those Medically Necessary Health Care Services described in the Covered Services Sections. The term Health Care Services include, as applicable, any treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds, and other services rendered or supplied by, or at the direction of, Providers.

Creditable Coverage means health care coverage which is continuous to a date within 62 days of the Insured's Enrollment Date. Such health care coverage may include any of the following:

1. a group health plan;
2. individual health insurance;
3. Medicare Part A and Part B;
4. Medicaid;
5. benefits to members and certain former members of the uniformed services and their dependents;
6. a medical care program of the Indian Health Service or of a tribal organization;
7. a State health benefits risk pool;
8. a health plan offered under chapter 89 of Title 5, United States Code;
9. a public health plan; or
10. a health benefit plan of the Peace Corps.

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

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

Detoxification means a process whereby an alcohol or drug intoxicated, or alcohol or drug dependent, Insured is assisted through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician or Psychologist, while keeping the physiological risk to the Insured 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 Health Care Financing Administration, and the Florida Agency for Health Care Administration (or a similar regulatory agency of another state) to provide hemodialysis and peritoneal dialysis services and support.

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

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

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

Effective Date with respect to Insureds properly enrolled when coverage first becomes effective, means 12:01 a.m. on the date so specified on the Individual Application and cover page of the BlueChoice For Individual Under 65 Contract; and with respect to Insureds who are subsequently enrolled, means 12:01 a.m. on the date on which coverage will commence as specified in the Enrollment and Effective Date of Coverage Section of the Contract.

Eligible Dependent means a Contractholder's: (1) legal spouse or (2) natural, newborn, Adopted, foster, or step child(ren) (or a child for whom the Contractholder has been court-appointed as legal guardian or legal custodian) who is:

1. dependent upon the Contractholder for financial support;

2. under the limiting age set forth in the Eligibility Requirements for Dependent(s) subsection of the Contract; and

3. living in the household of the Contractholder or a full-time student.

A newborn child of a Covered Person other than the Contractholder or the newborn child of an Insured other than the Covered Employee's spouse is an Eligible Dependent hereunder. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Endorsement means any amendment to the Contract issued by BCBSF.

Enrollment Date means the date of enrollment of the individual under this Contract.

Enrollment Forms means those BCBSF forms which are used to maintain accurate enrollment files under this Contract. Such forms include: the Universal Individual Application for Insurance/Membership form and the Member Status Change Request form and any forms required by BCBSF for enrollment purposes.

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

1. such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the Florida Department of Health and approval for marketing has not, in fact, been given at the time such is furnished to the Insured;

2. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device;

3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations;

4. reliable evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;

5. reliable evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;

6. reliable evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently published Medical Literature in the United States, Canada, or Great Britain, 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 BCBSF):

1. records maintained by Physicians or Hospitals rendering care or treatment to the Insured or other patients with the same or similar Condition;

2. reports, articles, or written assessments in authoritative medical and scientific literature published in the United States, Canada, or Great Britain;

3. published reports, articles, or other literature of the United States Department of Health and Human Services or the United States Public Health Service, including any of the National Institutes of Health, or the United States Office of Technology Assessment;

4. the written protocol or protocols relied upon by the treating physician or institution or the protocols of another Physician or institution studying substantially the same evaluation, treatment, therapy, or device;

5. the written informed consent used by the treating physician or institution or by another Physician or institution studying substantially the same evaluation, treatment, therapy, or device; or

6. the records (including any reports) of any institutional review board of any institution which has reviewed the evaluation, treatment, therapy, or device for the Condition in question.

NOTE: Health Care Services which are determined by BCBSF to be Experimental or Investigational are excluded (see the Covered Services Section). In determining whether a Health Care Service is Experimental or Investigational, BCBSF may also rely on the predominant opinion among experts, as expressed in the published authoritative literature, that usage of a particular evaluation, treatment, therapy, or device should be substantially confined to research settings or that further studies are necessary in order to define safety, toxicity, effectiveness, or effectiveness compared with standard alternatives.

FDA means the United States Food and Drug Administration.

Foster Child means a person under the age of 18 who is placed in the Contractholder's residence and care by the Florida Department of Health & Rehabilitative Services in compliance with *Florida Statutes* or by a similar regulatory agency of another state in compliance with that state's applicable laws.

Full-time Student is one who is enrolled in, and actually attends, an accredited college or university for five months during the Calendar Year in which this Contract is in effect.

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.

Grace Period means the 31-day period immediately following the Premium due date as indicated on the Contractholder's billing statement.

Health Care Services include treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds, and other services rendered or supplied, by or at the direction of, Providers.

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

Home Health Care means Physician directed professional, technical and related medical and personal care services provided in the Insured's home or residence on a visiting or part-time bases by a Home Health Agency.

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

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

The term Hospital does not include: an Ambulatory Surgical Center; a Skilled Nursing Facility; a stand-alone Birthing Center; a facility for diagnosis care and treatment of Mental Health Services or Substance Dependency Care and Treatment; a convalescent, rest or nursing home; or a facility which primarily provides Custodial, educational, or Rehabilitative Therapies.

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

Identification Card means the card(s) issued by BCBSF to Contractholders. The card is the property of BCBSF, and is not transferable to another person. Possession of such card in no way verifies that a particular individual is eligible for, or covered under, the Contract.

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

Individual Application for Health Insurance means the form(s) provided by or acceptable to BCBSF, which an individual must complete and submit to BCBSF when applying for coverage as a Contractholder.

Insured means any Contractholder or Covered Dependent.

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

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

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

Massage or Massage Therapy means the manipulation of superficial tissues of the human body by using the hand, foot, arm, or elbow.

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

Material Misrepresentation is the omission, concealment of facts or incorrect statements made on an application or medical statement by an applicant, Insured or Contractholder which would have affected our underwriting decision to issue this Contract, issuance of different benefits, or issuance of this Contract only at a higher rate had they been known.

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

Medically Acceptable means that an applicant(s) has submitted a medical history application and based on BCBSF's underwriting regulations, has been approved by BCBSF to be acceptable for coverage.

Medically Necessary or **Medical Necessity** means, for coverage and payment purposes only, that a Health Care Service is required for the identification, treatment, or management of a Condition, and is, in the opinion of BCBSF:

1. consistent with the symptom, diagnosis, and treatment of the Insured's Condition;
2. widely accepted by the practitioners' peer group as efficacious and reasonably safe based upon scientific evidence;
3. universally accepted in clinical use such that omission of the service or supply in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment;
4. not Experimental or Investigational;
5. not for cosmetic purposes;
6. not primarily for the convenience of the Insured, the Insured's family, the Physician or other provider; and

7. the most appropriate level of service, care or supply which can safely be provided to the Insured. When applied to inpatient care, Medically Necessary further means that the services cannot be safely provided to the Insured in an alternative setting.

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.

Member Status Change Request form means the form(s) provided by or acceptable to BCBSF, which a Contractholder must complete and submit through BCBSF, and received by BCBSF, when adding or deleting a Covered Dependent.

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

Mental and Nervous Disorder means any and all disorders set forth in the diagnostic categories of the most recently published edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

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

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

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

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

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

Partial Hospitalization means treatment in which the patient receives at least seven hours of institutional care during a portion of a 24-hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered a "home" for purposes of this definition.

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

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

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

Physician means any individual who is properly licensed by the State of Florida, or other similar states' applicable laws, 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.

Placement or Placed means the process of a person giving a child up for Adoption and the prospective parent receiving and Adopting the child, or the process where a Foster Child will reside with and be cared for by the Insured and includes all actions by any person or agency participating in the process, or as otherwise defined by *Florida Statutes*.

PPO means, or refers to, the network of PPO Providers available to Insureds under this Contract.

PPO Provider means, or refers to, any health care Provider who or which, at the time Health Care Services were rendered to an Insured, was under contract with BCBSF to participate in BCBSF's network of preferred Providers, such Providers also known as "Preferred Patient Care℠" or "PPC℠" Providers or BCBSF PPC℠ Providers. The term PPO Provider also refers, when applicable, to health care Providers in certain counties who or which, at the time Health Care Services were rendered to an Insured, were under contract to participate as PPC℠ Providers. An Insured, when receiving Covered Services from any PPC℠ Provider, is also considered a policyholder, as that term is defined and used in the applicable PPC Provider agreement between such Provider and BCBSF. For purposes of this Contract, the term PPO Provider also refers, when applicable, to any health care Provider located outside the State of Florida who or which, at the time Health Care Services were rendered to an Insured, participated as Host Plan PPO Providers under the Blue Cross and Blue Shield Association's BlueCard® Program.

PPO Schedule Amount means the amount BCBSF will base payment on for a Covered Service rendered by a health care Provider who, at the time the Covered Service was rendered, was a BCBSF PPC Provider. This amount is determined and established by BCBSF and is a pre-established maximum schedule amount which may vary by geographical area. The amount of charges credited to the Deductible requirement will not exceed the Allowed Amount.

Premium means the total amount the Contractholder must pay BCBSF periodically for coverage under this Contract. The Premium is determined on the basis of the applicable Rates, Risk Class and the number of individuals covered under this Contract.

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

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

Provider means any facility, person or entity recognized for payment by BCBSF and defined in the Contract.

Psychiatric Facility means a facility licensed to provide for the Medically Necessary care and treatment of Mental Health Services. For purposes of this Contract, a Psychiatric Facility is not a Hospital, as defined herein.

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

Rate means the amount(s) BCBSF charges Insureds for coverage. The Rate will vary depending upon the Insured's Risk Class.

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

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

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

Rider is an amendment BCBSF may issue with this Contract which restricts coverage or benefits under this Contract.

Risk Class is a grouping of Insureds who have similar characteristics. For example, Insureds who: are the same sex; in the same age bracket; have similar medical Conditions (including whether they use tobacco products); live in the same geographical area; and who have elected the same benefit plan may be group into a Risk Class. The Contractholder's Risk Class is determined by BCBSF.

Skilled Nursing Facility means an institution or part thereof which is licensed as a Skilled Nursing Facility by the State of Florida, or a similar applicable law of another state, accredited as a Skilled Nursing Facility by the Joint Commission on Accreditation of Healthcare Organizations or recognized as a skilled nursing facility by the Secretary of Health and Human Services of the United States under Medicare, unless such

accreditation or recognition requirement has been waived by BCBSF; and which provides Covered Services that are skilled nursing services, as determined by BCBSF, to Insureds under a contract then in effect.

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

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

Standard Reference Compendium means (1) The United States Pharmacopoeia Drug Information; (2) The American Medical Association Drug Evaluation; or (3) The American Hospital Formulary Service Hospital Drug Information.

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 Care and Treatment. For purposes of this Contract, a Substance Abuse Facility is not a Hospital.

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

Traditional Insurance Providers are those health care Providers who are not PPO Providers, but who or which have entered into a contract then in effect to participate in BCBSF's traditional provider programs (these programs also known as Payment for Physician Services "PPS" or Payment for Hospital Services "PHS"), as applicable, in Florida or in certain counties outside of Florida, when such programs exist.

Universal Individual Application For Insurance/Membership means the BCBSF form that individual(s) must submit to the BCBSF when applying for coverage during the 30 day period immediately following the Effective Date of coverage.

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.

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Home Office
4800 Deerwood Campus Parkway
Jacksonville, Florida 32246

Contract Number:XJU333-55-6666
Effective Date:01/01/98

ENDORSEMENT: MEDISCRIPT® PHARMACY PROGRAM

This Endorsement is to be attached to, and made apart of the Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Contract issued to the Contractholder. The Contract is hereby amended by adding the following Mediscript® Pharmacy Program provisions.

Introduction

Under this BCBSF MediScript® Pharmacy Program Endorsement, BCBSF provides coverage to Insureds for Covered Prescription Drugs and/or Covered Syringes and Needles purchased at any Pharmacy. In order to obtain benefits under this Endorsement, Insureds must first pay for Covered Prescription Drugs and/or Covered Syringes and Needles and submit a claim form to BCBSF for processing and payment. Insureds may be able to reduce their out-of-pocket expenses by purchasing Covered Prescription Drugs from Participating Pharmacies and by selecting Generic Prescription Drugs rather than Brand Name Prescription Drugs.

Participating Pharmacies are Pharmacies participating in BCBSF's statewide network of contracting Pharmacies in Florida and, for Insureds traveling or residing outside Florida, National Network Pharmacies. National Network Pharmacies are Pharmacies outside of Florida participating in a national network of Pharmacies available to BCBSF Insureds through BCBSF's Pharmacy Benefit Manager.

The coverage to be provided under this MediScript® Pharmacy Program Endorsement is subject to the definitions in the Glossary of Terms and the Calendar Year Deductible(s) as set forth in the Contract. Coverage will also be subject to the following Coinsurance rules:

Generic	Participating Pharmacy	Non-Participating Pharmacy
Prescription Drug	Coinsurance percentage* applicable to ***Providers Participating in PPO***	Coinsurance percentage* applicable to ***Providers Not Participating in PPO***
Brand Name Prescripton Drug or Syringes and Needles	Coinsurance percentage* applicable to ***Providers Not Participating in PPO***	Coinsurance percentage* applicable to ***Providers Not Participating in PPO***

*Note: The percentage referred to means the Coinsurance percentage payable by BCBSF. Please refer to the Schedule of Benefits for the specific percentage amount. The unpaid percentage of the Participating Pharmacy Allowance is the Insured's Coinsurance responsibility and will apply towards the Insured's ***Individual Coinsurance Limit*** as set forth in the Schedule of Benefits.

Additionally, the coverage to be provided by BCBSF under this Endorsement is subject to any limitations and specific and/or general exclusions set forth in this Endorsement. Coverage is also subject to all exclusions and limitations contained in the Contract.

To the extent of any conflict between any specific provision in this Mediscript® Pharmacy Program Endorsement and the provisions of the Contract which it amends, the provisions of this Endorsement shall control.

Unless otherwise specified, in order to be covered under this Endorsement, Prescription Drugs and/or Covered Syringes and Needles must be:

1. prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his/her license;

2. dispensed by a Pharmacist;

3. be Medically Necessary as defined by BCBSF; and

4. not otherwise limited or excluded herein.

For further details concerning the Calendar Year Deductible(s) and the Coinsurance percentage(s) applicable to Covered Prescription Drugs and Covered Syringes and Needles, please refer to the Schedule of Benefits which is a part of the Contract.

Pharmacy Alternatives and Reimbursement Rules

Insureds may fill their Prescriptions for Covered Prescription Drugs and/or Covered Syringes and Needles at any Pharmacy of their choice. Under the Mediscript® Pharmacy Program Endorsement, the amount of BCBSF's reimbursement for, and the reimbursement rules applicable to, Covered Prescription Drugs and/or Covered Syringes and Needles will vary depending on the Pharmacy selected (i.e., Participating Pharmacy verses Non Participating Pharmacy and whether the Prescription Drug is a Brand Name Prescription Drug or a Generic Prescription Drug).

For reimbursement purposes, there are two (2) types of Pharmacies: (1) "Participating Pharmacies" and (2) "Non-Participating Pharmacies." Participating Pharmacies are Pharmacies participating in BCBSF's MediScript® Pharmacy Program or the national Pharmacy network belonging to BCBSF's Pharmacy Benefit Manager at the time Covered Prescription Drugs and/or Covered Syringes and Needles are purchased by an Insured. These Pharmacies have agreed not to charge or collect more than the Participating Pharmacy Allowance per Prescription for Covered Prescription Drugs and/or Covered Syringes and Needles.

There are two (2) types of Participating Pharmacies: (1) Pharmacies in Florida that have signed a MediScript® Participating Pharmacy Provider Agreement with BCBSF and (2) National Network Pharmacies. National Network Pharmacies are Pharmacies outside of Florida participating in the national network of Pharmacies available to BCBSF Insureds through BCBSF's Pharmacy Benefit Manager.

A Non-Participating Pharmacy is a Pharmacy which has not agreed to participate in BCBSF's MediScript® Participating Pharmacy Program and which is not a National Network Pharmacy.

To verify if a Pharmacy is a Participating Pharmacy, the Insured may refer to the Pharmacy Program Provider Directory then in effect and/or call the customer service phone number on the front cover of the Contract or on the Insured's Identification Card.

NOTE: In order to be eligible to be charged the Participating Pharmacy Allowance under this Endorsement, an Insured must, prior to the filling of a Prescription, present his or her BCBSF Identification Card to the Participating Pharmacy. The Participating Pharmacy must be able to verify that the Insured is, in fact, covered by BCBSF.

Reimbursement Rules for Participating Pharmacies Located In Florida

BCBSF's reimbursement for Covered Prescription Drugs and/or Covered Syringes and Needles purchased at Participating Pharmacies located in Florida will be based upon the "Participating Pharmacy Allowance." The Participating Pharmacy Allowance for Participating Pharmacies in Florida is established by BCBSF. Such Participating Pharmacies have agreed to charge the Insured no more than the Participating Pharmacy Allowance and, therefore, the Insured's financial obligation will include the following:

1. the payment of any applicable Calendar Year Deductible(s) and/or Coinsurance requirements;

2. the payment of expenses for non-covered, limited, or excluded Prescription Drugs and non-covered, limited, or excluded syringes and needles and Drugs;

3. the payment of expenses in excess of any maximum benefit limitation; and

4. the payment of any applicable benefit reductions or penalties.

Participating Pharmacies in Florida have agreed to provide the Insured with all of the information necessary to file a claim with BCBSF. BCBSF's reimbursement will be:

1. made directly to the Contractholder;

2. subject to the Calendar Year Deductible; and

3. based on the Participating Pharmacy Allowance, at the following Coinsurance percentages as set forth in the Schedule of Benefits.

	Coinsurance Amount
Generic Prescription Drug	Coinsurance percentage aplicable to ***Providers Participating in PPO***
Brand Name Prescription Drug or Syringes and Needles	Coinsurance percentage applicable to ***Providers Not Participating in PPO***

Reimbursement Rules for Participating Pharmacies Located Outside of Florida Which Are National Network Pharmacies

BCBSF provides, for Insureds traveling or residing outside Florida, benefits for Covered Prescription Drugs and/or Covered Syringes and Needles purchased at a National Network Pharmacy. A National Network Pharmacy has agreed to charge Insureds for Covered Prescription Drugs and/or Covered Syringes and Needles BCBSF's Pharmacy Benefit Manager's Participating Pharmacy Allowance. Therefore, an Insured's financial obligation will include the following:

1. the payment of any applicable Calendar Year Deductibles(s) and/or Coinsurance requirement;

2. the payment of expenses for non-covered, limited, or excluded Prescription Drugs and non- covered, limited, or excluded syringes and needles and Drugs;

3. the payment of expenses in excess of any maximum benefit limitation; and

4. the payment of any applicable benefit reductions or penalties.

National Network Pharmacies have agreed to provide the Insured with all of the information necessary to file a claim with BCBSF. BCBSF's reimbursement will be:

1. made directly to the Contractholder;

2. subject to the Calendar Year Deductible; and

3. based on BCBSF's Pharmacy Benefit Manager's Participating Pharmacy Allowance, at the following Coinsurance percentage as set forth in the Schedule of Benefits.

	Coinsurance Amount
Generic Prescription Drug	Coinsurance percentage aplicable to ***Providers Participating in PPO***
Brand Name Prescription Drug or Syringes and Needles	Coinsurance percentage applicable to ***Providers Not Participating in PPO***

Reimbursement Rules for Non-Participating Pharmacies

"Non-Participating Pharmacies" are Pharmacies which have not agreed to participate in BCBSF's MediScript® Participating Pharmacy Program and which are not National Network Pharmacies. BCBSF's reimbursement for Covered Prescription Drugs and/or for Covered Syringes and Needles is based upon BCBSF's Participating Pharmacy Allowance.

Non-Participating Pharmacies have **NOT** agreed to accept BCBSF's or BCBSF's Pharmacy Benefit Manager's Participating Pharmacy Allowance; therefore, the Insured's financial responsibility will include the following:

1. the payment of any difference between BCBSF's "Participating Pharmacy Allowance" and the Non-Participating Pharmacy's charge;

2. the payment of any applicable Calendar Year Deductible(s) and/or Coinsurance requirements;

3. the payment of expenses for non-covered, limited, or excluded Prescription Drugs and non-covered, limited, or excluded syringes and needles and Drugs;

4. the payment of expenses in excess of any maximum benefit limitation; and

5. the payment of any applicable benefit reductions or penalties.

BCBSF's reimbursement will be:

1. made directly to the Contractholder;

2. subject to the Calendar Year Deductible; and

3. based on the "Participating Pharmacy Allowance" and payable at the Coinsurance percentage applicable to ***Providers Not Participating in PPO***, as set forth in the Schedule of Benefits

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Coverage for Prescription Drugs and Syringes and Needles

All Prescription Drugs and/or Covered Syringes and Needles are covered under the Contract unless otherwise limited or excluded herein, or limited or excluded by any Endorsements to the Contract. In order to be covered under this Endorsement, Prescription Drugs and/or Covered Syringes and Needles must be prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his/her license, dispensed by a Pharmacist, and be Medically Necessary.

The only medical supplies and/or equipment which are covered under this Endorsement are syringes and needles prescribed in conjunction with Insulin or Imitrex. Syringes and needles which are included in Anaphylactic kits are also covered. Other medical supplies and/or equipment are not covered under this Endorsement.

BCBSF's Coverage and Benefit Guidelines for Prescription Drugs

In providing benefits for Covered Prescription Drugs and/or Covered Syringes and Needles, BCBSF may apply the benefit guidelines set forth below, as well as any other applicable reimbursement rules specific to particular Covered Services listed in the Contract:

- **Diabetic Coverage**

All Prescription Drugs used in the treatment of diabetes will be covered subject to the limitations and exclusions listed in this Endorsement. Insulin is only covered if prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license. Syringes and needles for dispensing Insulin will be covered only when prescribed in conjunction with Insulin.

Exclusion
All diabetic supplies and equipment, except for syringes and needles prescribed in conjunction with Insulin, are excluded from coverage under this Endorsement.

NOTE: Other diabetic supplies and equipment (e.g., blood glucose testing strips, lancets, glucometers, etc.) may be covered under other provisions of the Contract although specifically excluded under this Endorsement.

- **Mineral Supplements, Fluoride Drugs or Vitamins**

Prescription prenatal vitamins, oral single-product fluoride (non-vitamin supplementation), Prescription sustained release niacin, Prescription folic acid, Prescription oral hematinic agents, dihydrotachysterol and calcitriol are covered only when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his/her license.

Exclusion
Non-prescription mineral supplements and non-prescription vitamins are excluded from coverage under this Endorsement.

- **Self Injectable Drugs**

The only self-administered injectable Prescription Drugs covered under this Endorsement are Insulin, Imitrex and Prescription Drugs contained in Anaphylactic kits (i.e. Epi-Pen, Epi-Pen Jr., Ana-Kit). Syringes and needles prescribed in conjunction with Insulin or Imitrex or contained in Anaphylactic kits are covered.

Exclusion
All self-administered injectable Prescription Drugs, except for Drugs included in Anaphylactic kits, Insulin and Imitrex, are excluded. Syringes and needles which are not prescribed in conjunction with Insulin or Imitrex or contained in Anaphylactic kits are excluded.

Limitations

Coverage and benefits for Covered Prescription Drugs and/or Covered Syringes and Needles under this Endorsement are subject to the following limitations in addition to all other provisions and exclusions of the Contract:

1. a maximum quantity of a One-Month Supply per Covered Prescription Drug and/or Covered syringes and Needles;

2. refills must be filled within six months or one year from the original Prescription date, depending on federal law designations.

Exclusions

Expenses for the following are excluded under this MediScript® Pharmacy Program Endorsement:

1. Prescription Drugs which are covered and payable under a specific Covered Service category of the Covered Services Section of the Contract (e.g., Prescription Drugs which are dispensed and billed by a facility or Provider);

2. Except for Insulin, Imitrex, and Prescription Drugs contained in Anaphylactic kits, any Prescription Drugs obtained from a Pharmacy which are dispensed for administration by intravenous infusion or injection regardless of the setting in which such Prescription Drugs are to be administered or type of provider administering such Prescription Drugs;

3. Any Drug which can be purchased over the counter without a Prescription, even though a written Prescription is provided (e.g., Drugs which do not require a Prescription) except for those items listed in BCBSF's Coverage and Benefit Guidelines for Prescription Drugs set forth in this Endorsement (e.g. Insulin);

4. Contraceptive injectable Prescription Drugs and implants (e.g., IUD, etc.) inserted for purposes of contraception; oral contraceptive Prescription Drugs; and Prescription diaphragms;

5. All injectable Prescription Drugs, other than Prescription Drugs contained in Anaphylactic kits, Insulin, and Imitrex;

6. Syringes and needles which are not prescribed in conjunction with Insulin or Imitrex or contained in Anaphylactic kits;

7. All supplies and equipment other than syringes and needles prescribed in conjunction with Insulin or Imitrex or Covered Syringes or Needles contained in Anaphylactic kits;

8. Prescription Drugs and syringes and needles (which would otherwise be covered) dispensed prior to the Effective Date of the Contract;

9. Prescription Drugs and syringes and needles (which would otherwise be covered) dispensed after the termination date of the Contract;

10. Any charge for therapeutic devices or appliances (e.g., support garments and other non-medical substances) regardless of their intended use, medical or other supplies (except for Covered Syringes and Needles) and equipment;

11. Prescription Drugs and Covered Syringes and Needles in excess of the limitations specified in this Endorsement;

12. Prescription Drugs and Covered Syringes and Needles which are furnished to the Insured without cost;

13. Prescription Drugs and syringes and needles which are Experimental or Investigational;

14. Mineral supplements, fluoride or vitamins except for those items listed in BCBSF's Coverage and Benefit Guidelines for Prescription Drugs;

15. Any appetite suppressant and/or other Prescription Drug indicated or used for purposes of weight reduction or control;

16. Injectable Drugs other than Insulin, Imitrex and Anaphylactic kits;

17. Immunization agents, biological sera, blood and blood plasma;

18. Any Prescription Drug indicated or used for the treatment of infertility;

19. Prescription Drugs used for cosmetic purposes including but not limited to Minoxidil, Rogaine, Renova. (Retin-A is excluded after age 26);

20. Prescription Drugs prescribed by a Pharmacist;

21. Drugs used for Smoking Cessation (e.g., Zyban, Nicorette);

22. Drugs listed in the Homeopathic Pharmacopoeia;

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

24. Prescription Drugs which have not been approved by the FDA, as required by federal law, for distribution or delivery into interstate commerce;

25. Prescription Drugs and syringes and needles which are not Medically Necessary;

26. Prescription Drugs indicated or used for sexual dysfunction (e.g., Viagra, Muse, Edex, Caverject, papaverine, Yocon, and phentolamine);

27. Any Prescription Drug prescribed in excess of the manufacturer's recommended specifications for dosages, frequency of use, or duration of administration as set forth in the manufacturer's insert for such Prescription Drug. This exclusion does not apply if:

    a. the dosages, frequency of use, or duration of administration of a Prescription Drug has been shown to be safe and effective as evidenced in published peer-reviewed medical or pharmacy literature;

b. the dosages, frequency of use, or duration of administration of a Prescription Drug is part of an established nationally recognized therapeutic clinical guideline such as those published in the United States by American Medical Association, National Heart Lung and Blood Institute, American Cancer Society, American Heart Association, National Institutes of Health, American Gastroenterological Association, Agency for Health Care Policy and Research; or

c. BCBSF, in its sole discretion, waives this exclusion with respect to a particular Prescription Drug or therapeutic classes of Prescription Drugs;

28. Any Prescription Drug prescribed in excess of the dosages, frequency of use, or duration of administration shown to be safe and effective for such Prescription Drug as evidenced in published peer-reviewed medical or pharmacy literature or nationally recognized therapeutic clinical guidelines such as those published in the United States by American Medical Association, National Heart Lung and Blood Institute, American Cancer Society, American Heart Association, National Institutes of Health, American Gastroenterological Association, Agency for Health Care Policy and Research unless BCBSF, in its sole discretion, decides to waive this exclusion with respect to a particular Prescription Drug or therapeutic classes of Prescription Drugs.

Submitting a Claim for Reimbursement for Covered Prescription Drugs and/or Covered Syringes and Needles and BCBSF's Claims Processing

In order to obtain benefits under this MediScript® Pharmacy Program Endorsement, Insureds must first pay for Covered Prescription Drugs and/or Covered Syringes and Needles and submit a properly completed claim form (with any required documentation). BCBSF must receive the Insured's claim form. All claim forms must contain the following information:

1. the Contractholder's name;

2. the Contractholder's Contract or Identification number;

3. name of the person for whom the Prescription Drug was dispensed;

4. date of birth of the person for whom the Prescription Drug was dispensed;

5. gender of the person for whom the Prescription Drug was dispensed; and

6. relationship to the Contractholder (e.g., spouse, child, etc.).

Claim forms for Covered Prescription Drugs and/or Covered Syringes and Needles must be accompanied by an itemized statement from the Pharmacy. The itemized statement for a Prescription Drug must include:

1. the name of the person for whom the Prescription Drug was dispensed;

2. the date the Prescription was purchased; the Prescription number; whether the Prescription is new or a refill;

3. the metric quantity of the Prescription;
4. the National Drug Code for the Prescription (label number; product number; package);
5. the name of the prescribing Physician;
6. the Pharmacy name, address, and BCBSF identification number; and
7. the charge for each Covered Prescription Drug purchased.

Pharmacy claims, including the itemized statement, must be sent to the following address:

Blue Cross and Blue Shield of Florida
PAID Prescriptions, LLC
MediScript® Prescription Program
P.O. Box 738
Lee's Summit, MO 64063-0738

NOTE: Participating Pharmacies have agreed to provide Insureds with all of the information necessary for claims filing purposes.

Additional Definitions

Certain important terms applicable to this MediScript® Pharmacy Program Endorsement are set forth below. For additional applicable definitions, please refer to the Glossary of Terms Section in the Contract.

Brand Name Prescription Drug(s)

A Prescription Drug which is marketed or sold using a trademark or a proprietary or brand name.

Covered Prescription Drug(s)

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

Covered Syringes and Needles

Syringes and needles prescribed and purchased either in conjunction with Insulin or included in Anaphylactic kits, and syringes and needles prescribed and purchased in conjunction with an injectable formulation of Imitrex.

Drug

Any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound.

FDA

United States Food and Drug Administration.

Generic Prescription Drug

A Prescription Drug containing the same active ingredients, but not necessarily the same inactive excipients (e.g., coatings, binders, capsules, coloring etc.) as the original or pioneer drug marketed under a brand or proprietary name and which is normally available after the original or pioneer Drug's patent expires. As determined by BCBSF, or BCBSF's Pharmacy Benefit Manager, a Generic Prescription Drug is identified by an "established name" pursuant to 21 U.S.C. § 352(e), by a generic name assigned by the United States Adopted Names Council, or by an official or nonproprietary name regardless of the manufacturer.

National Drug Code (NDC)

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

National Network Pharmacy

A Pharmacy located outside of Florida which is part of the national network of Pharmacies established by BCBSF's contracting Pharmacy Benefit Manager.

Non-Participating Pharmacy

A Pharmacy which is not a Participating Pharmacy.

One-Month Supply

A maximum quantity per Prescription up to a 31-day supply as defined by the Drug manufacturer's, dosing recommendations.

Participating Pharmacy

As to Pharmacies located in Florida, a Pharmacy that has signed a Participating Pharmacy Provider Agreement with BCBSF to participate in the MediScript® Pharmacy Program. As to Pharmacies located outside of Florida, Pharmacies which are National Network Pharmacies are Participating Pharmacies. National Network Pharmacies are Pharmacies outside of Florida participating in a national network of Pharmacies available to BCBSF Insureds through BCBSF's Pharmacy Benefit Manager.

Participating Pharmacy Allowance

The maximum amount allowed to be charged by a Participating Pharmacy per Prescription for Covered Prescription Drugs and/or Covered Syringes and Needles under this Endorsement.

Pharmacist

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

Pharmacy

An establishment licensed as a Pharmacy pursuant to Chapter 465 of the *Florida Statutes*, or a similar law of another state, where Prescription Drugs are dispensed by a Pharmacist.

Pharmacy Benefit Manager

An organization that has established, and manages, a pharmacy network and other pharmacy management programs for third party payers and employers which has entered into an arrangement with BCBSF to make such a network and/or programs available to Insureds.

Prescription

An order for Drugs or medicinal supplies by a Physician or other health care professional authorized by law to prescribe such Drugs or supplies.

Prescription Drug

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

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

BLUE CROSS BLUE SHIELD OF FLORIDA, INC.

M. Cascone, Jr.
President

NOTICE TO INSUREDS REGARDING COVERAGE FOR BREAST RECONSTRUCTION SURGERY

The law[1], referred to as *The Women's Health And Cancer Rights Act of 1998*, regarding breast cancer and reconstructive surgery, requires insurers which provide medical and surgical benefits with respect to a mastectomy, to provide in a case of an insured who is receiving benefits in connection with a mastectomy, coverage for:

- reconstruction of the breast on which the mastectomy has been performed
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications for all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

An insurer may not:

- deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the individual health insurance coverage, solely for the purpose of avoiding the requirements of the Women's Health And Cancer Rights Act of 1998; and
- penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce such a provider to provide care to an individual participant or beneficiary in a manner inconsistent with the Women's Health And Cancer Rights Act of 1998.

Nothing in this law shall be construed to prevent an insurer from negotiating the level and type of reimbursement with a provider for care provided in accordance with this act.

The Women's Health And Cancer Rights Act was effective as of October 21, 1998.

[1] Department of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1999 (HR 4328; P.L. 105-277). This law, Title IX - Women's Health And Cancer Rights, amended subpart 3 or part B of Title XXVII of the Public Health Service Act (42 U.S.C. 300gg-51 et.seq.).

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Home Office
4800 Deerwood Campus Parkway
Jacksonville, Florida 32246

ENDORSEMENT

This Endorsement is to be attached to and made a part of the current Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Contract and any Endorsements issued therewith. The Contract is hereby amended as follows:

The Health Care Provider Alternatives and Reimbursement Rules Section of the Contract is hereby amended by deleting the Eligible Providers subsection and replacing it with the following:

Eligible Providers

The following categories of Providers are eligible to participate as BCBSF PPC Providers and/or Traditional Insurance Providers.

- Acute Care General Hospitals/Osteopathic Hospitals
- Ambulatory Surgical Centers
- Dialysis Centers
- Doctors of Chiropractic (D.C.)
- Doctors of Dental Medicine (D.M.D.)
- Doctors of Dental Science (D.D.S.)
- Doctors of Dental Surgery (D.D.S.)
- Doctors of Medicine (M.D.)
- Doctors of Optometry (O.D.)
- Doctors of Osteopathy (D.O.)
- Doctors of Podiatric Medicine (D.P.M.)
- Durable Medical Equipment Providers
- Home Health Agencies
- Independent Clinical Laboratories
- Mental Health Providers
- Outpatient Rehabilitation Facility
- Physical Therapy Providers
- Prosthetists/Orthotists
- Psychiatric Facilities
- Psychologists
- Skilled Nursing Facilities
- Substance Abuse Facilities

The Glossary of Terms Section of the Contract is hereby amended by adding the definition of Outpatient Rehabilitation Facility, deleting the definition of Skilled Nursing Facility and replacing it with the definition below:

Outpatient Rehabilitation Facility

An entity which renders, through providers properly licensed pursuant to Florida law or the similar law or laws of another state: outpatient physical therapy; outpatient speech therapy; outpatient occupational therapy; outpatient cardiac rehabilitation therapy; and outpatient massage for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition. Further, such an entity must meet BCBSF's criteria for eligibility as an Outpatient Rehabilitation Facility. The term Outpatient Rehabilitation Facility, as used herein, shall not include any Hospital including a general acute care Hospital, or any separately organized unit of a Hospital, which provides comprehensive medical rehabilitation inpatient services, or rehabilitation outpatient services, including, but not limited to, a Class III "specialty rehabilitation hospital" described in Chapter 59A, *Florida Administrative Code* or the similar law or laws of another state.

Skilled Nursing Facility

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

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

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

M. Cascone, Jr.

M. Cascone, Jr.
President

PPO & Traditional Participating Providers - Skilled Nursing Facilities

County	Facility	Address	Phone
Alachua	North Florida Special Care Center	6700 Northwest 10th Place Gainesville, FL 32605	(352) 331-3111
Alachua	Palm Garden of Gainesville	227 SW 62nd Boulevard Gainesville, FL 32607	(352) 331-0601
Brevard	Tandem/Arbors At Melbourne	3033 Sarno Road Melbourne, FL 32934	(407) 255-9200
Brevard	The Health Center of Merritt Island	500 Crockett Boulevard Merritt Island, FL 32953	(407) 454-4035
Broward	Broward Convalescent Home	1330 South Andrews Avenue Ft. Lauderdale, FL 33316	(954) 524-5587
Broward	Hallandale Rehabilitation Center	2400 E. Hallandale Beach Boulevard Hallandale, FL 33009	(954) 457-9717
Broward	Memorial Manor	777 South Douglas Road Pembroke Pines, FL 33025	(954) 431-1100
Broward	Springtree Walk	4251 Springtree Drive Sunrise, FL 33351	(954) 572-4251
Broward	St. John's Rehabilitation Hospital & Nursing Center	4740 N. State Road 7, Bldg. C #100 Lauderdale Lakes, FL 33319	(954) 739-6233
Broward	Tamarac Convalescent Center	7901 NW 88th Avenue Tamarac, FL 33321	(954) 722-9330
Charlotte	Arbors At Port Charlotte	18480 Toledo Blade Boulevard Port Charlotte, FL 33948	(941) 743-4700
Charlotte	Kingsway Health Center	400 Kings Highway Port Charlotte, FL 33980	(941) 255-5855
Charlotte	Mariner Health Care of Port Charlotte	25325 Rampart Boulevard Port Charlotte, FL 33983	(941) 629-7466
Citrus	Surrey Place Convalescent Center	2730 More Knighton Court Lecanto, FL 34416	(352) 746-9500
Clay	IHS of Orange Park	2029 Professional Center Drive Orange Park, FL 32073	(904) 272-6194
Clay	Life Care Center of Orange Park	2145 Kingsley Avenue Orange Park, FL 32073	(904) 272-2424
Clay	Tandem/Arbors at Orange Park	1215 Kingsley Avenue Orange Park, FL 32073	(904) 296-8922
Collier	Imperial Healthcare Center	900 Imperial Golf Course Boulevard Naples, FL 34110	(941) 591-4800
Dade	IHS at Greenbriar Nursing Center	9820 North Kendall Drive Miami, FL 33176	(305) 271-6311
Dade	St. Anne's Nursing Center	11855 Quail Roost Drive Miami, FL 33177	(305) 252-4000
Dade	Villa Maria	1050 NE 125th Street North Miami Beach, FL 33161	(305) 891-8850
Duval	IHS of Jacksonville	1650 Fouraker Road Jacksonville, FL 32221	(904) 786-8668
Duval	Palm Garden of Jacksonville	5725 Spring Park Road Jacksonville, FL 32216	(904) 733-6954
Duval	River Garden Hebrew Home	11401 Old St. Augustine Road Jacksonville, FL 32258	(904) 260-1818
Duval	Tandem/Arbors at Jacksonville	4101 Southpoint Drive E. Jacksonville, FL 32216	904) 296-6800
Escambia	Tandem/Arbors at Pensacola	235 W. Airport Boulevard Pensacola, FL 32505	(850) 857-5200
Hernando	Brooksville Nursing Center	1114 Chatman Boulevard Brooksville. FL 34601	(352) 796-6701
Hillsborough	Arbors At Tampa	2811 Campus Hill Drive Tampa, FL 33612	(813) 972-9700
Hillsborough	IHS of Brandon	702 South Kings Avenue Brandon, FL 33511	(813) 651-1818
Hillsborough	Mariner Health Care of Tampa	3117 West Gandy Boulevard Tampa, FL 33611	(813) 261-5500
Hillsborough	Palm Garden of Sun City	3850 Upper Creek Drive Ruskin, FL 33573	(813) 633-2875
Hillsborough	Palm Garden of Tampa	3612 E. 138th Avenue Tampa, FL 33613	(813) 972-8775
Hillsborough	Tandem/ Arbors of Brandon	701 Victoria Street Brandon, FL 33510	(813) 681-4220
Manatee	IHS at Braden River	2010 Manatee Avenue E. Bradenton, FL 34208	(941) 747-3706
Manatee	IHS of Bradenton	2302 59th Street, W. Bradenton, FL	(941) 792-8480
Manatee	IHS at Riverfront	105 15th Street E. Bradenton, FL 34208	(813) 748-4031
Manatee	Sunbridge Health Center of Bradenton	5627 9th Street E. Bradenton, FL 34203	(941) 753-8941
Marion	IHS Palm Garden of Ocala	3400 S.W. 27th Avenue Ocala, FL 34474	(352) 854-6262

County	Facility	Address	Phone
Martin	Mariner Health Care of Palm City	2505 SW Martin Highway Palm City, FL 34990	(561) 288-0060
Martin	Martin Nursing & Restorative Care Center	6011 SE Tower Drive Stuart, FL 34997	(561) 464-5911
Orange	IHS of Central Florida	1900 Mercy Drive Orlando, FL 32858	(407) 299-5404
Orange	IHS of Winter Park	2970 Scarlett Road Winter Park, FL 32793	(407) 671-8030
Orange	Palm Garden of Orlando	654 N Econlockhatchee Trail Orlando, FL 32825	(407) 273-6158
Orange	The Health Care Center of Ocoee	1556 Maguire Road Ocoee, FL 34761	(407) 877-2272
Orange	The Health Center of Windemere	4875 Cason Cove Drive Orlando, FL 32811	(561) 483-9282
Osceola	Osceola Health Care Center	4201 W. New Nolte Road St. Cloud, FL 34769	(407) 957-3341
Palm Beach	Avante at Lake Worth	2501 N. A Street Lake Worth, FL 33460	(561) 585-9301
Palm Beach	IHS OF Florida At West Palm Beach	2939 S. Haverhill Road West Palm Beach, FL 33415	(561) 641-3130
Palm Beach	Palm Garden of West Palm Beach	300 Executive Center Drive West Palm Beach, FL 33401	(561) 471-5566
Palm Beach	Regents Park of Boca Raton	6363 Verde Trail Boca Raton, FL 33433	(561) 483-9282
Palm Beach	Renova Health Center	750 Bayberry Drive Lake Park, FL 33403	(561) 844-4396
Palm Beach	Sun Bridge of the Palm Beaches	6414 13th Road S West Palm Beach, FL 33145	(561) 478-9900
Pasco	Arbors At Bayonet Point/Hudson	8132 Hudson Avenue Hudson, FL 34667	(727) 863-3100
Pasco	Bayonet Point Health & Rehabilitation Center	7210 Beacon Woods Drive Hudson, FL 34667	(727) 863-1521
Pasco	Bear Creek Nursing Center	8041 State Route 52 Hudson, FL 34669	(727) 863-5488
Pasco	Harborside - Gulf Coast	4927 Voorhees Road New Port Richey, FL 34653	(727) 848-3578
Pasco	Heather Hill Nursing Home	6630 Kentucky Avenue New Port Richey, FL 34653	(727) 849-6939
Pasco	Royal Oak Nursing Center	37300 Royal Oak Lane Dade City, FL 33525	(727) 567-3122
Pinellas	Alpine Health & Rehabilitation Center	3456 21st Avenue S. St. Petersburg, FL 33711	(727) 327-1988
Pinellas	Arbors At Safety Harbor	1410 4th Street Safety Harbor, FL 34695	(727) 726-1181
Pinellas	Arbors At St Petersburg	9393 Park Boulevard Seminole, FL 33777	(727) 391-2200
Pinellas	Concordia Manor	321 13th Avenue N. St. Petersburg, FL 33701	(727) 822-3030
Pinellas	Coquina Key Health & Rehabilitation of St. Petersburg	435 42nd Avenue S. St. Petersburg, FL 33705	(727) 822-1871
Pinellas	Harborside - Clearwater	1980 Sunset Point Clearwater, FL 33765	(727) 443-1588
Pinellas	Harborside - Palm Harbor	2600 Highlands Boulevard Palm Harbor, FL 34684	(727) 785-5671
Pinellas	Harborside - Tampa Bay	3865 Tampa Road Oldsmar, FL 34677	(352) 855-4661
Pinellas	IHS of Florida at Clearwater	2055 Palmetto Street Clearwater, FL 34625	(727) 461-6613
Pinellas	IHS of Pinellas Park	8701 49th Street, N. Pinellas Park, FL 34666	(727) 546-4661
Pinellas	IHS of St. Petersburg	811 Jackson Street, N. St. Petersburg, FL 33705	(727) 896-3651
Pinellas	IHS at Tarpon Springs	900 Beckelt Way Tarpon Springs, FL 34689	(727)934-0876
Pinellas	Mariner Heath Care of Belfair	1150 Ponce De Leon Boulevard Clearwater, FL 33756	(727) 585-5491
Pinellas	Mariner Health Care of Clearwater	4470 East Bay Drive Clearwater, FL 34624	(727) 530-7100
Pinellas	Mariner Health Care of Pinellas Point	5601 31st Street S. St. Petersburg, FL 33712	(727) 867-8871
Pinellas	Palm Garden of Clearwater	3480 McMullen Booth Road Clearwater, FL 33761	(727) 786-6697
Pinellas	Palm Garden of Largo	10500 Starkey Road Largo, FL 33777	(727) 397-8166
Pinellas	Palm Garden of Pinellas	200 16th Avenue S E Largo, FL 33771	(727) 585-9377
Pinellas	S. Heritage Health & Rehabilitation	718 Lakeview Avenue S. St. Petersburg, FL 33705	(727) 894-5125

PPO & Traditional Participating Providers - Skilled Nursing Facilities

County	Facility	Address	Phone
Polk	Briar Hill Nursing Center dba IHS	919 Old Winter Haven Road Auburndale, FL 33823	(941) 967-4125
Polk	Tandem/Arbors At Lakeland	2020 W. Lake Parker Drive Lakeland, FL 33805	(941) 682-7580
Polk	The Health Center of Plant City	701 N. Wilder Road Plant City, FL 33566	(813) 752-3611
Sarasota	Arbors of Sarasota	4783 Fruitville Road Sarasota, FL 34232	(941) 378-8000
Sarasota	Harborside - Pinebrook	1240 Pinebrook Road Venice, FL 34292	(941) 488-6733
Sarasota	Harborside - Sarasota	4602 Northgate Court Sarasota, FL 34234	(941) 355-2913
Sarasota	IHS of Sarasota at Beneva	741 Beneva Road Sarasota, FL 34232	(941) 957-0310
Sarasota	IHS of Venice North	437 South Nokomis Avenue Venice, FL 34285	(941) 488-9696
Sarasota	Sarasota Healthcare Center	5157 Park Club Drive Sarasota, FL 34235	(941) 377-0022
Seminole	Tandem/Arbors at W. Altamonte	1099 W.Town Parkway Altamonte Springs, FL 32714	(407) 865-7116
St. Lucie Port	St. Lucie Nursing & Restorative Care	7300 Oleander Avenue Port St. Lucie, FL 34952	(561) 466-4100
Volusia	The HealthCare of Daytona Beach	550 National HealthCare Drive Daytona Beach, FL 32114	(904) 257-6362

PPO & Traditional Participating Providers - Outpatient Rehabilitation Facilities

County	Facility	Address	Phone
Alachua	Heartland Rehabilitation-Gainesville	908 Northwest 57th Street Bldg. A Gainesville, FL 32605	(352) 332-7332
Alachua	HS Sports Medicine & Rehabilitation Center	7120 N.W. 11th Place Gainesville, FL 32605	(352) 333-6886
Bay	HS Rehabilitation Center	1710 Lisenby Avenue Panama City, FL 32405	(850) 784-4878
Brevard	HS Rehabilitation Center	3285 Garden Street Suite 1 Titusville, FL 32796	(321) 264-0161
Brevard	HS Sports Medicine & Rehabilitation Center	5200 Babcock Street NE Suite 400 Palm Bay, FL 32905	(321) 984-9606
Brevard	HS Sports Medicine & Rehabilitation Center	1340 Medical Pk Drive 2nd Floor Melbourne, FL 32901	(321) 459-0303
Brevard	HS Sports Medicine & Rehabilitation Center	2401 West Eau Galle Boulevard Suite 6 Melbourne, FL 32935	(321) 259-6599
Brevard	HS Sports Medicine & Rehabilitation Center	1676 W Hibiscus Boulevard Melbourne, FL 32901	(321) 676-5723
Brevard	HS Sports Medicine & Rehabilitation Center	7640 N. Wickham Road Suite 110 Melbourne, FL 32940	(321) 259-9606
Brevard	HS Sports Medicine & Rehabilitation Center	4989 South Washington Avenue Titusville, FL 32796	(321) 383-9606
Brevard	HS Sports Medicine & Rehabilitation Center	220 Sykes Creek Parkway Merritt Island, FL 32953	(321) 459-0303
Broward	Healthsouth Sports Medicine & Rehabilitation Center	454 North University Drive Pembroke Pines, FL 33024	(954) 443-1926
Broward	HS of Coral Springs	2804 University Drive Coral Springs, FL 33065	(954) 227-8040
Broward	HS of Downtown Broward	1555 S. Federal Highway Ft. Lauderdale, FL 33316	(954) 462-6005
Broward	HS of E. Ft. Lauderdale	6002 N. Federal Highway Ft. Lauderdale, FL 33308	(954) 938-9040
Broward	HS of Hollywood	3702 Washington Street Suite 101 Hollywood, FL 33021	(954) 986-2299
Broward	HS of Lighthouse Point	4756 N. Federal Highway Lighthouse Point, FL 33064	(954) 946-8877
Broward	HS of North Plantation	350 N. Pine Island Road Level 3 Plantation, FL 33324	(954) 474-2525
Broward	HS of Plantation	600 S. Pine Island Road Suite 200 Plantation, FL 33324	(954) 382-1110
Broward	HS of Weston	2229 N. Commerce Parkway Weston, FL 33326	(954) 659-8986
Broward	HS Rehabilitation Center of Kendall	17796 S.W. 2nd Street Pembroke Pines, FL 33029	(954) 438-7800
Clay	Heartland Rehabilitation-Fleming Island	4711 Highway 17 S. Suite B3 Orange Park, FL 32073	(904) 264-9400
Clay	Heartland Rehabilitation-Middleburg	3839 County Road 218 E. Middleburg, FL 32068	(904) 282-8640
Clay	Heartland Rehabilitation-Orange Park	2233 Park Avenue Orange Park, FL 32073	(904) 264-0792
Clay	HS Sport Medicine & Rehabilitation Center of Orange Park	2128 Park Avenue Orange Park, FL 32073	(904) 264-0921
Columbia	Heartland Rehabilitation-Lake City	1367 W Duval Street Lake City, FL 32055	(904) 752-7332
Columbia	HS Sport Medicine & Rehabilitation Center of Lake City	2290 S. First Street Lake City, FL 32025	(904) 752-1652
Dade	Healthsouth Rehabilitation Center	3808 SW 137th Avenue Miami, FL 33175	(305) 551-3338
Dade	HS Hand Center of Kendall	10300 Sunset Drive Suite 325 Miami, FL 33173	(305) 412-3313
Dade	HS of Miami Lakes	15150 Bull Run Road Miami Lakes, FL 33014	(305) 364-0969
Dade	HS Rehabilitation Center of Kendall	8980 SW 97th Avenue Miami, FL 33176	(305) 271-3223
Dade	HS Sports Medicine & Rehabilitation Center	3705 W. 20th Avenue Suite 125 Hialeah, FL 33012	(305) 558-2629
Dade	HS Sports Medicine & Rehabilitation Center	20295 NE 29th Place Suite 201 Aventura, FL 33180	(305) 933-5942
Dade	HS Sports Medicine & Rehabilitation Center	3280 Ponce De Leon Boulevard Coral Gables, FL 33134	(305) 444-0909
Dade	HS Sports Medicine & Rehabilitation Center	13298 Biscayne Boulevard North Miami, FL 33181	(305) 891-0800
Dade	HS Sports Medicine & Rehabilitation Center	7867 North Kendall Drive Suite 60 Miami, FL 33156	(305) 598-5722
Duval	Heartland Rehabilitation-Arlington	6500 Ft. Caroline Road Jacksonville, FL 32277	(904) 745-5599
Duval	Heartland Rehabilitation-Beaches	1884 South Third Street Jacksonville Beach, FL 32250	(904) 249-4000
Duval	Heartland Rehabilitation-Emerson	4555 Emerson Expressway Suite 110 Jacksonville, FL 32207	(904) 346-0025
Duval	Heartland Rehabilitation-Mandarin	11363 San Jose Boulevard Suite 201 Jacksonville, FL 32223	(904) 260-6212
Duval	Heartland Rehabilitation-Roosevelt	4495 Roosevelt Boulevard Suite 15 Jacksonville, FL 32210	(904) 384-4415
Duval	Heartland Rehabilitation-Southside	3837 Southside Boulevard Suite 9 Jacksonville, FL 32216	(904) 642-0771
Duval	Heartland Rehabilitation-Westside	7764 Normandy Boulevard Suite 15 Jacksonville, FL 32221	(904) 781-5666
Duval	HS Sports Medicine & Rehabilitation Center	1325 San Marco Boulevard Suite 102 Jacksonville, FL 32207	(904) 396-4449
Duval	HS Sports Medicine & Rehabilitation Center	1403 Dunn Avenue Unit 26B Jacksonville, FL 32218	(904) 757-9119
Duval	HS Sports Medicine & Rehabilitation Center	422 Jacksonville Drive South Beach Professional Park Jacksonville, FL 32250	(904) 246-9181
Duval	HS Sports Medicine & Rehabilitation Center	3604 Cardinal Point Drive Jacksonville, FL 32257	(904) 448-8227
Escambia	HS Sports Medicine & Rehabilitation Center	2401 B Langley Avenue Pensacola, FL 32503	(850) 475-2660
Hernando	HS Sports Medicine & Rehabilitation Center	3037 Commercial Way Springhill, FL 34606	(352) 686-1000
Hernando	Rehabilitation Therapy Works	6226 Commercial Way Brooksville, FL 34613	(352) 597-8996
Hillsborough	HS Sports Medicine & Rehabilitation Center	4107 Hines Avenue Tampa, FL 33607	(813) 874-1009
Hillsborough	HS Sports Medicine & Rehabilitation Center	3500 E. Fletcher Avenue Suite 110 Tampa, FL 33613	(813) 971-9351
Hillsborough	HS Sports Medicine & Rehabilitation Center	615 Vanderburg Drive Brandon, FL 33511	(813) 684-2865
Hillsborough	HS Sports Medicine & Rehabilitation Center	2818 W. MLK Boulevard Tampa, FL 33607	(813) 876-0399
Hillsborough	HS Sports Medicine & Rehabilitation Center	609 S. Howard Street Suite 102 Tampa, FL 33606	(813) 258-2918
Hillsborough	HS Sports Medicine & Rehabilitation Center	3653 Madaca Lane Tampa, FL 33612	(813) 908-7936
Hillsborough	HS Sports Medicine & Rehabilitation Center	2406 W. Bradon Boulevard Brandon, FL 33511	(813) 654-0686
Hillsborough	HS Sports Medicine & Rehabilitation Center	4175 E. Fowler Avenue Tampa, FL 33617	(813) 978-1704
Hillsborough	HS Sports Medicine & Rehabilitation Center	2727 W. MLK Boulevard Tampa, FL 33617	(813) 354-0579
Hillsborough	Kessler Rehabilitation Management Systems	1 Urban Centre, Suite 760 4630 W. Kennedy Boulevard Tampa, FL 33609	(813) 281-0410
Lee	HS Sports Medicine & Rehabilitation Center	3401 Hancock Bridge Prky Ft. Myers, FL 33903	(941) 656-5055
Lee	HS Sports Medicine & Rehabilitation Center	2323 Del Prado Boulevard Suite 6B Cape Coral, FL 33990	(941) 574-8288

PPO & Traditional Participating Providers - Outpatient Rehabilitation Facilities

ounty	Facility	Address	Phone
evy	Heartland Rehabilitation-Chiefland	1105 N.W. 23rd Avenue Suite A Chiefland, FL 32626	(352) 493-7776
lanatee	Commonwealth Rehabilitation- Bradenton	2820 Manatee Ave W. Bradenton, FL 34205-4237	(941) 748-5707
lanatee	HS Rehabilitation Center of Bradenton	315 75th Street W. Bradenton, FL 34209	(941) 761-8894
lanatee	HS Sports Medicine & Rehabilitation Center	1300 Manatee Avenue E. Bradenton, FL 34208	(941) 747-5512
larion	HS Sports Medicine & Rehabilitation Center Ocala Hills Professional Center	2102 SW 20th Place Suite 500 Ocala, FL 34474	(352) 622-6644
lassau	Heartland Rehabilitation-Amelia Island	1885 S 14th Fernandina Beach, FL 32034	(904) 261-7878
Okaloosa	HS Sports Medicine & Rehabilitation Center	928 Mar Wall Drive Suite 104 Ft. Walton, FL 32547	(850) 863-4747
Okaloosa	HS Sports Medicine & Rehabilitation Center	554 Twin Cities Boulevard Unit A Niceville, FL 32578	(850) 729-3325
Okaloosa	HS Sports Medicine & Rehabilitation Center	1008 Airport Road Suite A Destin, FL 32541	(850) 837-3349
Orange	HS Rehabilitation Center of Orlando	453 N. Kirkman Road Suite 104 Orlando, FL 32811	(407) 629-7980
Orange	HS Rehabilitation Center of West Orange	10.000 W. Colonial Drive 3rd Floor, Suite 1302 Ocoee, FL 34761	(407) 292-0073
Orange	HS Sports Medicine & Rehabilitation Center	2056 Aloma Avenue 1st Floor Winter Park, FL 32792	(407) 629-7980
Orange	HS Sports Medicine & Rehabilitation Center	5979 Vineland Road Suite 301 Orlando, FL 32819	(407) 352-3508
Orange	HS Sports Medicine & Rehabilitation Center	11500 University Boulevard Orlando, FL 32817	(407) 382-0682
Orange	HS Sports Medicine & Rehabilitation Center	1405 South Orange Avenue 2nd Floor Orlando, FL 32806	(407) 839-6194
Orange	HS Sports Medicine & Rehabilitation Center of Sand Lake	7485 Sandlake Commons Boulevard Orlando, FL 32819	(407) 363-1141
Osceola	HS Sports Medicine & Rehabilitation Center	2330 Fortune Road Kissimmee, FL 34744	(407) 933-0061
Osceola	HS Sports Medicine & Rehabilitation Center	501-D East Oak Street Kissimmee, FL 34744	(407) 847-9110
Palm Beach	HS Corporation dba HS Sport Medicine	12773 West Forest Hill Blvd Suite 109 Wellington, FL 33414	(561) 793-7005
Palm Beach	HS Corporation dba HS Sport Medicine	4801 South Congress Avenue Suite 101 Lake Worth, FL 33461	(561) 750-7633
Palm Beach	HS of West Palm Beach	4440 Beacon Circle Suite 200 West Palm Beach, FL 33407	(561) 863-9000
Palm Beach	HS Rehabilitation Center of Delray Beach	1674 S. Federal Highway Delray Beach, FL 33483	(561) 272-8822
Palm Beach	HS Royal Palm Beach	8993 Okeechobe Boulevard Suite 101 Royal Palm Beach, FL 33411	(561) 793-7700
Palm Beach	HS Sports Medicine & Rehabilitation Center	990 NW 13th Street Boca Raton, FL 33486	(561) 750-7633
Palm Beach	HS Sports Medicine & Rehabilitation Center	901 North Congress Avenue Suite 103 Boynton Beach, FL	(561) 736-9891
Palm Beach	HS West Boca	20401 State Road 7 Boca Raton, FL 33498	(561) 482-8422
Pasco	HS Rehabilitation Center of Port Richey	11425 US Highway 19 N. Port Richey, FL 34652	(727) 869-3997
Pasco	HS Sports Medicine & Rehabilitation Center	5221 Hanff Lane New Port Richey, FL 34668	(727) 841-0515

County	Facility	Address	Phone
Pasco	R & F, Inc. d/b/a Commonwealth Rehabilitation Centers	6117 E. Trouble Creek Road New Port Richey, FL 34653	(727) 845-0800
Pinellas	Commonwealth Rehabilitation Center	3131 Mc Mullen Booth Road Clearwater, FL 33761	(727) 725-2585
Pinellas	Commonwealth Rehabilitation Center - Largo	11439 Ulmerton Road Largo, FL 33778	(727) 581-6800
Pinellas	Farese Pt. Centers	1890 W. Bay Drive Suite W-1 Largo, FL 33770	(727) 584-6160
Pinellas	HS Hand Center of Countryside	28100 US Highway 19 N. Suite 406 Clearwater, FL	(727) 799-8381
Pinellas	HS Rehabilitation Center of Clearwater	2472 Gulf to Bay Boulevard Clearwater, FL 34615	(727) 443-6766
Pinellas	HS Rehabilitation Center of Palm Harbor	2323 Curlew Road Suite 1A Palm Harbor, FL 34683	(727) 789-9831
Pinellas	HS Sports Medicine & Rehabilitation Center	1499 Gulf to Bay Boulevard Suite 100 Clearwater, FL 33755	(727) 443-3800
Pinellas	HS Sports Medicine & Rehabilitation Center	2685 Ulmerton Road Suite 210 Clearwater, FL 33762	(727) 540-0220
Pinellas	HS Sports Medicine & Rehabilitation Center	5900 9th Avenue N. St. Petersburg, FL 33710	(727) 345-3395
Polk	HS Sports Medicine & Rehabilitation Center	5351 Great Oak Drive Lakeland, FL 33815	(863) 682-6858
Polk	HS Sports Medicine & Rehabilitation Center	3900 South Florida Avenue Lakeland, FL 33813	(863) 647-3665
Sarasota	Joint Works	2031 Hawthorne Street Sarasota, FL 34239	(941) 316-0660
Seminole	HS Sports Medicine & Rehabilitation Center of Longwood	765 W. State Road 434 Suite A Longwood, FL 32771	(407) 830-1100
Seminole	HS Sports Medicine & Rehabilitation Center	652 Palm Springs Drive Altamonte Springs, FL 32701	(407) 339-8851
Seminole	HS Sports Medicine & Rehabilitation Center	4106 West Lake Mary Boulevard Suite 320 Lake Mary, FL 32746	(407) 333-3971
St. Lucie	HS Rehabilitation Center at PGA Village	8565 S. Commerce Center Drive Port St. Lucie, FL 34986	(561) 337-9440
St. Lucie	HS Rehabilitation Center at PGA Village	8565 S. Commerce Center Drive Port St. Lucie, FL 34986	(561) 337-9440
St. Lucie	HS Sports Medicine & Rehabilitation Center	10256 South Federal Highway Port St. Lucie, FL 34952	(561) 337-9440
St. Johns	HS Sports Medicine & Rehabilitation Center	1690-A US Highway 1 S. St. Augustine, FL 32086	(904) 810-2101
Suwannee	Heartland Rehabilitation-Live Oak	112 SW Irvin Street Live Oak, FL 32060	(904) 364-5051
Volusia	HS Sports Medicine & Rehabilitation Center of Daytona	1808 W. International Speedway Suite 403-A Daytona Beach, FL 32114	(904) 248-0447
Volusia	HS Sports Medicine & Rehabilitation Center of Deland (Stetson University-Wilson Athletic Center)	141 Pennsylvania Avenue Deland, FL 32720	(904) 740-7748
Volusia	HS Sports Medicine & Rehabilitation Center of Deltona	1555 Saxon Boulevard Suite 101-103 Deltona, FL 32725	(904) 574-5247
Volusia	HS Sports Medicine & Rehabilitation Center of New Smyrna	55 North Causeway New Smyrna Beach, FL 32169	(904) 424-0960
Volusia	HS Sports Medicine & Rehabilitation Center of Ormond	112 North Nova Road Ormond Beach, FL 32174	(904) 673-9880
Walton	HS Sports Medicine & Rehabilitation Center	931 US Highway 331 S. Unit I DeFuniak Springs, FL 32433	(850) 892-7844

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

SPECIAL ANNOUNCEMENT
REGARDING INDEPENDENT CLINCIAL LABORATORIES
Effective August 1, 2001

For your convenience and satisfaction, we are pleased to announce that, effective August 1, 2001, Laboratory Corporation of America (LabCorp) will become Blue Cross and Blue Shield of Florida's (BCBSF's) statewide participating independent clinical lab services provider. With facilities located throughout Florida, you may find it convenient to have your lab services performed at one of LabCorp's many facilities. To access LabCorp's current listing of facilities, please call LabCorp's Hotline at 1-888-522-2677 or visit LabCorp's website at www.labcorp.com.

With the addition of LabCorp to BCBSF's preferred provider and traditional networks, you may be able to lower your out-of-pocket expenses for lab services by using one of LabCorp's facilities or any one of the other 120 regional lab services providers that also participate with BCBSF. Attached please find a listing of participating independent clinical lab providers.

We encourage you to contact us by calling the customer service number on your Identification (ID) Card if you would like additional information regarding these changes or information regarding any of the benefits available to you. Thank you for the trust and confidence you have placed in us.

PPO & Traditional Providers - Independent Clinical Laboratories

County	Name
Alachua	Allergy Testing Laboratory
Alachua	Doctors Clinical Lab Of Gainesville
Alachua	Florida Clinical Practice Association Inc
Alachua	Roca Diagnostic Laboratory Inc
Bay	Alabama Reference Laboratories Inc
Brevard	Medical Labs Of Central Florida
Brevard	Melbourne Medical Laboratory Inc
Broward	Advanced Diagnostic Inc
Broward	Ameripath Florida Inc
Broward	Cleveland Clinic Florida
Broward	Clinical Laboratory Services Inc
Broward	Fidelity Laboratories Inc DBA Gateway Laboratory
Broward	Gambro Healthcare Laboratory Service, Inc
Broward	GYN Cytology & Pathology Associates
Broward	HDC Diagnostics
Broward	Immuno Laboratories Inc
Broward	Med Chem Laboratories Inc
Broward	Meditrend Consultants
Broward	Microbiology Associates
Broward	National Health Guard Inc
Broward	Oakridge Clinical Laboratory Llc
Broward	Outpatient Surgical Services Laboratory Inc
Broward	Royco Inc DBA Esrd Laboratory
Broward	Specially Laboratories
Broward	Stat Care Med Chem Laboratory
Broward	Unilab Of Dade
Citrus	Histopath Lab P A
Collier	Diagnostic Services Inc Immokalee
Collier	DSI Laboratories
Dade	Allergy And Cl Immunology Ctr Of Am
Dade	American Health Associates
Dade	Biotrace Laboratory
Dade	Finlay Clinical Lab Inc
Dade	Florida Dept HRS, Miami Branch Laboratory
Dade	Florida Family Laboratory
Dade	Florida Medical Laboratory
Dade	Genzyme Genetics
Dade	Pathologist Lab, George Loannides MD
Dade	Sayet Assoc Pathologist Refer Lab
Dade	Singer Clinical Laboratory
Dade	Triumph Recovery Inc

County	Name
Dade	UMDC Diabetes Research Institute Chemistry Lab
Dade	UMDC Pathology Reference Services
Dade	University Of Miami Clinical Immunology Lab
Dade	University Of Miami Dermatology And Cutaneous Surgery
Dade	University Of Miami Medicine Dept Thyroid Lab
Dade	University Of Miami Medicine-UMDC Division Of HEPA Hematology Diagnostic Lab
Dade	University Of Miami Medicine-UMDC Division Of HEPA Hepatology Diagnostic Lab
Dade	University Of Miami Surgery-UMDC Surgery Immuno Monitoring Lab
Duval	Consolidated Laboratory Services
Duval	Florida DHRS Central Lab
Duval	Harvey Bernhardt Laboratory
Duval	Internal Medical Group Inc
Duval	Jacksonville Cardiovascular Clinic
Duval	Rickie P Sander MD DBA United Lab Services
Duval	Sanford And Mullen MD
Duval	Southern Reference Laboratories Inc
Escambia	State Of Florida Department Of HRS Pensacola Branch Laboratory
Hendry	Hernando County Laboratories Inc
Highland	Gamar Laboratories
Hillsborough	FDHRS Tampa Branch Laboratory/Virology
Hillsborough	Florida Dept Of Health & Rehabilitation Services
Hillsborough	Gulfcoast Dermatopathology Lab Inc
Hillsborough	Immunology Rheumatology Allergy Laboratory
Hillsborough	Medigene Tampa Inc
Hillsborough	Pathologists Ref Lab Of SW Fl
Hillsborough	Tampa Pathology Laboratory
Hillsborough	University Medical Service Association Inc USF Pediatric Labs USF Medical Center
Hillsborough	University of S Florida Medical Cl Lab
Indian River	Doctors Clinic Laboratory
Lee	Diagnostic Services Inc
Lee	Integrated Regional Laboratories
Leon	Florida DHRS Tallahassee Branch Lab

County	Name
Marion	Cytocor Inc
Marion	Long Medical Laboratory Twin Oaks Medical Arts
Marion	Pagidipati Enterprises Inc Suncoast Clinical Laboratories
Martin	Martin Memorial Health Systems Clinical Lab
Orange	American Medical Laboratories Inc
Orange	Derrick And Associates Pathology Pa
Orange	Medgenetics Diagnostic Labs Inc
Orange	Orlando Branch Laboratory
Palm Beach	Diagnostic Laboratory
Palm Beach	First Physician Care Of South Florida Inc
Palm Beach	Florida Dept HRS West Palm Bch Branch
Palm Beach	Genetics Institute Of Florida
Palm Beach	Jasco Labs Inc DBA RSS Laboratories Inc
Palm Beach	Life Laboratory Inc
Palm Beach	Palm Beach Pathology DBA Martin Pathology Associates
Palm Beach	Strategic Medical Corporation
Pasco	Gulfcoast Reference Laboratory Inc
Pasco	Highland Diagnostic Center, Stephen Noel MD
Pasco	Physicians Stat Laboratory Inc
Pinellas	Allied Clinical Laboratories
Pinellas	Clearwater Clinical Laboratory
Pinellas	Medical Technology Laboratory
Pinellas	St Petersburg Medical Clinic
Polk	Micro Path Laboratories
Polk	Pathologists Ref Lab Of SW Florida
Putnam	Putnam Clinical Laboratories Inc
Sarasota	International Medical Laboratory
Sarasota	Venice Oncology Center Lab
Seminole	Derrick And Associates Pathology Pa Dermatopathology Office
St Johns	St Johns Biomedical Laboratories Inc
St. Lucie	Lookadoo Skyline Laboratory
Sumter	The Villages Clinical Laboratory
Volusia	Central Florida Pathologists Lab
Volusia	Doctors & Physicians Lab
Volusia	Medical Arts Lab Of Deltona
Volusia	Medical Diagnostics Laboratories Inc
Volusia	Tomoka Medical Laboratory Inc

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Home Office
4800 Deerwood Campus Parkway
Jacksonville, FL 32246
(Not for Profit Corporation)

ENDORSEMENT

Preferred Patient Care I or Preferred Patient Care II Application, Medical Riders, and Rate Modification Endorsement

A Part of the BlueChoice Contract

This Endorsement is to be attached to and forms a part of your BlueChoice Contract. Your application and supplemental application, if applicable, for Preferred Patient Care I or Preferred Patient Care II coverage, as applicable, as well as any medical and/or contract rider(s) and/or Rate Modification Endorsement(s) which were issued to you with your Preferred Patient Care I or Preferred Patient Care II contract are a part of your BlueChoice contract and continue to apply.

Blue Cross and Blue Shield of Florida, Inc.

M. Cascone, Jr.
President

Nothing in this Endorsement shall extend, vary, or waiver any of the provisions, benefits, exclusions, limitations, or conditions contained in such Contract other than as stated in this Endorsement.

19475-0601CA

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Home Office
4800 Deerwood Campus Parkway
Jacksonville, Florida 32231-0014

ENDORSEMENT

This Endorsement is to be attached to and made a part of your current Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Contract and any Endorsements or Riders attached thereto. The Contract is hereby amended as follows:

The Health Care Provider Alternatives and Reimbursement Rules Section of the Contract is hereby amended by deleting in its entirety the Eligible Providers subsection and replacing it with the following:

Eligible Providers The following categories of Providers are eligible to participate in BCBSF's PPC[sm] and/or Traditional Networks.

Acute Care General Hospitals/Osteopathic Hospitals
Ambulatory Surgical Centers
Dialysis Centers
Doctors of Chiropractic (D.C.)
Doctors of Dental Medicine (D.M.D.)
Doctors of Dental Science (D.D.S.)
Doctors of Dental Surgery (D.D.S.)
Doctors of Medicine (M.D.)
Doctors of Optometry (O.D.)
Doctors of Osteopathy (D.O.)
Doctors of Podiatric Medicine (D.P.M.)
Durable Medical Equipment Providers
Home Health Agencies
Independent Clinical Laboratories
Independent Diagnostic Testing Facilities
Mental Health Providers
Outpatient Rehabilitation Facilities
Physical Therapy Providers
Prosthetists/Orthotists
Psychiatric Facilities
Psychologists
Skilled Nursing Facilities
Substance Abuse Facilities

The Glossary of Terms Section of the Contract is hereby amended by adding the definition of Independent Diagnostic Testing Facility below:

Independent Diagnostic Testing Facility

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 Facility must be appropriately registered with the Agency for Health Care Administration and must comply with all applicable Florida law or laws of the State in which it operates. Further, such an entity must meet BCBSF's criteria for eligibility as an Independent Diagnostic Testing Facility.

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

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

M. Cascone, Jr.
President

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Home Office
4800 Deerwood Campus Parkway
Jacksonville, Florida 32231-0014

ENDORSEMENT: BLUECARD® PROGRAM

This Endorsement is to be attached to and made a part of your current Blue Cross and Blue Shield of Florida, Inc. (herein "BCBSF") Contract and any Endorsements or Riders attached thereto. The Contract is hereby amended by **replacing** the BlueCard® Program Section with the following:

BlueCard® Program

When you obtain health care services through BlueCard® outside the geographic area BCBSF serves, the amount you pay for Covered Services is calculated on the **lower** of:

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

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

Statutes in a small number of states may require the Host Blue to use a basis for calculating the Insured's liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate liability calculation methods for the Insured that differ from the usual BlueCard® method noted above in paragraph one of this section or require a surcharge, BCBSF would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

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

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

M. Cascone, Jr.
President

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross Blue Shield of Florida's financial strength grows in 1998.

The Blue Cross and Blue Shield Association licenses Blue Cross Blue Shield of Florida, Inc. (BCBSF) to offer products and services under the BLUE CROSS and BLUE SHIELD brand name. Blue Cross Blue Shield of Florida is an independent organization governed by its own Board of Directors and is solely responsible for its own debts and obligations.

During 1998, Blue Cross Blue Shield of Florida and our HMO subsidiary, Health Options, enjoyed a robust increase in enrollment, as another 256,000 members joined one of our plans, and more than 87 percent of our members renewed their health care coverage with us. In customer satisfaction surveys, we continue to find our members more satisfied with their health care coverage than the general public and more likely to recommend us to a friend. We thank you for your confidence.

To continue to meet the health care needs of our customers in today's dynamic environment, we must continue to strengthen our market leadership in Florida. On December 31, 1998, Health Options acquired Principal Health Care of Florida. This acquisition expanded our statewide member base, making Health Options the largest health maintenance organization in the state.

Health care will continue to require new and innovative systems, products and cutting-edge technologies. Policyholders' equity provides a strong foundation to support capability development and is an important measure of a company's financial ability to meet its obligations when claims expenses are higher than anticipated or during times of economic uncertainty. We are pleased to report that in 1998 equity grew from $770.8 million for year-end 1997 to $829.4 million for year-end 1998--an increase of $58.6 million.

Blue Cross Blue Shield of Florida, Inc. and Subsidiaries
CONSOLIDATED BALANCE SHEET*

	DECEMBER 31, 1998	1997
	(in millions)	
Assets		
Investments:		
Fixed maturities	**$ 811.8**	$ 815.6
Equity securities	**410.1**	330.2
Cash and cash equivalents	**235.9**	174.0
Total investments	**1,457.8**	**1,319.8**
Receivables:		
Premiums and other	**158.8**	151.4
Reimbursable contracts	**68.5**	64.7
Federal Employees Health Benefits Program	**126.6**	99.1
Property and equipment, net	**203.8**	179.2
Deferred expenses and other assets	**128.3**	44.7
Total assets	**$2,143.8**	**$1,858.9**
Liabilities		
Liabilities for policyholder benefits:		
Claims outstanding	**$ 307.5**	$ 286.7
Reimbursable contracts	**68.5**	64.7
Policy reserves	**177.3**	158.0
Total liabilities for policyholder benefits	**553.3**	**509.4**
Unearned premium income:		
Premiums	**139.6**	116.1
Federal Employees Health Benefits Program	**126.6**	99.1
Accrued payroll and related benefits	**156.2**	151.7
Bank overdrafts	**117.9**	81.5
Accounts payable and accrued expenses	**125.8**	130.3
Short-term borrowings	**95.0**	---
Total liabilities	**$ 1,314.4**	**$ 1,088.1**
Policyholders' Equity		
Policyholders' equity	**829.4**	770.8
Total liabilities and policyholders' equity	**$2,143.8**	**$1,858.9**

*As derived from the audited financial statements of Blue Cross Blue Shield of Florida, Inc. For a complete copy of the Plan's audited financial statements that were prepared in accordance with generally accepted accounting principles, please write to; BCBSF Public Relations Department, P.O. Box 44269, Jacksonville, Florida 32231-4269.

BlueChoice For Individuals Under 65 Non-Group Contract

Outline Of Coverage

Policy Form Number 19458 0800 CA

BE CERTAIN TO READ YOUR CONTRACT THOROUGHLY

THIS OUTLINE IS ONLY A BRIEF SUMMARY OF YOUR HEALTH COVERAGE BENEFITS AND IS NOT THE CONTRACT OF INSURANCE. THE CONTRACT ITSELF SETS FORTH THE RIGHTS AND OBLIGATIONS OF THE INSURED AND BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

WELCOME TO BLUE CROSS AND BLUE SHIELD OF FLORIDA

We are pleased to provide you with benefits for Health Care Services through a Contract underwritten by Blue Cross and Blue Shield of Florida, Inc. (hereinafter referred to as "BCBSF"). Your Contract includes benefits for certain Hospital and Physician expenses. It is designed to help protect you from the cost of illnesses or injuries.

NOTE: THIS "OUTLINE OF COVERAGE" ACCOMPANIES YOUR BLUECHOICE FOR INDIVIDUALS UNDER (BLUECHOICE) NON-GROUP CONTRACT AND CONTAINS A SUMMARY OF THE BENEFITS COVERED UNDER THAT CONTRACT AS REQUIRED BY FLORIDA LAW. THE CONTRACT MUST BE REFERRED TO FOR THE ACTUAL CONTRACTUAL GOVERNING PROVISIONS.

Please read your Contract thoroughly. Also, you should keep this Outline of Coverage with your Contract and any applicable Riders or Endorsements in a safe and convenient place so you can refer to it when needed.

BCBSF agrees to provide to covered individuals the health insurance benefits specifically provided in the BlueChoice Contract, subject to all the terms, conditions, limitations and exclusions contained in the Contract.

TABLE OF CONTENTS

INTRODUCTION

This Outline of Coverage will briefly acquaint you with the features of your BlueChoice for Individuals Under 65 Non Group Contract (BlueChoice). Please remember that this Outline of Coverage is not a Contract. The Contract is included for your reference. The Schedule of Benefits summarizes your financial responsibilities and includes benefit maximums. The Contract will always control benefits, exclusions, and limitations of your coverage. Please read the Outline of Coverage now and refer to it in the future as the need arises. If you have any questions, please feel free to contact our customer service department at the number located on the front cover of the Contract or on your Identification Card.

UNDERSTANDING YOUR FINANCIAL OBLIGATIONS

The Insured's Financial Obligations Section sets forth requirements and responsibilities that apply to Insureds under the Contract. Refer to the Schedule of Benefits for additional information concerning these requirements and financial responsibilities.

Deductible: Your Contract has a $1,000 Deductible for most Medically Necessary Covered Services each Calendar Year for each Insured. This means that before reimbursement of Covered Services begins, the Calendar Year Deductible must be satisfied before payment may be for certain Covered Services. Please refer to the Contract to determine the services which are subject to the Calendar Year Deductible.

Coinsurance: After each Insured has met the Calendar Year Deductible, BCBSF will pay as follows:

PPO Provider - 80% of the applicable Allowed Amount
Provider Not Participating in PPO - 60% of the PPO Allowance
Ambulance Services - 80% of the PPO Allowance
Prescription Drugs:
Generic - 80% of the Participating Pharmacy Allowance
Brand - 60% of the Participating Pharmacy Allowance

Office Services: Covered Physician Health Care Services (except for Durable Medical Equipment, Prosthetics, and Orthotics) rendered in a PPO Physician's office are only subject to the Copayment amount set forth on the Schedule of Benefits, when the PPO Physician practices in the following: Family Practice, General Practice, Internal Medicine, or Pediatrics.

Coinsurance Responsibility Limit/Maximum Out-of-Pocket Coinsurance Amount:

1. Individual Coinsurance Responsibility Limit

Once an Insured has reached the Individual Coinsurance Responsibility Limit amount as set forth in the Schedule of Benefits, the Insured will have no additional Coinsurance Responsibility for Medically Necessary Covered Services for the remainder of the Calendar Year and BCBSF will pay for Covered Services at 100 percent of the Allowed Amount.

2. Family Coinsurance Responsibility Limit

Once the Contractholder's family has reached the Family Coinsurance Responsibility Limit amount as set forth in the Schedule of Benefits, no Insured in the Contractholder's family will have any additional Coinsurance Responsibility for Medically Necessary Covered Services for the remainder of that Calendar Year and BCBSF will pay for Covered Services at 100 percent of the Allowed Amount. The maximum amount any Insured can contribute toward the Family Coinsurance Responsibility Limit is the amount applied toward the Individual Coinsurance Responsibility Limit amount.

NOTE: Coinsurance Responsibility Limits do not include the Calendar Year Deductible, Hospital Per Admission Deductible, any Copayment, any benefit penalty reduction, non-covered charges or any charges in excess of the Allowed Amount.

LIFETIME MAXIMUMS PER INSURED

1. Total Lifetime Maximum Benefit..... $2,000,000
2. Mental Health Services $10,000
3. Substance Dependency Care and Treatment Benefit Maximum (inpatient, outpatient, or any combination) $2,000
4. Hospice Benefit Maximum $5,200

CALENDAR YEAR MAXIMUMS PER INSURED

1. Mental Health Services Benefit Maximum:

   (a) Inpatient Hospital/Physician or combination of inpatient and Partial Hospitalization $2,000

   (b) Outpatient..... $600

2. Home Health Care Benefit Maximum $2,500
3. Skilled Nursing Facility Days Benefit Maximum..... 60
4. Low Protein Food Products Benefit Maximum $2,500
5. Combined Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations Benefit Maximum..... $1,500

NOTE:
Refer to the Contract for Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations reimbursement guidelines.

COVERED SERVICES

The following are Health Care Services which may be Covered Services under the Contract. Specific exclusions and limitations may apply to a particular type of Health Care Service. Please refer to the Contract to determine any applicable exclusions or limitations. All benefits for Covered Services are subject to the Insured's applicable financial responsibilities, benefit maximums (e.g., Calendar Year Deductible and Lifetime Maximum), the applicable Allowed Amount, limitations, exclusions, and all other provisions contained in the Contract (including the Schedule of Benefits) in accordance with BCBSF's Medical Necessity criteria and guidelines then in effect.

- **Adult Wellness** services for an adult (i.e., age 17 and older), includes the following:

  1. annual physical or gynecological exam;

  2. related wellness services (e.g., pap smears, Prostate Specific Antigen PSA, x-rays, laboratory services, and immunizations). Routine vision and hearing examinations and screenings are not covered.

  The adult wellness services above are not subject to the Individual Calendar Year Deductible, but are subject to the Copayment requirement, or applicable Coinsurance Responsibility depending on the location of service and the Provider's participating status.

  Benefits for Adult Wellness services are limited as set forth in the Schedule of Benefits.

- **Complications of Pregnancy**

  Health Care Services provided to an Insured for the treatment of complications of pregnancy may be Covered Services. Coverage for complications of pregnancy is limited to Covered Services to treat the Condition caused by the complication. Coverage of maternity care is not included in care of the Condition unless delivery is required to resolve the Condition. Additionally, coverage for complications of pregnancy are subject to any Pre-existing Condition limitations. For purposes of this section, the phrase "complications of pregnancy" means a Condition which is diagnosed as a separate Condition from the pregnancy. Refer to the Contract for specific details regarding complications of pregnancy.

  Note: The Contract does not provide coverage or benefits for maternity/obstetrical care unless the Contractholder purchased such coverage under the Optional Maternity/Obstetrical Care Benefits Endorsement.

- **Diagnostic Services**

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

  1. radiology, ultrasound and nuclear medicine, Magnetic Resonance Imaging (MRI);

  2. laboratory and pathology services;

3. services involving bones or joints of the jaw (e.g., services to treat temporomandibular joint TMJ dysfunction) or facial region if, under accepted medical standards, such diagnostic services are necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury;

4. approved machine testing (e.g., electrocardiogram EKG, electroencephalograph EEG, and other electronic diagnostic medical procedures);

5. genetic testing for the purposes of explaining current signs and symptoms of a possible hereditary disease.

Refer to the Contract for specific details regarding diagnostic services.

- **Durable Medical Equipment**

Durable Medical Equipment when provided by a Durable Medical Equipment Provider and when prescribed for an Insured by a Physician, limited to the most cost effective Durable Medical Equipment, which meets the Insured's needs as determined by BCBSF. Refer to the Contract for specific detail regarding Durable Medical Equipment.

- **Home Health Care Calendar Year Maximum $2,500**

Home Health Care Services are covered only when: 1) provided directly by (or indirectly through) a Home Health Agency licensed pursuant to Part IV Chapter 400 of the *Florida Statutes* or another state's applicable laws; 2) the Insured's Physician submits a written treatment plan to BCBSF; 3) the treatment plan is acceptable to BCBSF for coverage and payment purposes; and 4) the Insured is confined to home and is unable to carry out the basic activities of daily living. Refer to the Contract for specific details regarding Home Health Care.

- **Hospice Services Lifetime Maximum $5,200**

Health Care Services provided to an Insured in connection with a Hospice treatment program may be Covered Services, provided the Hospice treatment program is approved by the Insured's Physician and the Insured is not expected to live more than one year. BCBSF shall have the right to request that an Insured's Physician certify in writing the life expectancy of an Insured.

Benefits for Covered Services for Hospice are limited as set forth in the Schedule of Benefits.

- **Hospital Services**

Hospital services including:

1. room and board in a semi-private room when confined as an inpatient, unless the patient must be isolated from others for documented clinical reasons;

2. intensive care units, including cardiac, progressive and neonatal care;

3. use of operating and recovery rooms;
4. use of emergency rooms;
5. respiratory, pulmonary, or inhalation therapy (e.g., oxygen);
6. drugs and medicines administered (except for take home drugs) by the Hospital;
7. intravenous solutions;
8. administration of, including the cost of, whole blood or blood products;
9. dressings, including ordinary casts;
10. anesthetics and their administration;
11. transfusion supplies and equipment;
12. diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
13. chemotherapy and radiation treatment for proven malignant disease;
14. Physical, Speech, Occupational, Cardiac therapies; and
15. transplants as set forth in the Transplant Section.

Refer to the Contract for specific details regarding Hospital Services.

Note: The Contract does not provide coverage or benefits for maternity/obstetrical care unless the Contractholder purchased such coverage under the Optional Maternity Obstetrical Care Benefits Endorsement.

- **Mammograms**

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

Benefits for Mammograms are not subject to the Calendar Year Deductible, Coinsurance, or Copayment.

- **Mental Health Services Lifetime Maximum $10,000**

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

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

Refer to the Contract for specific details regarding Mental Health Services.

Benefits for care and treatment of Mental and Nervous Disorders are limited as set forth in the Schedule of Benefits.

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

The following outpatient therapies listed below when ordered by a Physician or other health care professional licensed to perform such services are covered:

1. Cardiac Therapy;
2. Occupational Therapy;
3. Physical Therapy;
4. Massage Therapy;
5. Speech Therapy; and
6. Spinal Manipulations.

The Schedule of Benefits sets forth the maximum amount that BCBSF will pay for any combination of the outpatient therapies and spinal manipulation services listed above. The outpatient Cardiac, Occupational, Physical, Massage and Speech Therapy and Spinal Manipulation benefits specified above are in addition to the Cardiac, Occupational, Physical and Speech Therapy benefits listed in the Home Health Care, Hospital, and Skilled Nursing Facility subsections of the Contract.

Refer to the Contract for specific details regarding Outpatient Cardiac, Occupational, Physical, Massage and Speech Therapy and Spinal Manipulation benefits.

- **Prescription Drugs**

The Contract provides coverage for certain Prescription Drugs and/or Covered Syringes and Needles purchased from a Pharmacy. Refer to the Mediscript® Pharmacy Program Endorsement for specific details regarding these benefits.

- **Skilled Nursing Facilities Days Maximum (60 Days)**

The following Health Care Services may be Covered Services when: 1) the Insured is an inpatient in a Skilled Nursing Facility; and 2) the Insured's Physician submits a treatment plan that is acceptable to BCBSF for coverage and payment purposes.

Refer to the Contract for specific details regarding Skilled Nursing Facilities services.

- **Substance Dependency Care and Treatment Lifetime Maximum $2,000 (inpatient, outpatient, or any combination)**

Substance Dependency Care and Treatment including:

1. Health Care Services (inpatient and outpatient or any combination thereof) provided to an Insured by a Physician, Psychologist in a program accredited by the Joint Commission of the Accreditation of Healthcare Organizations or approved by the State of Florida for the Detoxification or Substance Dependency Care and Treatment.

2. Physician and Psychologist outpatient visits for the care and treatment of substance dependency.

Benefits for Substance Dependency Care and Treatment are limited as set forth in the Schedule of Benefits.

Refer to the Contract for specific details regarding Substance Dependency Care and Treatment.

- **Transplant Services**

Limited to the procedures listed below, if coverage has been predetermined by BCBSF and if performed at a facility acceptable to BCBSF, subject to the conditions and limitations described below:

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

1. Bone Marrow Transplant, as defined herein, which is specifically listed in Rule 59B-12.001 of the *Florida Administrative Code* (or any successor rule or regulation) or covered by Medicare as described in the most recently published *Medicare Coverage Issues Manual* issued by the Health Care Financing Administration. BCBSF will cover the cost of donating bone marrow by a donor to an Insured to the same extent such cost would be covered for an Insured and subject to the same limitations and exclusions as would be applicable to an Insured. Coverage for the reasonable costs 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;

8. pancreas transplant performed simultaneously with a kidney transplant; or

9. lung-whole single or whole bilateral transplant.

Refer to the Contract for specific details on Transplant Services.

INDIVIDUAL BENEFIT UTILIZATION MANAGEMENT/UTILIZATION REVIEW PROGRAMS

ADMISSION CERTIFICATION REQUIREMENTS

All Hospital admissions in the State of Florida must be certified. The following penalties will apply for admissions within the State of Florida which are not certified.

1. Admissions to a Hospital that is a BCBSF PPC Provider - No penalty for the Insured. It is the responsibility of the PPC Hospital Physician to obtain admission certification.

2. Hospitals that are not BCBSF PPC Providers - any non certified admissions in the State of Florida are subject to a 25% benefit penalty reduction. The Insured is responsible for obtaining certification for the admission from BCBSF and for any applicable benefit reductions for failure to obtain such certification.

Case Management Program

This program may be made available by BCBSF, in its sole discretion, for those Insureds who have a catastrophic or chronic Condition. Under this voluntary program, BCBSF may elect to (but is not required to) offer alternative benefits or payment for cost-effective Health Care Services. These alternative benefits or payments may be made available by BCBSF on a case-by-case basis to Insureds who meet BCBSF's criteria then in effect. Such alternative benefits or payments, if any, will be made available in accordance with a treatment plan with which the Insured, or a representative of the Insured acceptable to BCBSF, and the Insured's Physician agree to in writing.

Discharge Planning

The Discharge Planning Program is completely voluntary for BCBSF and Insureds. Under this UM/UR program, BCBSF may (but shall not be required to) assist the Insured and the Insured's Physician identify health care resources which may be available in the Insured's community following hospitalization. BCBSF will, upon request, answer questions the Insured's Physician has regarding the Insured's coverage or benefits under the Contract following discharge from the Hospital.

PRE-EXISTING LIMITATIONS

Some conditions you had prior to the Effective Date of your coverage will not be covered by your Contract. The following is an explanation of what we mean and how the limitation applies to you and your covered Dependent(s).

BCBSF defines a Pre-existing Condition as any Condition which manifested itself, or of which there were symptoms which would cause a reasonable person to seek diagnosis or treatment, or which was the subject of medical advice or treatment by a provider during the 24 month period immediately preceding the Effective Date of the Insured's coverage.

CONDITIONS EXCLUDED BY RIDER

You will not be eligible to receive benefits for treatment of any Condition that we excluded from coverage by a Rider when you accepted coverage under the Contract. After two years following the Effective Date of your coverage, you may request that we remove the Rider(s) limiting your coverage. If we approve your request, we will advise you when the Rider(s) will no longer be in effect. Refer to the Contract for specific details regarding Rider removal requests.

LIMITATION OF COVERAGE FOR HEALTH CARE SERVICES

All coverage for Health Care Services is limited to coverage, which in the opinion of BCBSF, utilizes the most cost-effective setting, procedure, treatment, level of supply or level of service. For example, coverage is limited to the most cost-effective, Medically Necessary Prosthetic Device, Orthotic Device, or Durable Medical Equipment which, in the opinion of BCBSF, will restore to the Insured the function lost through a covered condition.

QUALIFIED EXCLUSION FOR AIDS AND ARC

If, in the opinion of a Physician, an Insured either first exhibited objective manifestations of Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Syndrome (ARC) which are not attributable to another cause, or tested HIV positive, or was diagnosed as having AIDS or ARC at any time prior to that Insured's first Anniversary Date, there is no coverage under the Contract for any expenses related, directly or indirectly, to AIDS or ARC. This exclusion is in addition to any other rights we have, including but not limited to, enforcement of the Pre-Existing Condition Limitation provision, and rescission or cancellation of the Contract for fraud or Material Misrepresentation. This exclusion shall not apply:

1. if we fail to assert this provision within the first two years of the Insured's coverage under the Contract; or

2. if we fail to notify the Insured, in writing, of the applicability of this provision within ninety (90) days of our determination that the Insured is subject to this provision.

GENERAL EXCLUSIONS

Please read this following list carefully. This is a list of services and supplies that will not, under any circumstances, be covered. The exclusions are limits upon the benefits described in your Contract. (Refer to your Contract for a complete explanation of exclusions.)

General Exclusions include, but are not limited to:

1. any Health Care Service received prior to an Insured's Effective Date or after the date an Insured's coverage terminates;

2. any Health Care Services to treat a Condition excluded under a Rider issued with the Contract;

3. any Health Care Services not specifically listed in the Covered Services Section or in any Endorsement issued with the Contract, unless such services are specifically required to be covered by applicable law;

4. any Health Care Services provided by a Physician or other health care Provider related to the Insured by blood or marriage;

5. any Health Care Service which is not Medically Necessary as defined in the Contract and determined by BCBSF. The ordering of a service by a health care Provider does not in itself make such service Medically Necessary or a Covered Service;

6. any Health Care Service for treatment of non-medical Conditions related to hyperkinetic syndromes, learning disabilities, mental retardation, or inpatient confinement for environmental change;

7. Experimental or Investigational services, except as otherwise covered under the Bone Marrow Transplant provision of the Transplant Services subsection, and except for any drug prescribed for the treatment of cancer that has been approved by the Federal Food and Drug Administration (FDA) for at least one indication, provided the drug is recognized for treatment of the Insured's cancer in a Standard Reference Compendium or recommended for treatment of the Insured's cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded;

8. any Health Care Services to treat a work related Condition to the extent the Insured is covered or required to be covered by Workers' Compensation law. Any Health Care Service to diagnose or treat any Condition resulting from or in connection with an Insured's job or employment will not be covered, 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;

9. any Health Care Services rendered at no charge;

10. any Health Care Service to diagnose or treat any Condition which initially occurred while an Insured was (or which, directly or indirectly, resulted from, or is in connection with, an Insured being) under the influence of alcoholic beverages, any chemical substance set forth in Section 877.111 of the *Florida Statutes*, or any substance controlled under Chapter 893 of the *Florida Statutes* (or, with respect to such statutory provisions, any successor statutory provisions). Notwithstanding, this exclusion shall not apply to the use of any prescription medication by the Insured if such medication is taken on the specific advice of a Physician in a manner consistent with such advice;

11. any Health Care Services to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with:

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

    b. the Insured's participation in, or commission of, any act punishable by law as a felony, or which constitutes riot, or rebellion;

    c. the Insured's engaging in an illegal occupation;

    d. services received at military or government facilities including service in the armed forces, reserves and/or National Guard;

    e. the Insured being under the influence of alcohol or any narcotic, unless taken on the specific advice of a Physician in a manner consistent with such advice; or

    f. an intentionally self-inflicted Condition, suicide or attempted suicide, whether the Insured is sane or insane.

12. court ordered care or treatment, unless otherwise covered;

13. any Health Care Services rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group.

Additional General Exclusions

Expenses for the following Health Care Services are also excluded. These exclusions are in addition to any exclusions specified above and in the Covered Services Section of your Contract.

Abortion, by choice; not Medically Necessary.

Arch Supports, orthopedic 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.

Autopsy or postmortem examination services, unless specifically requested by BCBSF.

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

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

Contraceptive medications, devices, and appliances, 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 subsection), including without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A), and hair implants/transplants.

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

Custodial Care, and any service of a custodial nature, including without limitation: Health Care Services primarily to assist the Insured in the activities of daily living; rest homes; home companions or sitters; home parents; domestic maid services; and respite care.

Dental 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 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, Child Cleft Lip and Cleft Palate Treatment Services.

Drugs:

1. Prescribed for uses other than the 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 the Insured's cancer in a Standard Reference Compendium or recommended for treatment of the Insured's cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.

2. All Drugs dispensed to, or purchased by, an Insured from a Pharmacy, except for Prescription Drugs as defined by, and covered under, the Mediscript® Pharmacy Program Endorsement or as otherwise covered when the Insured is inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility, or outpatient department of a Hospital.

3. Any non-Prescription medicine, remedy, vaccine, biological product (except insulin), pharmaceuticals or chemical compounds, vitamin, mineral supplements, fluoride products, over the counter drugs, products, or health foods.

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

Genetic Screening, including the evaluation of genes of an Insured to determine if they are carriers of an abnormal gene that puts them at risk for a disease.

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

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

Maternity/Obstetrical Care benefits including inpatient and outpatient maternity/obstetrical care benefits of a Midwife or Certified Nurse Midwife and/or Physician including prenatal care, delivery, and all services related to maternity/obstetrical care benefits and services or early termination of pregnancy unless the Contractholder purchased such coverage under the Optional Maternity/Obstetrical Care Benefits Endorsement.

Oral Surgery for the primary purpose of improving the appearance or self-perception of an individual, except as provided under the Covered Services Section.

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

Personal Comfort, Hygiene or Convenience Items and services deemed to be not Medically Necessary and not directly related to the treatment of the Insured including, but not limited to; beauty and barber services; clothing including support hose; radio and television; guest meals and accommodations; telephone charges; take-home supplies; travel expenses; other than Medically Necessary Ambulance services; motel/hotel accommodations; air conditioners; air or water purification systems; water softening systems, humidifiers; or physical fitness equipment; hand rails and grab bars; and massages except as provided in the Covered Services Section of the Contract.

Private Duty Nursing Care rendered at any location.

Rehabilitative Therapies provided to an Insured on an inpatient or outpatient basis, except as provided in the following categories of the Covered Services Section: 1) Hospital; 2) Skilled Nursing Facility; 3) Home Health Care; and 4) Outpatient Cardiac, Occupational, Physical, Speech, Massage Therapies and Spinal Manipulations.

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

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

Smoking Cessation Programs, including any service to eliminate or reduce the dependency on, or addiction to, tobacco, including but not limited to nicotine withdrawal programs and nicotine products (e.g., gum, transdermal patches, etc.).

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

Training and Educational Programs, or materials, including, but not limited to programs or materials for pain management and vocational rehabilitation.

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

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

Weight Control Services including any service to lose, gain, or maintain weight, including without limitation: any weight control/loss program; appetite suppressants; dietary regimens; food or food supplements; exercise programs; equipment; whether or not it is part of a treatment plan for a Condition. For coverage concerning treatment of Morbid Obesity, refer to the surgical procedures category of the Covered Services Section of the Contract.

Wigs and/or cranial prosthesis.

Work Related Condition Services to the extent the Insured is covered or required to be covered by Workers' Compensation law. Any Health Care Service to diagnose or treat any Condition resulting from or in connection with an Insured's job or employment will not be covered under the Contract, 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.

WHO IS ELIGIBLE FOR COVERAGE

Eligibility Requirements for Contractholders

To be Eligible to be a Contractholder, a person must:

1. be bona fide resident of the State of Florida;

2. apply for and be named on the Individual Application for Health Insurance as a Contractholder;

3. determined by BCBSF to be Medically Acceptable;

4. pay the required Premiums; and

5. be under the age of 65 and not eligible for Medicare on the Effective Date of coverage.

Eligibility Requirements for Dependent(s)

An individual who meets the eligibility criteria for Eligible Dependents specified below is eligible to apply for coverage as an Eligible Dependent only if the individual: 1) was named on the Individual Application for Health Insurance; 2) was determined by BCBSF to be Medically Acceptable; 3) pays the required Premiums; 4) is under the age of 65 and not eligible for Medicare on the Effective Date of coverage:

1. the Contractholder's present spouse;

2. the Contractholder's natural, newborn, Adopted, foster, or step child(ren) (or a child for whom the Contractholder has been court-appointed as legal guardian or legal custodian) until the end of the Calendar Year, in which the child reaches age 19, and who is:

   a. dependent upon the Contractholder for financial support; and

   b. living in the household of the Contractholder; or

   c. a Full-Time Student.

3. the newborn child of an Insured other than the Contractholder or the newborn child of an Insured other than the Contractholder's spouse. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Note: It is the Insured's sole responsibility to establish that a child meets the applicable requirements for eligibility. Eligibility will terminate the end of the Calendar Year in which the child no longer meets the eligibility criteria required to be an Eligible Dependent.

Extension of Eligibility for Dependent Children

Students

A Covered Dependent child(ren) may be covered to the end of the Calendar Year in which the child(ren) reaches the limiting age of 23, if the child meets all of the following requirements:

1. the child is dependent on the Contractholder for support;

2. the child's legal residence is within the household of the Contractholder; and

3. the child is a Full-time Student.

Handicapped Children

A handicapped dependent child is eligible to continue coverage beyond the limiting age as a Covered Dependent if such child is otherwise eligible for coverage under the Contract, incapable of self-sustaining employment by reason of mental retardation or physical handicap, and chiefly dependent upon the Contractholder for support and maintenance provided that the symptoms or causes of such child's handicap existed prior to such child's 19th birthday. This eligibility shall terminate on the last day of the month in which the child does not meet the requirements for extended eligibility as a handicapped child.

CONDITIONS OF RENEWAL AND TERMINATION

The Contract is conditionally renewable. This means that it automatically renews each year on the Anniversary Date unless terminated earlier in accordance with the terms of the Contract. BCBSF may terminate the Contract or refuse to renew it if:

1. Premiums are not paid in accordance with the terms of the Contract or BCBSF has not received timely Premium payments;

2. an Insured performs an act, or engages in any practice, that constitutes fraud or makes an intentional misrepresentation of material fact; or

3. an Insured fails to comply with a material provision of the Contract.

If BCBSF decides to terminate the Contract or not renew it, based on one of the actions listed above, BCBSF will provide at least 45 days advance written notice.

PREMIUMS

The first Premium payment is due before the Effective Date of the Contract. Each following Premium payment is due as indicated on the Contractholder's application unless the Contractholder and BCBSF agree on some other method and/or frequency of Premium payment. The Premium is due and payable on or before the due date of the Premium unless the Contractholder and BCBSF agree to another Premium due date.

Your Premium payments are payable to:

Blue Cross and Blue Shield of Florida, Inc.
P.O. Box 2913
Jacksonville, FL 32231

COORDINATION OF BENEFITS: (also referred to as COB)

This is a limitation of benefits provided under the Contract and is designed to avoid the cost of duplication of payments for institutional and professional services when you are covered by two or more insurance plans, policies, or programs which provide health care benefits.

SUBROGATION:

Should you incur Medically Necessary Health Care Services and receive benefits under the Contract, we will acquire all rights of recovery or causes of action you may have against any person or organization, up to the amount of benefits we have paid. You must sign and deliver to us any documents we need, and do whatever else is necessary to protect our subrogation rights.

HOW TO FILE A CLAIM FOR BENEFITS/TIME REQUIREMENTS

PPO Providers and Traditional Insurance Providers have agreed to file with BCBSF claims for Health Care Services they rendered to Insureds. In the event a Provider who renders services to an Insured does not file a claim for such services, it is the Insured's responsibility to file the claim with BCBSF.

A claim must be received by BCBSF within 90 days of the date the service or supply was rendered, or if it is not reasonably possible to file the claim within such 90 day period, the Insured shall ensure that the claim is filed as soon as possible. In any event, no claim for Health Care Services will be considered for payment if, BCBSF does not receive the claim at the address indicated on the Insured's Identification Card within one year of the date the Health Care Service was rendered unless the Insured was legally incapacitated.

To file a claim, the Insured must obtain an itemized statement from the health care Provider and attach it to a completed BCBSF claim form. The Insured may obtain a BCBSF claim form by contacting the local BCBSF office or by calling the customer service department at the number located on the front cover of the Contract or on your Identification Card. The itemized statement must contain the following information:

1. the date the service or supply was provided;
2. a description of the service or supply;
3. the amount actually charged by the Provider;
4. the diagnosis;
5. the Provider's name and address;
6. the patient's name; and
7. the Contractholder's name.

The itemized statement and claim form must be sent to BCBSF at the address indicated on the Insured's Identification Card:

NOTE: Special claims processing rules may apply, when amounts are payable by BCBSF for Health Care Services rendered outside the State of Florida, under the BlueCard® Program. (See the BlueCard® Program Section of the Contract)

GLOSSARY OF TERMS

The Glossary of Terms Section will define many of the words and phrases used throughout the Contract. 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 that section of the Contract or where used in the Contract.

This Outline of Coverage is only a brief summary of the benefits available to you for Health Care Services and is not the Contract of insurance. The Contract itself sets forth the rights and obligations of the Insured and Blue Cross and Blue Shield of Florida, Inc.

ClassAction.org

This complaint is part of ClassAction.org's searchable class action lawsuit database and can be found in this post: Lawsuit Claims Blue Cross and Blue Shield of Florida Wrongfully Denied Coverage for 'Widely Performed' Acid Reflux Procedure