BlueChoice

Evidence of Coverage for Covered Plan Participants of

Diocese of Palm Beach Health Plan Trust

This Evidence of Coverage for Covered Plan Participants Contains Deductible Provisions

For Customer Service Assistance:
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98620 – Plans 0702/0727
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The Group Health Plan established by Diocese of Palm Beach Health Plan Trust and serviced by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) provides an innovative combination of a preferred provider organization (PPO) program and traditional benefits programs. Under the Group Health Plan, Covered Plan Participants may receive greater benefits when obtaining Covered Services from a Preferred Patient Care (“PPC”) Provider; however, benefits are also provided for Covered Services rendered by non-PPC Providers.

Covered Plan Participants are free to select any health care Provider; however, benefits under the Group Health Plan will only be paid for Covered Services rendered by a Provider who is recognized for payment by this Group Health Plan Description at the time the Covered Plan Participant receives Health Care Services.

To find out about a health care Provider’s participation status, you may review the PPO Provider Directory then in effect at www.floridablue.com and/or call the customer service telephone number in this Evidence of Coverage for Covered Plan Participants of Diocese of Palm Beach Health Plan Trust or on the Identification Card. Covered Plan Participants should also carefully review the Schedule of Benefits which is a part of this Evidence of Coverage for a detailed list of his or her financial responsibilities. This is important because the Covered Plan Participant’s financial responsibilities, including any applicable Copayments, Deductibles, and Coinsurance responsibilities, **may vary** depending upon the Providers the Covered Plan Participant chooses.

Serviced by
Blue Cross and Blue Shield of Florida, Inc.

Table of Contents

Introduction to the Evidence of Coverage for Covered Plan Participants of Diocese of Palm Beach Health Plan Trust

This Evidence of Coverage, which includes the Schedule of Benefits, describes the Covered Plan Participant's rights and obligations and those of Diocese of Palm Beach Health Plan Trust. It is important that each Covered Plan Participant read the Evidence of Coverage carefully and become familiar with its terms, including its coverage, benefits, exclusions and limitations.

Set out below are highlights from the Evidence of Coverage 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 **Covered Plan Participant's Financial Obligations** section sets forth requirements and responsibilities that apply to Covered Plan Participants under this Evidence of Coverage. Refer to the Schedule of Benefits for additional information concerning these requirements and financial responsibilities.

The **Health Care Provider Alternatives** section sets forth payment rules established for Covered Services depending on the health care Provider selected by a Covered Plan Participant 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 for Coverage** section describes who is eligible for coverage and how and when this coverage begins.

The **Glossary of Terms** section defines many of the words and phrases used throughout the Evidence of Coverage. 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 Evidence of Coverage.

Other sections contained in this Evidence of Coverage explain when benefits may change; how and when coverage stops; how to obtain coverage if coverage ends; how benefits will be coordinated with other policies or plans; the Group Health Plan's subrogation rights and 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 Insurance Providers.

Section 1: Covered Plan Participant's Financial Obligations

This section sets out a Covered Plan Participant's financial obligations under this Evidence of Coverage. Important information concerning these financial obligations is set forth in the Schedule of Benefits. If a Covered Employee did not receive, or cannot find, the Schedule of Benefits, which is a part of this Evidence of Coverage, it is important that the Covered Plan Participant call the customer service telephone number in this Evidence of Coverage or on their Identification Card.

Deductible Requirement

Individual Deductible

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

Family Deductible

Once the Covered Employee's family has reached such limit, no Covered Plan Participant in that family will have any additional Deductible responsibility for the remainder of that Benefit Period. The maximum amount that any Covered Plan Participant in the family can contribute toward the family Deductible is the amount applied toward the individual Deductible amount.

Hospital Per Admission Deductible

The Hospital Per Admission Deductible must be satisfied by each Covered Plan Participant, for each Hospital admission, before any payment will be made for any claim for inpatient Health Care Services. The Hospital Per Admission Deductible applies regardless of the reason for the admission and is in addition to the Deductible requirement.

Emergency Room Per Visit Deductible

The Emergency Room Per Visit Deductible is set forth in the Schedule of Benefits. The Emergency Room Per Visit Deductible applies regardless of the reason for the visit, is in addition to the Deductible, and applies to emergency room Services in or outside the state of Florida. The Emergency Room Per Visit Deductible must be satisfied by each Covered Plan Participant for each visit.

- If the Covered Plan Participant is admitted to a PPO Hospital as an inpatient at the time of the emergency room visit, the Emergency Room Per Visit Deductible will be waived.
- If the Covered Plan Participant is admitted to a Hospital that is not a PPO Participating Provider as an inpatient at the time of the emergency room visit to the same facility, the PPO Coinsurance and Emergency Room Per Visit Deductible and/or Deductible applicable to Providers not Participating in PPO will apply to that admission.

Out-of-Pocket Maximums

After the Covered Plan Participant has satisfied the applicable Deductible responsibility, claims for Covered Services will be paid at the Coinsurance percentage of the applicable Allowance or Allowed Amount as set forth in the Schedule of Benefits.

1. Individual Out-of-Pocket Maximum

   Once a Covered Plan Participant has reached the individual out-of-pocket

maximum amount as set forth in the Schedule of Benefits, the Covered Plan Participant will have no additional Cost Share responsibility for the remainder of that Benefit Period and Covered Services will be at 100 percent of the Allowance or Allowed Amount.

2. Family Out-of-Pocket Maximum

   Once the Covered Plan Participant's family has reached the family out-of-pocket maximum amount as set forth in the Schedule of Benefits, no Covered Plan Participant in the Covered Plan Employee's family will have any additional Cost Share for the remainder of that Benefit Period and payment for Covered Services will be at 100 percent of the Allowance or Allowed Amount. The maximum amount any Covered Plan Participant can contribute toward the family out-of-pocket maximum is the amount applied toward the individual out-of-pocket maximum amount.

   Note: The out-of-pocket Benefit Period maximums include the Deductible, Hospital Per Admission Deductible, Emergency Room Per Visit Deductible, any Copayment (if applicable) and Coinsurance. Any benefit penalty reductions, non-covered charges or any charges in excess of the Allowance or Allowed Amount will not accumulate toward the out-of-pocket Benefit Period maximums.

Prior Coverage Credit for Out-of-Pocket Coinsurance Limitation

A Covered Plan Participant shall be given credit for the satisfaction or partial satisfaction of any out-of-pocket coinsurance limitation met by such Covered Plan Participant under a prior group, blanket, or franchise insurance or Health Maintenance Organization (HMO) policy maintained by Diocese of Palm Beach Health Plan Trust if the Group Health Plan replaces such a policy. This provision only applies if the prior group, blanket, or franchise insurance or Health Maintenance Organization (HMO) policy purchased by Diocese of Palm Beach Health Plan Trust was in effect immediately preceding the Effective Date of the Group Health Plan. In administering this provision, the following rules will apply:

a. For the initial Benefit Period of coverage under this Evidence of Coverage only, charges credited by Diocese of Palm Beach Health Plan Trust's prior insurer, toward a Covered Plan Participant's out-of-pocket coinsurance limitation, during the 90-day period immediately preceding the Effective Date of the Group Health Plan, shall be credited to that Covered Plan Participant's Out-of-Pocket Coinsurance requirement, under this Evidence of Coverage, but only to the extent those charges were for Health Care Services that would have been Covered Services under this Evidence of Coverage.

b. Prior coverage credit under this Evidence of Coverage only applies at the initial enrollment of the entire Group. Each Covered Plan Participant is responsible for providing any information necessary to apply this prior coverage credit.

Benefit Maximum Carryover

If immediately before the Effective Date of this Group Health Plan Description, a Covered Plan Participant was covered under a prior group policy issued by BCBSF to Diocese of Palm Beach Health Plan Trust, amounts applied to a Covered Plan Participant's benefit maximums under the prior BCBSF policy will be applied toward the Covered Plan Participant's benefit maximums under this Evidence of Coverage.

Additional Financial Responsibilities

In addition to the financial obligations set forth above, Covered Plan Participants 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 Benefit Period maximums);
4. charges in excess of the applicable Allowed Amount; and
5. any benefit reduction (e.g., benefit penalties resulting from a Covered Plan Participant's failure to comply with any Individual Benefit Utilization Management/Utilization Review Program requirements).

Special Payment Rules

Emergency Services in an Emergency Room

Payment for Emergency Services rendered by a non-PPO Provider that has not entered into an agreement with BCBSF to provide access to a discount from the billed amount of that Provider will comply with the provisions of section 627.64194(4) of the Florida Statutes, if section 627.64194(2) of the Florida Statutes is applicable to the Services rendered.

Additionally, payments for Emergency Services by a non-PPO Provider will comply with any applicable federal law.

Non-Emergency Services

Payment for Services rendered by a non-PPO Provider will comply with section 627.64194(4) of the Florida Statutes when:

- such Services are rendered in an Ambulatory Surgical Center, Hospital, mobile surgical facility or Urgent Care Center that are PPO Providers; and
- the Covered Plan Participant does not have the ability and opportunity to choose a PPO Provider at the Ambulatory Surgical Center, Hospital, mobile surgical facility or Urgent Care Center that is a PPO Provider, who is available to treat the Covered Plan Participant; and,
- section 627.64194(3) of the Florida Statutes is applicable to the Services rendered.

In no event, subject to this Special Payment Rules subsection, will non-PPO Providers be paid more than their charges for the Services rendered.

Section 2: Health Care Provider Alternatives and Reimbursement Rules

Introduction

Covered Plan Participants have access to BCBSF's statewide network of PPO Providers in addition to BCBSF's statewide program of Traditional Insurance Providers.

Covered Plan Participants 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. The reimbursement rules for Covered Services varies, as explained below, depending on the health care Provider selected by a Covered Plan Participant to provide Health Care Services. To find out about a health care Provider's participation status, a Covered Plan Participant can review the current PPO Provider Directory at www.floridablue.com and/or call the customer service telephone number in this Evidence of Coverage or on the Covered Plan Participant's Identification Card.

It is the Covered Plan Participant'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 Health Care Services are rendered. Please note that certain categories of PPO Providers may not be available in all geographic regions. This includes anesthesiologists, radiologists, pathologists and emergency room Physicians. The Group Health Plan will pay for Covered Services rendered by any Physician listed above in a Hospital setting (i.e., inpatient, outpatient, or emergency room) at the PPO Provider benefit level. If such Covered Services were rendered by a Physician who is not a PPO Provider, the Covered Plan Participant will be responsible for the difference between what the Group Health Plan pays and the Physician's charge if the Physician is not participating in BCBSF's Traditional Program. Claims paid in accordance with this note will be applied to the PPO Deductibles and PPO Out-of-Pocket Maximums.

Value Choice Providers

Some Providers, designated by BCBSF, may provide Services other than advanced imaging, maternity and Medical Pharmacy at a lower cost share. The DED will be waived for these Services and are available at a lower cost share of $5 when they are rendered in the Value Choice Provider's office. To find a Value Choice Provider the Covered Plan Participant may access the most recent provider directory at www.floridablue.com. These Providers will be designated under the heading Value Choice Providers. Advanced imaging, maternity and Medical Pharmacy Services will remain at the Cost Share listed on the Schedule of Benefits.

Specialty Pharmacy

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

Using the Specialty Pharmacy to provide these Specialty Drugs should lower the amount the Covered Plan Participant has to pay for these medications, while helping to preserve their

benefits. Please refer to the Medication Guide for a list of Specialty Pharmacies.

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, a Covered Plan Participant can review the PPO Provider Directory then in effect at www.floridablue.com and/or call the customer service telephone number in this Evidence of Coverage or on the Covered Plan Participant'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 a Covered Plan Participant any amounts in excess of BCBSF's PPO Schedule Amount, except as otherwise permitted under the terms of their Provider contracts and this Evidence of Coverage. The payment for Covered Services rendered by a BCBSF PPC℠ Provider, if any, will always be made directly to the BCBSF PPC℠ Provider.

When a Covered Plan Participant receives Covered Services from a BCBSF PPC℠ Provider, the Group Health Plan's payment of expenses will be at the Coinsurance percentage set forth in the Schedule of Benefits based on BCBSF's Allowed Amount for such Services. The Covered Plan Participant'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 Evidence of Coverage.

Reimbursement Rules for Non-PPC Providers

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 Professional 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 in full for Covered Services. Traditional Insurance Providers have agreed to file claims for the Services they render. They have also agreed not to bill or otherwise collect from a Covered Plan Participant any amounts in excess of BCBSF's Allowed Amount, except as otherwise permitted under the terms of this Evidence of Coverage and their Provider contract. The payment for Covered Services rendered by a Traditional Insurance Provider, if any, will always be made directly to the Provider.

   The Covered Plan Participant's financial responsibility for Services rendered by Traditional Insurance Providers includes, but is not limited to:

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

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

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

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

2. 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 Allowed Amount as payment in full for Covered Services. Covered Plan Participants receiving Health Care Services from such Providers are responsible for filing claims in connection with those Services and payment for those Services. The Covered Plan Participant's financial responsibility includes:

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

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

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

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

e. the payment of the difference between BCBSF's Allowed Amount and the Provider's charges.

3. 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 not eligible to participate as BCBSF PPC Providers or as Traditional Insurance Providers, a Covered Plan Participant can review the PPO Provider Directory then in effect at www.floridablue.com and/or call the customer service telephone number in this Evidence of Coverage or on the Covered Plan Participant's Identification Card. The Covered Plan Participant is responsible for filing claims for Health Care Services rendered by these Providers. The payment, if any, for Covered Services rendered by these Providers will be at the Coinsurance percentage set forth in the Schedule of Benefits. The Covered Plan Participant's financial responsibility includes:

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

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

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

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

e. the payment of the difference between BCBSF's Allowed Amount 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, and without limitation, any of the following:

- an assignment of the benefits due the Covered Plan Participant under this Evidence of Coverage;

- an assignment of the right to receive payments due under this Evidence of Coverage; or
- an assignment of a claim for damage resulting from a breach, or an alleged breach, of the Group Health Plan.

BCBSF reserves the right to honor an assignment of benefits to a non-participating Provider who 1) is a licensed Hospital, Physician, or dentist and the benefits which have been assigned are for care provided pursuant to section 395.1041, *Florida Statutes*; or 2) is an Ambulance Provider that provides transportation for Services from the location where an "emergency medical condition", defined in section 395.002(8) *Florida Statutes*, first occurred to a Hospital, and the benefits which have been assigned are for transportation to care provided pursuant to section 395.1041, *Florida Statutes*. A written attestation of the assignment of benefits may be required.

Note: For additional reimbursement rules for certain out-of-state PPO Providers, see the “BlueCard Program” section of this Evidence of Coverage.

Section 3: BlueCard® Program

Out-of-Area Services

Overview

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

When Covered Plan Participants receive care outside of Florida, they will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("Nonparticipating Providers") don't contract with the Host Blue. BCBSF's payment practices in both instances are described below.

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard Program

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

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

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

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

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

Special Cases: Value-Based Programs

If Covered Plan Participants receive Covered Services under a Value-Based Program inside a Host Blue's service area, Covered Plan Participants will not be responsible for paying

any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to BCBSF through average pricing or fee schedule adjustments. Additional information is available upon request.

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

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, BCBSF will include any such surcharge, tax or other fee as part of the claim charge passed on to Covered Plan Participants.

Nonparticipating Providers Outside Florida

When Covered Services are provided outside of Florida by Nonparticipating Providers, payment will be based on the Allowance and Allowed Amount, as defined in the Glossary of Terms section of the Evidence of Coverage.

Blue Cross Blue Shield Global Core™ Program

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

If Covered Plan Participants need medical assistance services (including locating a doctor or hospital) outside the BlueCard Service Area, Covered Plan Participants should call the Blue Cross Blue Shield Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

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

Outpatient Services

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

Submitting a Blue Cross Blue Shield Global Core Claim

When Covered Plan Participants pay for Covered Services outside the BlueCard Service Area, Covered Plan Participants must submit a claim to obtain reimbursement. For institutional and professional claims, Covered Plan Participants should complete a Blue Cross Blue

Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the Covered Plan Participant's claim. The claim form is available from the Blue Cross Blue Shield Global Core Service Center or online at www.bcbsglobalcore.com. If Covered Plan Participants need assistance with their claim submission, Covered Plan Participants should call the Blue Cross Blue Shield Global Core Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

Section 4: Individual Benefit Utilization Management/ Utilization Review Programs

Introduction

Under the ASO Agreement with Diocese of Palm Beach Health Plan Trust, BCBSF has agreed to provide certain Utilization Management and Utilization Review Programs. In this regard, 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 this Group Health Plan and, under certain limited circumstances, present opportunities, as explained below, for 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 Covered Plan Participant and the Covered Plan Participant's treating Physicians and health care Providers together with the Covered Plan Participant. Covered Plan Participants 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 Evidence of Coverage. In fulfilling this responsibility, neither BCBSF nor Diocese of Palm Beach Health Plan Trust shall be deemed to participate in or override the medical decisions of any Covered Plan Participant's health care Provider.

Admission Notification Program

As explained below, the Admission Notification Program requirements vary depending on whether or not the Hospital utilized is a BCBSF PPC[sm] Provider. A BCBSF PPC[sm] Provider is a PPO Provider in the state of Florida, or in certain counties outside of Florida, that is also a "Preferred Patient Care[sm]" or "PPC[sm]" Provider (or in a BCBSF Provider network program that replaces, in whole or part, such PPC[sm] program). To find out about a health care Provider's participation status, you can review the Provider Directory then in effect, access BCBSF's website at www.floridablue.com and/or call the customer service phone number on this Evidence of Coverage or on your Identification Card.

1. **Admission Notification Requirements for Inpatient Admissions to Facilities that are BCBSF PPC Providers**

   Under the Admission Notification Program, BCBSF must be notified of ALL inpatient admissions (i.e., elective, planned, urgent or emergency) to a Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility that is a BCBSF PPC[sm] Provider.

   The Admission Notification Program requirements for admissions to such facilities are the Provider's sole responsibility. You are not responsible for satisfying such requirement; however, you should ask the facility if BCBSF has been notified.

2. **Your Admission Notification Requirements for Admissions to Florida Hospitals that are not BCBSF PPC Providers**

   The Admission Notification Program also requires you to notify BCBSF of ANY

admission (e.g., elective, planned, urgent, or emergency) to a Hospital in the state of Florida that is not a BCBSF PPC℠ Provider, by calling the customer service number on your Identification Card.

Concurrent Review Program

The concurrent review program is completely voluntary for BCBSF and Covered Plan Participants. 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 coverage and/or payment should continue 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 Covered Plan Participant'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 Evidence of Coverage and not for the purpose of recommending or providing medical care.

Discharge Planning

The discharge planning program is completely voluntary for BCBSF and Covered Plan Participants. Under this UM/UR program, BCBSF may (but shall not be required to) assist the Covered Plan Participant and the Covered Plan Participant's Physician identify health care resources which may be available in the Covered Plan Participant's community following hospitalization. BCBSF will, upon request, answer questions the Covered Plan Participant's Physician has regarding the Covered Plan Participant's coverage or benefits under this Evidence of Coverage following discharge from the Hospital.

Case Management Program

This program may be made available by BCBSF, in its sole discretion, for those Covered Plan Participants who have a catastrophic or chronic Condition. Under this voluntary program, Diocese of Palm Beach Health Plan Trust 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 Covered Plan Participants 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 Covered Plan Participant, or a representative of the Covered Plan Participant acceptable to BCBSF, and the Covered Plan Participant's Physician agree to in writing. In addition, Diocese of Palm Beach Health Plan Trust will be required to specifically agree to such treatment plan.

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 Covered Plan Participant or any other person insured by BCBSF or Diocese of Palm Beach Health Plan Trust at any time. Nothing contained in this section shall be deemed a waiver of BCBSF's right to enforce this Evidence of Coverage in strict accordance with its terms. The terms of this Evidence of Coverage 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 Covered Plan Participant, 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 Covered Plan Participant or the Covered Plan Participant's representative, the Hospital and/or the Physician of the review decision.

Prior Coverage Authorization/Pre-Service Notification Programs

It is important for the Covered Plan Participant to understand BCBSF's prior coverage authorization programs and how the Provider the Covered Plan Participant selects and the type of Service the Covered Plan Participant receives affects these requirements and ultimately how much the Covered Plan Participant is responsible for paying under this Evidence of Coverage.

The Covered Plan Participant or the Covered Plan Participant's Provider will be required to obtain prior coverage authorization from BCBSF for:

1. certain **Prescription Drugs** denoted with a special symbol in the Medication Guide as requiring prior authorization; or
2. **advanced diagnostic imaging Services**, such as CT scans, MRIs, MRA and nuclear imaging.

Prior coverage authorization requirements vary, depending on whether Services are rendered by a BCBSF PPC[sm] Provider or a Provider who is not a BCBSF PPC[sm] Provider, as described below:

BCBSF PPC[sm] Providers

It is the BCBSF PPC[sm] Provider's sole responsibility to comply with our prior coverage authorization requirements, and therefore the Covered Plan Participant will not be responsible for any benefit reductions if prior coverage authorization is not obtained before Medically Necessary Services are rendered.

Once BCBSF has received the necessary medical documentation from the Provider, BCBSF will review the information and make a prior coverage authorization decision, based on BCBSF's established criteria then in effect. The Provider will be notified of the prior coverage authorization decision.

Providers who are not BCBSF PPC[sm] Providers

1. In the case of **Prescription Drugs** denoted with a special symbol in the Medication Guide as requiring prior authorization, it is the Covered Plan Participant's sole responsibility to comply with BCBSF's prior coverage authorization requirements when the Covered Plan Participant uses a Provider who is not a BCBSF PPC[sm] Provider **before** the Prescription Drug is purchased or administered. **The Covered Plan Participant's failure to obtain prior coverage authorization will result in denial of coverage for such Prescription Drug, including any Service related to the Prescription Drug or its administration.**

   For additional details on how to obtain prior coverage authorization, and for a list of Prescription Drugs that require prior coverage authorization, please refer to the Medication Guide.

2. In the case of **advanced diagnostic imaging Services** such as CT scans, MRIs,

MRA and nuclear imaging, it is the Covered Plan Participant's sole responsibility to comply with BCBSF's prior coverage authorization requirements when rendered or referred by a Provider who is not a BCBSF PPC℠ Provider **before** the advanced diagnostic imaging Services are provided. **The Covered Plan Participant's failure to obtain prior coverage authorization will result in denial of coverage for such Services**.

For additional details on how to obtain prior coverage authorization for advanced diagnostic imaging Services, the Covered Plan Participant may call the customer service phone number on the back of the Covered Plan Participant's ID Card.

Once the necessary medical documentation has been received from the Covered Plan Participant and/or the Provider, who is not a BCBSF PPC Provider, BCBSF or a designated vendor, will review the information and make a prior coverage authorization decision, based on BCBSF's established criteria then in effect. The Covered Plan Participant will be notified of the prior coverage authorization decision.

See the "Claims Processing" section for information on what a Covered Plan Participant can do if prior coverage authorization is denied.

Note:

1. Prior coverage authorization is not required when Emergency Services are rendered for the treatment of an Emergency Medical Condition.
2. Prior coverage authorizations expire on the earlier of, but not to exceed 12 months:
    a. the termination date of the Covered Plan Participant's policy, or
    b. the period authorized by BCBSF, as indicated in the letter the Covered Plan Participant receives from BCBSF.

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

Section 5: Medical Necessity

In order for Health Care Services to be covered under this Evidence of Coverage, such Services must be: 1) not otherwise limited or excluded under this Evidence of Coverage; 2) rendered while coverage is in force; 3) within the Covered Services Categories set forth in the Covered Services Section; and 4) Medically Necessary, as defined in the Glossary of Terms section of this Evidence of Coverage.

It is important to remember that any review of Medical Necessity by BCBSF or Diocese of Palm Beach Health Plan Trust is solely for the purpose of determining coverage or benefits under this Evidence of Coverage and not for the purpose of recommending or providing medical care. In this respect, BCBSF or Diocese of Palm Beach Health Plan Trust may review specific medical facts or information pertaining to a Covered Plan Participant. Any such review, however, is strictly for the purpose of determining, among other things, whether a Health Care Service provided or proposed meets the applicable 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 Covered Plan Participant and the Covered Plan Participant's treating Physicians and health care Providers. Covered Plan Participants and their Physicians are responsible for deciding what medical care should be rendered or received and when that care should be provided. Diocese of Palm Beach Health Plan Trust is solely responsible for determining whether expenses incurred, or to be incurred, for medical care are, or would be, covered under this Evidence of Coverage. In making coverage decisions, neither BCBSF nor Diocese of Palm Beach Health Plan Trust shall be deemed to participate in or override the medical decisions of a Covered Plan Participant or a Covered Plan Participant'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. staying in the Hospital because supervision in the home, or care in the home, is not available or is inconvenient; or being hospitalized for any Service which could have been provided adequately in an alternate setting (e.g., Hospital outpatient department or at home with Home Health Care Services); or
4. inpatient admissions to a Hospital, Skilled Nursing Facility, or any other facility for the purpose of Custodial Care, convalescent care, or any other Service primarily for the convenience of the patient and/or his or 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 Diocese of Palm Beach Health Plan Trust or BCBSF) or a Covered Service. Please refer to the Glossary of Terms for the definition of "Medically Necessary or **Medical Necessity".**

Section 6: Covered Services

Introduction

The following subsections describe the Health Care Services which may be Covered Services under this Evidence of Coverage. All benefits for Covered Services are subject to the Covered Plan Participant's applicable financial responsibilities, benefit maximums (e.g., Deductible), the applicable Allowed Amount, limitations, exclusions, and all other provisions contained in this Evidence of Coverage (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 Evidence of Coverage only if the Services are:

1. within the Covered Services Categories set forth in this Covered Services section;
2. rendered by an appropriate licensed health care Provider who is recognized for payment herein;
3. Medically Necessary, as defined in this Evidence of Coverage;
4. rendered while a Covered Plan Participant's coverage is in force; and
5. not specifically or generally limited or excluded under this Evidence of Coverage.

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 Evidence of Coverage when processing a Covered Plan Participant's claim after the Covered Plan Participant has obtained such Services and a claim has been received by BCBSF for such Services. In some circumstances, Diocese of Palm Beach Health Plan Trust or BCBSF may, but are not required to, determine whether Health Care Services are Covered Services under this Evidence of Coverage before the Covered Plan Participant is provided the Service. For example, Diocese of Palm Beach Health Plan Trust or BCBSF may determine whether a proposed transplant is a Covered Service under this Evidence of Coverage before such transplant is provided. Neither BCBSF nor Diocese of Palm Beach Health Plan Trust are obligated to determine, in advance, whether any Service not yet provided would be a Covered Service unless BCBSF has specifically designated that a Service is subject to a prior authorization requirement as described in the Individual Benefit Utilization Management/Utilization Review Programs section. BCBSF and Diocese of Palm Beach Health Plan Trust are also not obligated to cover or pay for any Service that has not actually been rendered.

In determining whether Health Care Services are Covered Services under this Evidence of Coverage, 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 Evidence of Coverage except as otherwise permitted under the Group Health Plan Description, and, therefore, neither the Covered Plan Participant, nor Diocese of Palm Beach Health Plan Trust, nor any health care Provider or other person should rely on any such written or verbal representation.

BCBSF's Benefit Guidelines

In providing benefits for Covered Services, the benefit guidelines set forth below apply as well as any other applicable reimbursement rules

specific to particular categories of Health Care Services:

1. The reimbursement for certain Health Care Services is included within the Allowed Amount for the primary procedure, and therefore no additional amount is payable for any such Services and/or supplies.
2. The 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. The 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 Evidence of Coverage. For ease of reference, limitations and exclusions which apply to specific Services have been included in this subsection. Any specific limitations and/or exclusions included in this subsection are in addition to any other limitations and/or exclusions listed in this Evidence of Coverage including those listed in the General Exclusions section.

Accident Care

Health Care Services to treat an injury resulting from an Accident not related to a Covered Plan Participant's job or employment.

Exclusion:

Health Care Services to treat an injury resulting from an Accident related to a Covered Plan Participant'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.

Acupuncture

Acupuncture when performed by an MD, DO or Acupuncturist licensed to perform Services by the state in which he/she practices and practicing within the scope and limitation of that license.

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

Ground Ambulance

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

1. For Emergency Medical Conditions – it is Medically Necessary to transport a Covered Plan Participant from the place an Emergency Medical Condition occurs to the nearest Hospital that can provide the Medically Necessary level of care. If it is determined that the nearest Hospital is unable to provide the Medically Necessary level of care for the Emergency Medical Condition, then coverage for Ambulance Services shall extend to the next nearest Hospital that can provide Medically Necessary care; or
2. For limited non-emergency ground Ambulance transport – it is Medically Necessary to transport a Covered Plan Participant by ground:

a. from a non-PPO Hospital to the nearest PPO Hospital that can provide care;

b. to the nearest PPO or non-PPO Hospital for a Condition that requires a higher level of care that was not available at the original Hospital;

c. to the nearest more cost-effective acute care facility as determined solely by BCBSF; or

d. from an acute facility to the nearest cost-effective sub-acute setting.

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

Air and Water Ambulance

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

1. the pick-up point is not accessible by ground Ambulance, or
2. speed in excess of the ground vehicle is critical for a Covered Plan Participant's health or safety.

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

Exclusion:

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

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

Condition,unless such Services are authorized by BCBSF in advance.

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 at the Ambulatory Surgical Center (except for take-home drugs);
4. intravenous solutions;
5. dressings, including ordinary casts;
6. anesthetics and their administration;
7. administration and cost of whole blood or blood products (except as outlined in the Drugs exclusion of the General Exclusions section);
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, 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 the 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.

Autism Spectrum Disorder

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

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

Payment Guidelines for Autism Spectrum Disorder

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

Exclusion:

Any Services for the treatment of Autism Spectrum Disorder other than as specifically identified as covered in this section.

Note: In order to determine whether such Autism Spectrum Disorder Services are covered under this Evidence of Coverage, BCBSF reserves the right to request a formal written treatment plan signed by the treating Physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

Behavioral Health Services

Mental Health Services

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

1. Physician office visits;
2. Intensive Outpatient Treatment (rendered in a facility), as defined in this Evidence of Coverage;
3. Partial Hospitalization, as defined in this Evidence of Coverage, when provided under the direction of a Physician; and
4. Residential Treatment Services, as defined in this Evidence of Coverage.

Exclusion:

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

Substance Dependency Treatment Services

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

Care and treatment for Substance Dependency includes the following:

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

BCBSF may provide you with information on resources available to you for non-medical ancillary services like vocational rehabilitation or employment counseling, when BCBSF is able to. BCBSF does not pay for any services that are provided to you by any of these resources; they are to be provided solely at your expense. You acknowledge that BCBSF does not have any contractual or other formal arrangements with the Provider of such services.

Exclusion:

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

Breast Reconstructive Surgery

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

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 Covered Plan Participant's Physician must specifically prescribe such services and such services must be consequent to treatment of the cleft lip or cleft palate.

Clinical Trials

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

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

1. a PPO Provider has indicated such trial is appropriate for you; or
2. you provide BCBSF with medical and scientific information establishing that your participation in such trial is appropriate.

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

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

Exclusion:

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

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

Colonoscopy

Benefits for Colonoscopy are provided for once every 5 years starting at age 50 under this Evidence of Coverage.

Concurrent Physician Care

Physician medical Services, provided: (a) the additional Physician actively participates in the Covered Plan Participant'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 Services

Dental Services are limited to the following:

1. Care and stabilization treatment rendered within 62 days of an Accidental Dental Injury 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 a Covered Plan Participant in a Hospital or Ambulatory Surgical Center if:
    a. the Covered Plan Participant is under 8 years of age when it is determined by a dentist and the Covered Plan Participant's Physician that dental treatment is necessary due to a dental Condition that is significantly complex, or the Covered Plan Participant has a developmental disability in which patient management in the dental office has proven to be ineffective; or
    b. the Covered Plan Participant has one or more medical Conditions that would create significant or undue medical risk in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

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 Covered Plan Participant'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 purpose of explaining current signs and symptoms of a possible hereditary disease; and
6. Prostate Specific Antigen (PSA) tests for routine screening or diagnostic purposes.

Dialysis Services

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

Down Syndrome

Down syndrome Services provided to a Covered Dependent who is under the age of 18, or if 18 years of age or older is attending high school, consisting of:

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

Payment Guidelines for Down Syndrome

Applied Behavior Analysis Services for Down syndrome must be authorized in accordance with criteria established by BCBSF, **before** such Services are rendered. Services performed without authorization will be denied.

Authorization for coverage is not required for Emergency Services provided for the treatment of an Emergency Medical Condition.

Note: In order to determine whether such Services are covered under this Booklet, we reserve the right to request a formal written treatment plan signed by the treating Physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

Durable Medical Equipment

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

Reimbursement Guidelines for Durable Medical Equipment

Supplies and Service to repair medical equipment may be Covered Services only if the Covered Plan Participant owns the equipment or is purchasing the equipment. The Allowed 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) the Allowed Amount. The total Allowed Amount for such rental equipment will not exceed the total purchase price. Durable Medical Equipment includes, but is not limited to wheelchairs, crutches, canes, walkers, hospital beds, and oxygen equipment.

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

Exclusion:

Equipment which is primarily for the convenience and/or comfort of the Covered Plan Participant, the Covered Plan Participant'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; 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.

Emergency Services and Urgent Care Services

Emergency Services for treatment of an Emergency Medical Condition are covered when rendered by PPO Providers and non-PPO Providers without the need for any prior authorization from BCBSF.

Urgent Care Services

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

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

Enteral Formulas

Prescription and non-prescription enteral formulas for home use 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 Covered Plan Participant 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 a Covered Plan Participant'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.

Hearing Aids

External hearing aids and services related to the fitting or provision of hearing aids, including tinnitus maskers, batteries, and cost of repair.

Exclusion:

Implantable hearing aids and services related to the fitting or provision of implantable hearing aids.

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 Covered Plan Participant's Physician submits a written treatment plan; 3) the treatment plan is acceptable for coverage and payment purposes; and 4) the Covered Plan Participant 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); and
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; and
8. food, housing, and home delivered meals.

Hospice Services

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

1. approved by the Covered Plan Participant's Physician; and
2. the Covered Plan Participant's doctor has certified to BCBSF in writing that the Covered Person's life expectancy is 12 months or less.

Recertification is required every six months.

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 by the Hospital (except for take-home drugs);
7. intravenous solutions;
8. administration of and cost of whole blood or blood products (except as outlined in the

Drugs exclusion of the General Exclusions section);

9. dressings, including ordinary and waterproof casts;
10. anesthetics and their administration;
11. transfusion supplies and equipment;
12. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
13. Physical, Speech, Occupational, Cardiac Therapies; and
14. transplants as set forth in the Transplant Services category in this section.

Exclusion:

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

Inpatient Rehabilitation

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

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

Inpatient Rehabilitation Services are subject to the Per Admission Deductible, if applicable, and any benefit maximum set forth in the Schedule of Benefits.

Exclusion:

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

Mammograms

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

Benefits for Mammograms are not subject to the Deductible, Coinsurance, or Copayment (if applicable).

Mastectomy Services

Breast cancer treatment including treatment for physical complications relating to a Mastectomy (including lymphedemas), and outpatient post-surgical follow-up in accordance with prevailing medical standards as determined by the Covered Plan Participant's attending Physician and the Covered Plan Participant. 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 Covered Plan Participant. The treating Physician, after consultation with the Covered Plan Participant, may choose the appropriate setting.

Maternity Services

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

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

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

Medical Pharmacy

Physician-administered Prescription Drugs which are rendered in a Physician's office are subject to an additional Cost Share amount that is in addition to the office visit Cost Share amount. The Medical Pharmacy Cost Share amount applies to each Prescription Drug and does not include the administration of the Prescription Drug.

The Covered Plan Participant's plan may also include a maximum monthly amount the Covered Plan Participant will be required to pay out-of-pocket for Medical Pharmacy, when such Services are provided by a Physician who is a PPC Provider or a Specialty Pharmacy. If the Covered Plan Participant's plan includes a Medical Pharmacy out-of-pocket monthly maximum, it will be listed on the Schedule of Benefits and only applies after the Covered Plan Participant has met the PPO Deductible, if applicable.

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

Note: For purposes of this benefit, allergy injections and immunizations are not considered Medical Pharmacy.

Newborn Care

A newborn child of a Covered Plan Participant 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 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.

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

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 Covered Plan Participant when due to irreparable damage, wear, a change in the Covered Plan Participant'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:

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

Osteoporosis Screening, Diagnosis, and Treatment

Screening, diagnosis, and treatment of osteoporosis for high-risk individuals, 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

Outpatient therapies listed below when ordered by a Physician or other health care professional licensed to perform such Services:

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

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

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

Massage Therapy: 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 and Physical Therapy

1. Reimbursement for covered Massage Services is limited to no more than four (4) 15-minute Massage treatments per day, not to exceed the Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations benefit maximum listed on the Schedule of Benefits.
2. Reimbursement for a combination of covered Massage and Physical Therapy Services rendered on the same day is limited to no more than four (4) 15-minute treatments per day for combined Massage and Physical Therapy treatment, not to exceed the Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations benefit maximum listed on the Schedule of Benefits.
3. Reimbursement for covered Physical Therapy Services rendered on the same day as spinal manipulation is limited to one (1) Physical Therapy treatment per day not to exceed fifteen (15) minutes in length.

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.

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

Reimbursement Guidelines for Spinal Manipulation

1. Reimbursement for covered spinal manipulation is limited to no more than 26

spinal manipulations per Benefit Period, or the maximum benefit listed in the Schedule of Benefits, whichever occurs first.

2. Reimbursement for covered Physical Therapy Services rendered on the same day as spinal manipulation is limited to one (1) Physical Therapy treatment per day, not to exceed fifteen (15) minutes in length.

The Schedule of Benefits sets forth the maximum number of visits covered under the plan for any combination of the outpatient therapies and spinal manipulation Services listed above. For example, even if the Covered Plan Participant may have only been administered two (2) of the spinal manipulations for the Benefit Period, any additional spinal manipulations for that Benefit Period will not be covered if the Covered Person has already met the combined therapy visit maximum with other Services.

Oxygen

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

Physician Services

Covered Services include medical Services such as office visits and allergy testing and treatment or surgical Health Care Services provided by a Physician, including Services rendered in the Physician's office or in an outpatient facility. Certain Physician Services can be rendered electronically through a computer via the Internet (E-Visits). E-Visits are covered when rendered in accordance with the Coverage Access Rules below.

Payment Rules for E-Visits

Expenses for E-Visits are covered only if:

1. the Covered Plan Participant is an established patient of the Physician rendering the Services at the time the Services are provided; and
2. the Services are provided in response to an online inquiry the Covered Plan Participant sent to the Physician.

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

Exclusion

1. Expenses for failure to keep a scheduled appointment or scheduled E-visit and for telephone consultations (except as indicated as covered under the Preventive Service category of this section).
2. Health Care Services provided solely through audio-only telephone; email messages; text messages; facsimile transmission; U.S. Mail or other parcel service; or any combination thereof.

Preventive Health Services

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

1. evidence-based items or Services that have in effect a rating of 'A' or 'B' in the current recommendations of the U.S. Preventive Services Task Force established under the Public Health Service Act;

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

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

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

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

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

Exclusion:

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

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 Covered Plan Participant when due to irreparable damage, wear, or a change in the Covered Plan Participant'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 (including the first temporary prosthesis if it is determined to be necessary) prescribed for each specific Condition.

Self-Administered Prescription Drugs

The Following Self-Administered Drugs are covered:

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

   Specialty Drugs used to increase height or bone growth (e.g., growth hormone), must meet the following criteria in order to be covered:

   a. Must be prescribed for Conditions of growth hormone deficiency documented with two abnormally low stimulation tests of less than 10 ng/ml and one abnormally low growth hormone dependent peptide or for Conditions of growth hormone deficiency associated with loss of pituitary function due to trauma, surgery, tumors, radiation or disease, or for state mandated use as in patients with AIDS.

   b. Continuation of growth hormone therapy only covered for Conditions associated with significant growth hormone deficiency when there is evidence of continued responsiveness to treatment. Treatment is considered responsive in children less than 21 years of age, when the growth hormone dependant peptide (IGF-1) is in the normal range for age and Tanner development stage; the growth velocity is at least 2 cm per year, and studies demonstrate open epiphyses. Treatment is considered responsive in both adolescents with closed epiphyses and for adults, who continue to evidence growth hormone deficiency and the IGF-1 remains in the normal range for age and gender.

Note: Specialty Drugs purchased from a Provider who is not a BCBSF PPC^{sm} Provider for delivery to the Covered Plan Participant at home will be subject to the benefit maximum set forth in the Schedule of Benefits.

Skilled Nursing Facilities

The following Health Care Services may be Covered Services when: 1) the Covered Plan Participant is an inpatient in a Skilled Nursing Facility; and 2) the Covered Plan Participant's Physician submits a treatment plan that is acceptable to BCBSF and/or Diocese of Palm Beach Health Plan Trust 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 and cost of, whole blood or blood products (except as outlined in the Drugs exclusion of the "General Exclusions" section)**;**
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 Covered Plan Participant maximum number of days per Benefit Period set forth on the Schedule of Benefits are also excluded.

Surgical Assistant Services

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

Surgical Procedures

Surgical procedures performed by a Physician including the following:

1. surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes;
2. oral surgical procedures for excisions of tumors, cysts, abscesses, and lesions of the mouth;
3. surgical procedures involving bones or joints of the jaw (e.g., temporomandibular joint [TMJ]) and facial region if, under accepted medical standards, such surgery is necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury;
4. surgical procedures performed on a Covered Plan Participant for the treatment of morbid obesity (e.g., intestinal bypass, stomach stapling, balloon dilation) and the associated care provided the Covered Plan Participant has not previously undergone the same or similar procedure in the lifetime of this Group Health Plan;

   Exclusion:

   Surgical procedures for the treatment of morbid obesity including: intestinal bypass; stomach stapling; balloon dilation and associated care for the surgical treatment of morbid obesity, if the Covered Plan Participant has previously undergone the same or similar procedures in the lifetime of this Group Health Plan.
5. Services of a Physician for the purpose of rendering a second surgical opinion and related diagnostic Services to help determine the need for surgery.
6. Gender reassignment surgery and Services related to gender dysphoria or gender transition are covered.

   Exclusions:

   The following Services, which are considered cosmetic in nature, are not covered when used to improve the gender-specific appearance of an individual. Examples of Services which are considered cosmetic include, but are not limited to:

a. reduction thyroid chondroplasty;

b. liposuction;

c. rhinoplasty;

d. facial bone reconstruction;

e. face lift;

f. blepharoplasty;

g. voice modification surgery;

h. hair removal/hairplasty; or

i. breast augmentation.

BCBSF's Reimbursement Guidelines for Surgical Procedures

a. Reimbursement for multiple surgical procedures, performed in addition to the primary surgical procedure, on the same or different areas of the body, during the same operative session will be based on 50 percent of the Allowed Amount for any secondary surgical procedure(s) performed and the Coinsurance or Copayment (if any) indicated in the Covered Plan Participant's Schedule of Benefits. 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 and/or Diocese of Palm Beach Health Plan Trust, is not clearly identified and/or do 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.

Telemedicine Services

Telemedicine services as defined in the Evidence of Coverage.

Transplant Services

Limited to the procedures listed below, if coverage has been predetermined by BCBSF and/or Diocese of Palm Beach Health Plan Trust and if performed at a facility acceptable to BCBSF and/or Diocese of Palm Beach Health Plan Trust, subject to the conditions and limitations described below:

Transplant includes pre-transplant, transplant and post-discharge Services and treatment of complications after transplantation. Benefits will only be paid 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 Centers for Medicare and Medicaid Services. Coverage will be provided for the cost of donating bone marrow by a donor to a Covered Plan Participant to the same extent such cost would be covered for a Covered Plan

Participant and subject to the same limitations and exclusions as would be applicable to a Covered Plan Participant. 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 (including a ventricular assist device, if indicated, when used as a bridge to heart transplantation);
4. heart-lung combination transplant;
5. liver transplant;
6. kidney transplant;
7. pancreas transplant;
8. pancreas transplant performed simultaneously with a kidney transplant; or
9. whole single or whole bilateral lung transplant.

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

BCBSF and/or Diocese of Palm Beach Health Plan Trust will make a prior benefit determination concerning the proposed transplant; however, BCBSF must be given the opportunity to evaluate the clinical results of the Covered Plan Participant'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 Covered Plan Participant or their Physician of the coverage decision.

For covered transplants, and all related complications, the Group Health Plan 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.

Covered Plan Participants may call the customer service telephone number indicated in this Evidence of Coverage or on the Covered Plan Participant's Identification Card in order to determine which Bone Marrow Transplants are covered under this Evidence of Coverage.

<u>Exclusion:</u>

The following are excluded:

1. transplant procedures not included in the list above, or otherwise excluded under this Evidence of Coverage (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 the Group Health Plan;
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 Covered Plan Participant;

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 Centers for Medicare and Medicaid Services as evidenced in the most recently published *Medicare Coverage Issues Manual;*

7. any Service in connection with identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant. 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 Covered Plan Participant or the Covered Plan Participant's family to and from the approved facility;

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

10. any temporary lodging; and

11. any artificial heart or mechanical device that replaces either the atrium and/or the ventricle.

Section 7: General Exclusions

Introduction

This Evidence of Coverage expressly excludes expenses for the following Health Care Services, supplies, drugs or charges. The following exclusions are in addition to any exclusions specified in the "Covered Services" section or any other section of this Evidence of Coverage.

General Exclusions include, but are not limited to:

1. any Health Care Service received prior to a Covered Plan Participant's Effective Date or after the date a Covered Plan Participant's coverage terminates, unless coverage is extended in accordance with the Extension of Benefits section;
2. any Health Care Service not specifically listed in the Covered Services section or in any Endorsement attached hereto, unless such Services are specifically required to be covered by applicable law;
3. any Health Care Service a Covered Person renders to him or herself or those renedered by a Physician or other health care Provider related to the Covered Person by blood or marriage;
4. any Health Care Service which is not Medically Necessary as defined in this Evidence of Coverage and determined by BCBSF or Diocese of Palm Beach Health Plan Trust. The ordering of a Service by a health care Provider does not in itself make such Service Medically Necessary or a Covered Service;
5. Experimental or Investigational Services, except as otherwise covered under the Bone Marrow Transplant provision described in the Transplant Services category of the "Covered Services" section**;**
6. Health Care Services to treat an injury resulting from an Accident related to a Covered Plan Participant'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.
7. any Health Care Service rendered at no charge;
8. any Health Care Service to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with:
    a. war or an act of war, whether declared or not;
    b. the Covered Plan Participant's participation in, or commission of, any act punishable by law as a felony, or which constitutes riot, or rebellion except for an injury resulting from an act of domestic violence or a medical condition;
    c. the Covered Plan Participant's engaging in illegal occupation, except for an injury resulting from an act of domestic violence or a medical condition;
    d. Services received at military or government facilities to treat a Condition arising out of the Covered Plan Participant's service in the armed forces, reserves and/or National Guard; or
9. court-ordered care or treatment, unless otherwise covered;
10. any Health Care Service rendered by or through a medical or dental department maintained by or on behalf of an employer,

mutual association, labor union, trust, or similar person or group;

11. Health Care Services that are not patient-specific, as determined solely by BCBS; and.
12. Health Care Services that do not comply with the most recent version of the Ethical Religious Directories for Catholic Facilities issued by the National Catholic Conference of Catholic Bishops.

Additional General Exclusions

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

Abortion, as described in the most recent version of the *Ethical Religious Directives for Catholic Facilities* issued by the National Catholic Conference and approved by the National Catholic Conference of Catholic Bishops.

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

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

Autopsy or postmortem examination Services, unless specifically requested by Diocese of Palm Beach Health Plan Trust or 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 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 Injections medications, devices, appliances, or other Health Care Services when provided for contraception.

Cosmetic Services, including any service to improve the appearance or self-perception of an individual (except as covered under the Breast Reconstructive Surgery 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 ,or services used to improve the gender specific appearance of an individual including, but not limited to reduction

thyroid chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification surgery, hair removal/hairplasty, breast augmentation

Costs related to telephone consultations (except as indicated as covered under the Preventive Health Services category of the COVERED SERVICES section) , failure to keep a scheduled appointment, or completion of any form and /or medical information.

Custodial Care, and any Service of a Custodial nature, including and without limitation: Health Care Services primarily to assist the Covered Plan Participant 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 that has been proven safe, effective and accepted for the treatment of the specific medical Condition for which the drug has been prescribed, as evidenced by the results of good quality controlled clinical studies published in at least two or more peer-reviewed full length articles in respected national professional medical journals. This exclusion also does not apply to any drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the drug is recognized for treatment of the Covered Plan Participant's particular cancer in a Standard Reference Compendium, or is recommended for treatment of the Covered plan Participant's particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.
2. All drugs dispensed to, or purchased by, an Covered Plan Participant from a pharmacy. This exclusion does not apply to drugs dispensed to a Covered Plan Participant when:
    a. the Covered Plan Participant is an inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility or a Hospice facility;
    b. the Covered Plan Participant is in the outpatient department of a Hospital;
    c. dispensed to the Covered Plan Participant's Physician for administration to the Covered Plan Participant in the Physician's office and prior coverage authorization has been obtained (if required).
    d. the Covered Plan Participant is receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills BCBSF for such drugs , including Self-Administered Prescription Drugs that are rendered in connection with a nursing visit; and.
    e. defined by, and covered under, a BCBSF Pharmacy Program Endorsement to this Certificate.
3. Any non-Prescription medicines, remedies, vaccines, biological products (except

insulin), pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, over-the-counter drugs, products, or health foods, except as described in the Preventive Health Services category of the "Covered Services" section.

4. Any drug which is indicated or used for sexual dysfunctional (e.g., Cialis, Levitra, Viagra, Caverject). The exception described in exclusion number one above does not apply to sexual dysfunction drugs excluded under this paragraph.
5. Any Self-Administered Prescription Drug except when indicated as covered in the "Covered Services" section of this Evidence of Coverage.
6. Blood or blood products used to treat hemophilia, except when provided to a Covered Plan Participant for:

   a. emergency stabilization;

   b. during a covered inpatient stay, or

   c. when proximately related to a surgical procedure.

   The exceptions to the exclusion for drugs purchased or dispensed by a pharmacy described in subparagraph number two do not apply to hemophilia drugs excluded under this exclusion.
7. Drugs, which require prior coverage authorization when prior coverage authorization is not obtained.
8. Specialty Drugs used to increase height or bone growth (e.g., growth hormone) except for Conditions of growth hormone deficiency documented with two abnormally low stimulation tests of less than 10 ng/ml and one abnormally low growth hormone dependent peptide or for Conditions of growth hormone deficiency associated with loss of pituitary function due to trauma, surgery, tumors, radiation or disease, or for state mandated use as in patients with AIDS.

   Continuation of growth hormone therapy will not be covered except for Conditions associated with significant growth hormone deficiency when there is evidence of continued responsiveness to treatment. (See the Covered Services section for additional information.)
9. New Prescription Drug(s), as defined in the Glossary of Terms section.
10. Convenience Kits, as defined in the Glossary of Terms section of the Evidence of Coverage.
11. Drugs that are FDA approved, but lack proven benefits and/or efficacy as defined in the product prescribing information or noted in BCBSF's coverage policy as an output from our Pharmacy and Therapeutics Committee, Medical Policy Committee or any other nationally recognized source.

Food and Food Products prescribed or not, except as covered in the Enteral Formulas category of the "Covered Services" section.

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 a Covered Plan Participant to determine if they are carriers of an abnormal gene that puts them at risk for a Condition, except as provided under the Preventive Health Services category of the "Covered Services" section.

Immunizations except those covered under the Preventive Health Services category of the "Covered Services" section.

Motor Vehicle Accidents Injuries and Services a Covered Plan Participant incurred

due to an accident involving any motor vehicle for which no-fault insurance is available.

Oral Surgery the primary purpose of which is to improve the appearance or self-perception of an individual, except as provided under the Covered Services section.

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

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

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

Personal Comfort, Hygiene or Convenience Items and services deemed to be not Medically Necessary and not directly related to the treatment of the Covered Plan Participant 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; humidifiers; or Physical fitness equipment; and massages except as covered in the Covered Services Section of this Evidence of Coverage.

Private Duty Nursing Care rendered at any location.

Rehabilitative Therapies provided to a Covered Plan Participant on an inpatient or outpatient basis, except as provided in the Hospital, Inpatient Rehabilitation, Skilled Nursing Facility, Home Health Care, and Outpatient Cardiac, Occupational, Physical, Speech, Massage Therapies and Spinal Manipulation Services categories of the Covered Services section.

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

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.), except as indicated as covered under the Preventive Health Services category of the COVERED SERVICES section.

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

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

Training and Educational Programs, or materials, including, but not limited to programs or materials for pain management and vocational rehabilitation, except as provided under the Diabetes Outpatient Self Management category of the Covered Services section.

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

Volunteer Services or Services which would normally be provided free of charge to a Covered Plan Participant 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.

Wigs and/or cranial prosthesis.

Section 8: Eligibility for Coverage

Each Eligible Employee or other individual who is eligible to participate in the Group Health Plan, and who meets and continues to meet the eligibility requirements described in this Evidence of Coverage, shall be entitled to apply to become a Covered Plan Participant of the Group Health Plan. Such eligibility requirements shall be binding and no change in such requirements shall be permitted except as permitted by Diocese of Palm Beach Health Plan Trust and provided BCBSF has been notified in writing of such change and agreed to service such changes. Acceptable documentation that an individual meets and continues to meet the eligibility requirements (e.g., court order naming the Eligible Employee as the legal guardian or "Adoption" documentation) may be required.

Eligibility Requirements for Covered Employees

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

A waiting period is the time between the first day of employment and the first day of coverage under the plan. The waiting period is counted in the Pre-existing Condition Limitation exclusion time.

To be eligible, you must be:

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

Eligibility Requirements for Dependents

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

1. The Covered Employee's Spouse.
2. The Covered Employee's natural, newborn, Adopted, Foster, or step child(ren) (or a child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian) who has not reached the end of the Calendar Year in which he or she reaches age 26 (or in the case of a Foster Child, is no longer eligible under the Foster Child Program), regardless of the dependent child's student or marital status, financial dependency on the Covered Employee, whether the dependent child resides with the Covered Employee, or whether the dependent child is eligible for or enrolled in any other health plan.
3. The newborn child of a Covered Dependent child who has not reached the end of the Calendar Year in which he or she becomes 26. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

   Note: If a Covered Dependent child who has reached the end of the Calendar Year in which he or she becomes 26 obtains a dependent of their own (e.g., through birth or adoption) such newborn child will not be eligible for this coverage and the Covered Dependent child will also lose his or her eligibility for this coverage. It is the Covered Employee's sole responsibility to establish that a child meets the applicable requirements for eligibility.

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

Extension of Eligibility for Dependent Children

A Covered Dependent child may continue coverage beyond the age of 26, provided he or she is:

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

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

Children with Disabilities

In the case of a dependent child with an intellectual or physical disability, such child is eligible to continue coverage as a Covered Dependent, beyond the age of 30, if the child is:

1. otherwise eligible for coverage under the Group Health Plan;
2. incapable of self-sustaining employment by reason of intellectual or physical disability; and
3. chiefly dependent upon the Covered Employee for support and maintenance provided that the symptoms or causes of the child's intellectual or physical disability existed prior to the child's 30th birthday.

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

Exception for Students on Medical Leave of Absence from School

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

Section 9: Enrollment and Effective Date of Coverage

Eligible Employees and Eligible Dependents may enroll for coverage according to the provisions set forth below.

Any individual (even if such individual is an Eligible Employee or Eligible Dependent) who is not properly enrolled hereunder shall not be covered under the Group Health Plan and neither Diocese of Palm Beach Health Plan Trust nor BCBSF shall have any obligation whatsoever with respect to such individual.

Enrollment Forms/Electing Coverage

To apply for coverage, the Eligible Employee must:

1. complete and submit, through Diocese of Palm Beach Health Plan Trust, the Enrollment Form;
2. provide any additional information needed to determine eligibility, if requested by BCBSF or Diocese of Palm Beach Health Plan Trust; and
3. complete and submit, through Diocese of Palm Beach Health Plan Trust, an Enrollment Form to add Eligible Dependents or delete Covered Dependents.

When making application for coverage, the Eligible Employee must elect one of the types of coverage available under Diocese of Palm Beach Health Plan Trust's program. Such types may include:

1. Employee Only Coverage. This type of coverage provides coverage for the Eligible Employee only.
2. Employee/One Dependent Coverage. This type of coverage provides coverage for the Eligible Employee and one eligible dependent only.
3. Employee/Family Coverage. This type of coverage provides coverage for the Eligible Employee and the employee's Eligible Dependents.

Enrollment Periods

The enrollment periods for applying for coverage are as follows:

1. **Initial Enrollment Period** is the period of time during which an Eligible Employee or Eligible Dependent is first eligible to enroll. It starts on the Eligible Employee's or Eligible Dependent's initial date of eligibility and ends no less than 30 days later.
2. **Annual Open Enrollment Period** is an annual 30-day period occurring no less than 30 days prior to the Anniversary Date, during which each Eligible Employee is given an opportunity to select coverage from among the alternatives, included in Diocese of Palm Beach Health Plan Trust's health benefit program.
3. **Special Enrollment Period** is the 30-day period of time immediately following a special circumstance during which an Eligible Employee or Eligible Dependent may apply for coverage. Special circumstances are described in the Special Enrollment Period subsection.

Employee Enrollment

1. An individual who is an Eligible Employee on Diocese of Palm Beach Health Plan Trust's Effective Date must enroll during the Initial Enrollment Period. The Eligible Employee shall become a Covered Employee as of the Effective Date of Diocese of Palm Beach Health Plan Trust Eligible Dependents may also be enrolled during the Initial Enrollment

Period. The Effective Date of coverage for an Eligible Dependents shall be the same as the Covered Employee's Effective Date.

2. An individual who becomes an Eligible Employee after Diocese of Palm Beach Health Plan Trust's Effective Date (for example, newly-hired employees) must enroll before or within the Initial Enrollment Period. The Effective Date of coverage.

Dependent Enrollment

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

Newborn Child – To enroll a newborn child who is an Eligible Dependent, the Covered Employee must submit an Enrollment Form through Diocese of Palm Beach Health Plan Trust prior to or during the 30-day period immediately following the date of birth. The Effective Date of coverage for a newborn child shall be the date of birth.

If the newborn is not enrolled within sixty days of the date of birth, the newborn child will not be covered, and may only be enrolled under this Evidence of Coverage during an Annual Open Enrollment Period, or in the case of a Special Enrollment event, during the Special Enrollment Period.

> **Note:** For a Covered Dependent child who has reached the end of the Calendar Year in which he or she becomes 26 and the Covered Dependent child obtains a dependent of their own (e.g., through birth or adoption), such newborn child will not be eligible for this coverage and cannot enroll. Further, the Covered Dependent child will also lose his or her eligibility for this coverage.

Adopted Newborn Child – To enroll an Adopted newborn child, the Covered Employee must submit an Enrollment Form through Diocese of Palm Beach Health Plan Trust to BCBSF prior to or during the 30-day period immediately following the date of birth. 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 Covered Employee prior to the birth of such child, whether or not such an agreement is enforceable. Diocese of Palm Beach Health Plan Trust may require the Covered Employee to provide any information and/or documents deemed necessary in order to administer this provision.

If the Adopted newborn child is not enrolled within sixty days of the date of birth, the Adopted newborn child will not be covered, and may only be enrolled under this Evidence of Coverage during an Annual Open Enrollment Period, or in the case of a Special Enrollment event, during the Special Enrollment Period.

If the Adopted newborn child is not ultimately Placed in the residence of the Covered Employee, there shall be no coverage for the Adopted newborn child. It is the responsibility of the Covered Employee to notify Diocese of Palm Beach Health Plan Trust within ten calendar days if the Adopted newborn child is not Placed in the residence of the Covered Employee.

Adopted/Foster Children – To enroll an Adopted or Foster Child, the Covered Employee must submit an Enrollment Form through Diocese of Palm Beach Health Plan Trust to BCBSF prior to or during the 30-day period immediately following the date of Placement. 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 Covered Plan Participant in compliance with Florida law. Diocese of Palm Beach Health Plan Trust may require the Covered Employee to provide any information and/or documents deemed

necessary in order to properly administer this section.

In the event Diocese of Palm Beach Health Plan Trust is not notified within 30 days of the date of Placement, the child will be added as of the date of Placement so long as the Covered Employee provides notice to Diocese of Palm Beach Health Plan Trust, and BCBSF receives the Enrollment Form within 60 days of the Placement. If the Adopted or Foster Child is not enrolled within 60 days of the date of Placement, the Adopted or Foster Child will not be covered, and the Covered Employee must make application during an Annual Open Enrollment Period.

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 through Diocese of Palm Beach Health Plan Trust. It is the responsibility of the Covered Employee to notify Diocese of Palm Beach Health Plan Trust 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 Covered Employee's status as a foster parent is terminated, coverage shall not be continued for any Foster Child. It is the responsibility of the Covered Employee to notify BCBSF through Diocese of Palm Beach Health Plan Trust that the Foster Child is no longer in the Covered Employee's care. Upon receipt of this notification, BCBSF will terminate the coverage of the child on the date the Covered Employee's status as a foster parent terminated.

Marital Status – A Covered Employee may apply for coverage of an Eligible Dependents due to a marriage that is valid both civilly and canonically. To apply for coverage, the Covered Employee must complete and submit an Enrollment Form through Diocese of Palm Beach Health Plan Trust to BCBSF. The Covered Employee must make application for enrollment within 30 days of the marriage. The Effective Date of coverage for an Eligible Dependents who is enrolled as a result of marriage is the date of the marriage.

Court Order – A Covered Employee may apply for coverage for an Eligible Dependent outside of the Initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided for a minor child under the Covered Employee's plan. To apply for coverage, the Covered Employee must complete and submit an Enrollment Form through Diocese of Palm Beach Health Plan Trust to BCBSF. The Covered Employee must make application for enrollment within 30 days of the court order. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order is the date required by the court.

Annual Open Enrollment Period

Eligible Employees and/or Eligible Dependents who did not apply for coverage during the Initial Enrollment Period or a Special Enrollment Period may apply for coverage during an Annual Open Enrollment Period. The Eligible Employee may enroll by completing an Enrollment Form during the Annual Open Enrollment Period.

The Effective Date of coverage for an Eligible Employee and any Eligible Dependents will be the date established by Diocese of Palm Beach Health Plan Trust.

Eligible Employees who do not enroll or change their coverage selection during the Annual Open Enrollment Period, must wait until the next Annual Open Enrollment Period, unless the Eligible Employee or Eligible Dependent is enrolled due to a special circumstance as outlined in the Special Enrollment Period subsection of this section.

Special Enrollment Period

An Eligible Employee and/or the Employee's Eligible Dependents may apply for coverage outside of the Initial Enrollment Period and Annual Enrollment Period as a result of a special enrollment event. To apply for coverage, the Eligible Employee and/or the Employee's Eligible Dependents must complete the applicable Enrollment Form and forward it to Diocese of Palm Beach Health Plan Trust within the time periods noted below for each special enrollment event.

An Eligible Employee and/or the Employee's Eligible Dependents may apply for coverage if one of the following special enrollment events occurs and the applicable Enrollment Form is submitted to Diocese of Palm Beach Health Plan Trust within the indicated time periods:

1. If an Eligible Employee loses coverage under another group health benefit plan (as an employee or dependent), or coverage under other health insurance (except in the case of loss of coverage under a Children's Health Insurance Program (CHIP) or Medicaid, see #3 below), or COBRA continuation coverage that the Eligible Employee was covered under at the time of initial enrollment provided that:

    a) when offered coverage under this plan at the time of initial eligibility, the Eligible Employee stated, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment; and

    b) the Eligible Employee lost their other coverage under a group health benefit plan or health insurance coverage (except in the case of loss of coverage under a CHIP or Medicaid, see #3 below) as a result of termination of employment, reduction in the number of hours they work, reaching or exceeding the maximum lifetime of all benefits under other health coverage, the employer ceased offering group health coverage, death of their spouse, divorce, legal separation or employer contributions toward such coverage was terminated; and

    c) the Eligible Employee submits the applicable Enrollment Form to Diocese of Palm Beach Health Plan Trust within 30 days of the date their coverage was terminated

    Note: Loss of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the prior health coverage) is not a qualifying event for special enrollment.

    or

2. If, when offered coverage under this plan at the time of initial eligibility, the Eligible Employee stated, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment; and the Eligible Employee gets married or obtains a dependent through birth, Adoption or Placement in anticipation of Adoption and the Eligible Employee submits the applicable Enrollment Form to Diocese of Palm Beach Health Plan Trust within 30 days of the date of the event.

    or

3. If the Eligible Employee or their Eligible Dependents lose coverage under a CHIP or Medicaid due to loss of eligibility for such coverage or become eligible for the optional state premium assistance program and the Eligible Employee submits the applicable Enrollment Form to Diocese of Palm Beach Health Plan Trust within 60 days of the date such coverage was terminated or the date the Eligible Employee becomes eligible for

the optional state premium assistance program.

Other Provisions Regarding Enrollment and Effective Date of Coverage

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

Section 10: Termination of an Individual Covered Plan Participant's Coverage

Termination of a Covered Employee's Coverage

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

1. on the date the Group Health Plan terminates;
2. on the date the ASO Agreement between BCBSF and Diocese of Palm Beach Health Plan Trust terminates;
3. on the last day of the month that the Covered Employee no longer meets the definition of a Full-time employee or on July 31st for teachers who complete their contract year and leave the employment of the Diocese of Palm Beach;
4. on the date the Covered Employee's coverage is terminated for cause (see the Termination of an Individual Coverage for Cause subsection); or
5. on the date specified by Diocese of Palm Beach Health Plan Trust that the Covered Employee's coverage terminates.

Termination of a Covered Dependent's Coverage

A Covered Dependent's coverage will automatically terminate:

1. at 12:01 a.m. on the date the Group Health Plan terminates;
2. at 12:01 a.m. on the date the Covered Employee's coverage terminates for any reason;
3. the Dependent becomes covered under an alternative health benefits plan which is offered through or in connection with the Group;
4. on the last day of the month that the Covered Dependent fails to continue to meet any of the applicable eligibility requirements (e.g., a child reaches the limiting age, or a spouse is divorced from the Covered Employee);
    a. as further clarification for purposes of this subsection, a Covered Dependent child who has reached the end of the Calendar Year in which he or she becomes 26, but who has not reached the end of the Calendar Year in which the Covered Dependent child becomes 30 will lose coverage if the Covered Dependent child incurs any of the following:
        i. marriage;
        ii. no longer resides in Florida or is no longer a Full-time or part-time student;
        iii. obtains a dependent (e.g. through birth or adoption); or
        iv. obtains other coverage.
    b. on the date specified by Diocese of Palm Beach Health Plan Trust that the Covered Dependent's coverage is terminated by Diocese of Palm Beach Health Plan Trust for cause; or
    c. on the date specified by Diocese of Palm Beach Health Plan Trust that the Covered Dependent's coverage terminates.

5. on the date the Dependent's coverage is terminated for cause (see the Termination of Individual Coverage for Cause subsection).

In the event the Covered Employee wishes to delete a Covered Dependent from coverage, an Enrollment Form should be forwarded to BCBSF through Diocese of Palm Beach Health Plan Trust.

In the event the Covered Employee wishes to terminate a spouse's coverage, (e.g., in the case of divorce), the Covered Employee must submit an Enrollment Form to Diocese of Palm Beach Health Plan Trust, prior to the requested termination date or within ten days of the date the divorce is final, whichever is applicable.

Termination of an Individual's Coverage for Cause

In the event any of the following occurs, Diocese of Palm Beach Health Plan Trust 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 Enrollment Forms completed, by or on behalf of the Covered Employee; or
3. misuse of the Identification Card.

Notice of Termination

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

Section 11: Eligibility for Coverage Under the Continuation of Group Health Coverage Plan

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

If you are an employee, spouse or dependent and are currently covered by the Diocese of Palm Beach Health Plan Trust Health Plan you can extend your coverage for up to 18 months after the date you ceased to be eligible for coverage if you:

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

For example, if a Covered Employee: 1) is no longer eligible for coverage as of June 30, 2000, due to termination of employment, and 2) the employee is not enrolled in any other health plan, the employee would be eligible for the Continuation of Group Health Coverage Plan until December 31, 2001 (assuming all conditions described in this letter are maintained).

Special Continuation of Group Health Coverage exception for Medicare enrollees

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

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

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

Election of Continuation of Group Health Coverage

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

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

If you lose coverage due to termination of employment or reduction of work hours, a notice of your rights and a Continuation of Group

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

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

Contribution Remittance

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

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

Extension of 18 Months of Continuation Coverage

You may continue coverage up to 36 months if termination of coverage is due to the death of a Covered Employee. The 18 months of continuation of coverage may be extended up to 29 months, if you or a Covered Dependent is determined to be disabled by the Social Security Administration on or before the date of the qualifying event or in the first 60 days of continued coverage.

Termination of Continuation Coverage Prior to Maximum Coverage Period

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

1. Coverage will terminate on the first day of the month for which the qualified beneficiary's Continuation of Health Coverage contribution is not timely paid.
2. Coverage will terminate on the date Diocese of Palm Beach Health Plan Trust ceases to maintain any group health plan for its employees.
3. Coverage will terminate for cause on the same basis coverage is terminated for cause with respect to similarly situated beneficiaries under the plan with respect to whom a qualified event has not occurred.
4. Coverage will terminate when the qualified beneficiary becomes entitled to Medicare or any other Governmental Health Plan during Continuation of Health Plan Coverage period.
5. Coverage will terminate when qualified beneficiary becomes covered by another group health or individual health plan.
6. If you extended coverage for up to 29 months due to disability and there is a final determination that you are no longer disabled, your coverage period will be reduced back to the original 18 month maximum coverage period.

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

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

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

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

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

Changes to Continuation of Group Health Coverage Plan

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

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

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

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

USERRA

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

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

- If eligible, your period of USERRA coverage can last for up to 24 months.
- Your Eligible Dependents do not have an independent right to elect USERRA coverage.
- Even if you do not elect to continue coverage during your period of military service, you have the right to be reinstated in the Plan when you are reemployed, generally without any waiting periods or exclusions (such as pre-existing condition exclusions) except for service-connected Illnesses or Injuries.

You must provide the Diocese of Palm Beach Health Plan Trust Benefits Department, with the documentation of such a leave at the onset of such a leave. This will insure proper continuation of benefits.

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

Section 12: The Effect of Medicare Coverage/Medicare Secondary Payer Provisions

When a Covered Plan Participant becomes covered under Medicare and continues to be eligible and covered under the terms of the Group Health Plan Description, coverage hereunder shall be primary and the Medicare benefits shall be secondary, but only to the extent required by law. In all other instances, coverage hereunder shall be secondary to any Medicare benefits. To the extent the Group Health Plan is primary, claims for Covered Services should be filed with BCBSF first.

Under Medicare, Diocese of Palm Beach Health Plan Trust MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to such Covered Plan Participant. Also, Diocese of Palm Beach Health Plan Trust MAY NOT induce such Covered Plan Participant to decline or terminate his or her group health insurance coverage and elect Medicare as primary payer.

A Covered Plan Participant who becomes 65 or who becomes eligible for Medicare due to End Stage Renal Disease ("ESRD") must notify Diocese of Palm Beach Health Plan Trust.

Individuals With End Stage Renal Disease

For a Covered Plan Participant who is entitled to Medicare coverage because of ESRD, group health coverage will be provided on a primary basis for 30 months beginning with the earlier of:

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

If Medicare was primary prior to the individual becoming eligible due to ESRD, then Medicare will remain primary (i.e., persons entitled due to disability whose employer has less than 100 employees, retirees and/or their spouses over the age of 65). Also, if group health insurance coverage was primary prior to ESRD entitlement, then the group health insurance coverage will remain primary for the ESRD coordination period. For individuals eligible for Medicare due to ESRD, group health coverage will be provided, as set forth herein, on a primary basis for 30 months.

Disabled Active Individuals

The Group Health Plan will provide primary coverage to Covered Plan Participants if:

1. Diocese of Palm Beach Health Plan Trust is a part of a health plan that has covered employees of at least one employer of 100 or more full-time or part-time employees on 50 percent or more of its regular business days during the previous Calendar Year; and
2. the Covered Plan Participants are entitled to Medicare coverage because of disability (unless they have ESRD).

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

1. For an enrolled individual, group health insurance coverage will be provided, as set forth herein, on a primary basis during any month in which that individual meets the description set out in the above paragraphs.
2. Individual entitlement to primary coverage under this sub-section will terminate automatically when:

a. the individual turns 65 years of age; or

b. the individual no longer qualifies for Medicare coverage because of disability; or

c. the individual elects Medicare as the primary payer. Coverage will terminate as of the day of such election.

3. Entitlement of the Covered Employee and/or his or her Covered Dependents to primary coverage under this subsection will terminate automatically if the Covered Employee no longer qualifies as such under applicable Medicare regulations and instructions. Diocese of Palm Beach Health Plan Trust shall notify BCBSF, without delay, of any such change in status.

Miscellaneous

1. This section shall be subject to, modified (if necessary) to conform to or comply with, and interpreted with reference to the requirements of federal statutory and regulatory Medicare Secondary Payer provisions as those provisions relate to Medicare beneficiaries who are covered under the Group Health Plan.

2. BCBSF shall not be liable to Diocese of Palm Beach Health Plan Trust or to any individual covered under the Group Health Plan on account of any nonpayment of primary benefits resulting from any failure of performance of Diocese of Palm Beach Health Plan Trust's obligations as set forth in this section.

Section 13: Duplication of Coverage Under Other Health Plans/Programs

Coordination of Benefits

Coordination of Benefits ("COB") is a limitation of coverage and/or benefits to be provided under the Group Health Plan. COB determines the manner in which expenses will be paid when a Covered Plan Participant 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. It is the Covered Employee's responsibility to provide BCBSF and Diocese of Palm Beach Health Plan Trust information concerning any duplication of coverage under any other health plan, program, or policy the Covered Employee or Covered Dependents may have. This means the Covered Employee must notify BCBSF and Diocese of Palm Beach Health Plan Trust in writing if any Covered Plan Participant has other applicable coverage or if there is no other coverage. The Covered Employee may be requested to provide this information at initial enrollment, by written correspondence annually thereafter, or in connection with specific Health Care Services received. If the information is not received, claims may be denied and the Covered Plan Participant will be responsible for payment of any expenses related to denied claims.

Health plans, programs or policies 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 or non-group health insurance, group-type self-insurance, or HMO plan;
2. any group plan issued by any Blue Cross and/or Blue Shield organization(s);
3. any other plan, program or insurance policy, including an automobile PIP insurance policy and/or medical payment coverage with which the law permits coordination of benefits;
4. Medicare, as described in The Effect of Medicare Coverage/Medicare Secondary Payer Provisions section; and
5. to the extent permitted by law, any other government sponsored health insurance program..

The amount of payment, if any, is based on whether or not the Group Health Plan is primary. When the Group Health Plan is primary, payment will be made for Covered Services without regard to the Covered Plan Participant's coverage under other plans. When the Group Health Plan is other than primary, 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 a Covered Plan Participant receives Covered Services from a PPO Provider or a Traditional Insurance Provider, "total reasonable expenses" shall mean the amount required to be paid to the Provider pursuant to the applicable agreement BCBSF has with such Provider. In the event that the primary payer's payment exceeds the Allowed Amount, no payment will be made for such Services.

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

1. The Group Health Plan always pays secondary to any medical payment, personal injury protection (PIP) coverage or no-fault coverage under any automobile

policy available to the Covered Plan Participant.

2. When the Group Health Plan covers the Covered Plan Participant as a Covered Dependent and the other plan covers the Covered Plan Participant as other than a dependent, the Group Health Plan will be secondary.
3. When the Group Health Plan covers a dependent child whose parents are not married (separated or divorced):
    a. the plan of the parent whose birthday, month and day, falls earlier in the year will be primary;
    b. if both parents have the same birthday, month and day, and the other plan has covered one of the parents longer than BCBSF, BCBSF will be secondary.
4. When BCBSCF covers a dependent child whose parents are not married, or are separated or divorced:
    a. the plan of the parent with custody is primary;
    b. the plan of the remarried parent with custody is primary; the step-parent's plan is secondary regardless of whether the re-married parent is the employee or a dependent under the step-parent's plan; and
    c. the plan of the parent without custody is last;
    d. regardless of which parent has custody, when a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is always primary.
5. When an employee or the employee's dependent and the Covered Person are covered under a plan that covers the Covered Person as a laid off or retired employee or as the employee's dependent and the other plan covers the Covered Person as a dependent:
    a. the plan that covers the Covered Person by virtue of active employment, e.g. as the dependent spouse of an active employee, is primary;
    b. if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.
6. When rules 1 through 6 above do not establish an order of benefits, the plan which has covered the Covered Person the longest shall be primary.
7. If the other plan does not have rules that establish the same order of benefits as under this Evidence of Coverage, the benefits under the other plan will be determined primary to the benefits under this Evidence of Coverage.

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

Non-Duplication of Government Programs and Workers' Compensation

The benefits under this Evidence of Coverage shall not duplicate any benefits to which the Covered Plan Participant is entitled to or eligible for under government programs (e.g., Medicare, Medicaid, Veterans Administration) to the extent allowed by law, or under any extension of benefits of coverage under a prior plan or program which may be provided or required by law.

Section 14: Claims Processing

Introduction

This section is intended to:

- help the Covered Plan Participant understand what the Covered Plan Participant or the Covered Plan Participant's treating Providers must do, under the terms of the Group Health Plan Description, in order to obtain payment for expenses for Covered Services they have rendered or will render to the Covered Plan Participant; and
- provide the Covered Plan Participant with a general description of the applicable procedures that will be used for making Adverse Benefit Determinations, Concurrent Care Decisions and for notifying the Covered Plan Participant when benefits are denied.

Types of Claims

For purposes of the Evidence of Coverage, there are three types of claims: 1) Pre-Service Claims; 2) Post-Service Claims; and 3) Claims Involving Urgent Care. It is important that the Covered Plan Participant become familiar with the types of claims that can be submitted to BCBSF and the timeframes and other requirements that apply.

Post-Service Claims

How to File a Post-Service Claim

This section defines and describes the three types of claims that may be submitted to BCBSF. Experience shows that the most common type of claim BCBSF will receive from the Covered Plan Participant or the Covered Plan Participant's treating Providers will likely be Post-Service Claims.

PPO Providers have agreed to file Post-Service Claims for services rendered to a Covered Plan Participant. In the event a Provider who renders Services to the Covered Plan Participant does not file a Post-Service Claim for such Services, it is the Covered Plan Participant's responsibility to file it with BCBSF.

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

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

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

The itemized statement and claim form must be received by BCBSF at the address indicated on the Covered Plan Participant's ID Card.

Note: Special claims processing rules may apply for Health Care Services received outside

the state of Florida under the BlueCard Program (See the BlueCard Program section of the Evidence of Coverage).

The Processing of Post-Service Claims

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

- Payment for Post-Service Claims

When payment is due under the terms of the Evidence of Coverage, BCBSF will use its best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, BCBSF will use its best efforts to pay (in whole or in part) for paper Post-Service Claims within 40 days of receipt. The Covered Plan Participant may receive notice of payment for paper claims within 30 days of receipt. If BCBSF is unable to determine whether the claim or a portion of the claim is payable because more or additional information is needed, BCBSF may contest the claim within the timeframes set forth below.

- Contested Post-Service Claims

In the event BCBSF contests an electronically submitted Post-Service Claim, or a portion of such a claim, BCBSF will use its best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is contested. In the event BCBSF contests a Post-Service Claim submitted on a paper claim form, or a portion of such a claim, BCBSF will use its best efforts to provide notice, within 30 days of receipt, that the claim or a portion of the claim is contested. The notice may identify: 1) the contested portion or portions of the claim; 2) the reason(s) for contesting the claim or a portion of the claim; and 3) the date that BCBSF reasonably expects to notify the Covered Plan Participant of the decision. The notice may also indicate whether more or additional information is needed in order to complete processing of the claim. If BCBSF requests additional information, BCBSF must receive it within 45 days of the request for the information. **If BCBSF does not receive the requested information, the claim or a portion of the claim will be adjudicated based on the information in the possession of BCBSF at the time and may be denied.** Upon receipt of the requested information, BCBSF will use its best efforts to complete the processing of the Post-Service Claim within 15 days of receipt of the information.

- Denial of Post-Service Claims

In the event BCBSF denies a Post-Service Claim submitted electronically, BCBSF will use its best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is denied. In the event BCBSF denies a paper Post-Service Claim, BCSBF will use its best efforts to provide notice, within 30 days of receipt, that the claim or a portion of the claim is denied. The notice may identify the denied portion(s) of the claim and the reason(s) for denial. It is the Covered Plan Participant's responsibility to ensure that BCBSF receives all information determined by BCBSF as necessary to adjudicate a Post-Service Claim. **If BCBSF does not receive the necessary information, the claim or a portion of the claim may be denied.**

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

Additional Processing Information for Post-Service Claims

In any event, BCBSF will use its best efforts to pay or deny all: 1) electronic Post-Service Claims within 90 days of receipt of the completed claim; and 2) Post-Service paper claims within 120 days of receipt of the

completed claim. Claims processing shall be deemed to have been completed as of the date the notice of the claims decision is deposited in the mail by BCBSF or otherwise electronically transmitted. Any claims payment relating to a Post-Service Claim that is not made by BCBSF within the applicable timeframe is subject to the payment of simple interest at the rate established by the Florida Insurance Code.

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

Pre-Service Claims

How to File A Pre-Service Claim

The Evidence of Coverage may condition coverage, benefits, or payment (in whole or in part), for a specific Covered Service, on the receipt by BCBSF of a Pre-Service Claim as that term is defined herein. In order to determine whether BCBSF must receive a Pre-Service Claim for a particular Covered Service, please refer to the Covered Services section and other applicable sections of the Evidence of Coverage. The Covered Plan Participant may also call the customer service number on the Covered Plan Participant's ID card for assistance.

BCBSF is not required to render an opinion or make a coverage or benefit determination with respect to a Service that has not actually been provided to the Covered Plan Participant unless the terms of the Evidence of Coverage require (or condition payment upon) approval by BCBSF for the Service before it is received.

Benefit Determinations on Pre-Service Claims Involving Urgent Care

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

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

BCBSF will use its best efforts to provide notice of a decision on a Pre-Service Claim not involving urgent care within 15 days of receipt provided additional information is not required for a coverage decision. BCBSF may extend this 15-day determination period one time for up to an additional 15 days. If such an extension is necessary, BCBSF will use its best efforts to provide notice of the extension and reasons for it. BCBSF will use its best efforts to provide notification of the decision on the Covered Plan Participant's Pre-Service claim within a total of

30 days of the initial receipt of the claim, if an extension of time was taken by BCBSF.

If additional information is necessary to make a determination, BCBSF will use its best efforts to: 1) provide notice of the need for additional information, prior to the expiration of the initial 15-day period; 2) identify the specific information that the Covered Plan Participant or the Covered Plan Participant's Provider may need to provide; and 3) inform the Covered Plan Participant of the date that BCBSF reasonably expects to notify the Covered Plan Participant of the decision. If BCBSF requests additional information, BCBSF must receive it within 45 days of the request for the information. BCBSF will use its best efforts to provide notification of the decision on the Covered Plan Participant's Pre-Service Claim within 15 days of receipt of the requested information.

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

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Services

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

- BCBSF and/or Diocese of Palm Beach Health Plan Trust has approved in writing coverage or benefits for an ongoing course of Services to be provided over a period of time or a number of Services to be rendered; and
- the reduction or termination occurs before the end of such previously approved time or number of Services; and
- the reduction or termination of coverage or benefits by BCBSF and/or Diocese of Palm Beach Health Plan Trust was not due to an amendment of the Evidence of Coverage or termination of the Covered Plan Participant's coverage as provided by the Evidence of Coverage.

BCBSF will use its best efforts to notify the Covered Plan Participant of such reduction or termination in advance so that the Covered Plan Participant will have a reasonable amount of time to have the reduction or termination reviewed in accordance with the Adverse Benefit Determination standards and procedures described below. In no event shall BCBSF be required to provide more than a reasonable period of time within which the Covered Plan Participant may develop the appeal before BCBSF actually terminates or reduces coverage for the Services.

Requests for Extension of Services

The Covered Plan Participant's Provider may request an extension of coverage or benefits for a Service beyond the approved period of time or number of approved Services. If the request for an extension is for a Claim Involving Urgent Care, BCBSF will use its best efforts to notify the Covered Plan Participant of the approval or denial of such requested extension within 24 hours after receipt of the request, provided it is received at least 24 hours prior to the expiration of the previously approved number or length of coverage for such Services. BCBSF will use its best efforts to notify the Covered Plan Participant within 24 hours if: 1) additional information is needed; or 2) the Covered Plan Participant or the Covered Plan Participant's representative failed to follow proper procedures in the request for an extension. If BCBSF and/or Diocese of Palm Beach Health Plan Trust request additional information, the Covered Plan Participant will have 48 hours to provide the requested information. BCBSF may notify the Covered Plan Participant orally or in writing, unless the Covered Plan Participant or the

Covered Plan Participant's representative specifically request that it be in writing. A denial of a request for extension of Services is considered an Adverse Benefit Determination and is subject to the Adverse Benefit Determination review procedure below.

Standards for Adverse Benefit Determinations

BCBSF will use its best efforts to provide notice of any Adverse Benefit Determination in writing. Notification of an Adverse Benefit Determination will include (or will be made available to the Covered Plan Participant free of charge upon request):

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

If the Covered Plan Participant's claim is a Claim Involving Urgent Care, BCBSF may notify the Covered Plan Participant orally within the proper timeframes, provided BCBSF follows up with a written or electronic notification meeting the requirements of this subsection no later than three days after the oral notification.

Additional Claims Processing Provisions

Release of Information/Cooperation

In order to process claims, BCBSF and/or Diocese of Palm Beach Health Plan Trust may need certain information, including information regarding other health care coverage the Covered Plan Participant may have. The Covered Plan Participant must cooperate with Diocese of Palm Beach Health Plan Trust and/or BCBSF's effort to obtain such information by, among other ways, signing any release of information form at the request of BCBSF. Failure by the Covered Plan Participant to fully cooperate with BCBSF and/or Diocese of Palm Beach Health Plan Trust may result in a denial of the pending claim.

Physical Examination

In order to make coverage and benefit decisions, Diocese of Palm Beach Health Plan Trust may, at its expense, require the Covered Plan Participant to be examined by a health care Provider of Diocese of Palm Beach Health Plan Trust's choice as often as is reasonably necessary while a claim is pending. Failure by the Covered Plan Participant to fully cooperate with such examination shall result in a denial of the pending claim.

Legal Actions

No legal action arising out of or in connection with coverage under the Group Health Plan may be brought against Diocese of Palm Beach Health Plan Trust within the 60-day period following receipt of the completed claim as required herein. Additionally, no such action may be brought after expiration of the applicable statute of limitations.

Fraud, Misrepresentation or Omission in Applying for Benefits

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 and/or Diocese of Palm Beach Health Plan Trust may have, in denial of the claim or cancellation or rescission of the Covered Plan Participant's coverage.

Explanation of Benefits Form

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

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

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 will have no liability or obligation for any delay in the payment of claims for Covered Services, except that BCBSF will make a good faith effort to make payment for such Services, taking into account the impact of the event. For the purpose 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.

Section 15: Relationships Between the Parties

BCBSF/Diocese of Palm Beach Health Plan Trust and Health Care Providers

Neither BCBSF nor Diocese of Palm Beach Health Plan Trust nor any of their officers, directors or employees provide Health Care Services to Covered Plan Participants. Rather, BCBSF and Diocese of Palm Beach Health Plan Trust and such individuals are engaged in making coverage and/or benefit decisions under this Evidence of Coverage. By accepting coverage and/or benefits under the Group Health Plan, Covered Plan Participants 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 or Diocese of Palm Beach Health Plan Trust. **In this regard, BCBSF and Diocese of Palm Beach Health Plan Trust hereby expressly disclaim any agency relationship, actual or implied, with any health care Provider.** BCBSF and Diocese of Palm Beach Health Plan Trust do not, by virtue of making coverage, benefit, and payment decisions, exercise any control or direction over the medical judgement or clinical decisions of any health care Provider. Any decisions made under this Group Health Plan 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 BCBSF nor Diocese of Palm Beach Health Plan Trust will assume liability for any loss or damage arising as a result of acts or omissions of any health care Provider.

BCBSF and Diocese of Palm Beach Health Plan Trust

Neither Diocese of Palm Beach Health Plan Trust nor any Covered Plan Participant is the agent or representative of BCBSF, and neither shall be liable for any acts or omissions of BCBSF, its agents, servants, or employees. Additionally, neither Diocese of Palm Beach Health Plan Trust, any Covered Plan Participant, nor BCBSF shall be liable, whether in tort or contract or otherwise, for any acts or omissions of any other person or organization with which BCBSF has made or hereafter makes arrangements for the provision of Covered Services. BCBSF is not the agent, servant, or representative of Diocese of Palm Beach Health Plan Trust or any Covered Plan Participant, and shall not be liable for any acts or omissions of Diocese of Palm Beach Health Plan Trust, its agents, servants, employees, any Covered Plan Participant, or any person or organization with which Diocese of Palm Beach Health Plan Trust has entered into any agreement or arrangement. By acceptance of coverage and/or benefits hereunder, each Covered Plan Participant agrees to the foregoing.

Medical Decisions - Responsibility of a Covered Plan Participant'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 Covered Plan Participant, the Covered Plan Participant's family and the Covered Plan Participant's treating Physician in accordance with the patient/Physician relationship. It is possible that the Covered Plan Participant or the Covered Plan Participant's treating Physician may

conclude that a particular procedure is needed, appropriate, or desirable, even though such procedure may not be covered.

Section 16: General Provisions

Access to Information

BCBSF and Diocese of Palm Beach Health Plan Trust shall have the right to receive, from any health care Provider rendering Services to a Covered Plan Participant, information that is reasonably necessary, as determined by Diocese of Palm Beach Health Plan Trust or 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 Covered Plan Participant authorizes every health care Provider who renders Health Care Services to a Covered Plan Participant, to disclose to BCBSF and Diocese of Palm Beach Health Plan Trust or to entities affiliated with BCBSF, upon request, all facts, records, and reports pertaining to such Covered Plan Participant's care, treatment, and physical or mental Condition, and to permit BCBSF and/or Diocese of Palm Beach Health Plan Trust to copy any such records and reports so obtained.

Compliance with Applicable Laws and Regulations

The terms of coverage and/or benefits to be provided under the Group Health Plan Description shall be deemed to have been modified by the parties, and shall be interpreted, so as to comply with applicable laws and regulations dealing with rates, benefits, eligibility, enrollment, termination, conversion, or other rights and duties of a Covered Plan Participant, Diocese of Palm Beach Health Plan Trust, 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 Covered Plan Participants 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 Evidence of Coverage. 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 Covered Plan Participants even if the Covered Plan Participant has not sought treatment by or through that Provider. By accepting coverage, each Covered Plan Participant hereby authorizes BCBSF to release to Providers claims information, including related medical information, pertaining to the Covered Plan Participant in order for any such Provider to evaluate the Covered Plan Participant's financial responsibility under this Evidence of Coverage.

Cooperation Required of Covered Plan Participants

Covered Plan Participants must cooperate with BCBSF and Diocese of Palm Beach Health Plan Trust, and must execute and submit to BCBSF and Diocese of Palm Beach Health Plan Trust any consents, releases, assignments, and other documents requested in order to administer, and exercise any rights hereunder. Failure to do so

may result in the denial of claims and will constitute grounds for termination for cause (See the Termination of an Individual's Coverage for Cause subsection in the Termination of Coverage section).

Customer Rewards Programs

From time to time, BCBSF may offer programs to its customers that provide rewards for following the terms of the program. BCBSF will tell Covered Plan Participant's about any available rewards programs in general mailings, member newsletters and/or on BCBSF's website. The Covered Plan Participant's participation in these programs is completely voluntary and will in no way affect the coverage available to the Covered Plan Participant under this Evidence of Coverage. BCBSF reserves the right to offer rewards in excess of $25 per year as well as the right to discontinue or modify any reward program features or promotional offers at any time without the Covered Plan Participant's consent.

Florida Agency for Health Care Administration Performance Data

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

Identification Cards

The Identification Cards issued to Covered Plan Participants in no way create, or serve to verify, eligibility to receive coverage and/or benefits hereunder. Identification cards must be destroyed or returned immediately following termination of the Covered Employee's coverage.

Modification of Provider Networks and Participation Status

The participation status of individual Providers in Provider networks available under this Evidence of Coverage are subject to change at any time without prior notice to, or approval of, Diocese of Palm Beach Health Plan Trust or any Covered Plan Participant. 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, Diocese of Palm Beach Health Plan Trust or any Covered Plan Participant. It is the Covered Plan Participant'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 Evidence of Coverage, a Covered Plan Participant's financial responsibility may vary depending upon a Provider's participation status.

Non-Waiver of Defaults

Any failure by Diocese of Palm Beach Health Plan Trust or 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 Diocese of Palm Beach Health Plan Trust or 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 Identification Card.

If to a Covered Plan Participant:

To the latest address provided by the Covered Plan Participant or to the Covered Employee's latest address on Enrollment Forms actually delivered to BCBSF.

The Covered Employee shall notify BCBSF immediately of any address change.

If to Diocese of Palm Beach Health Plan Trust:

To the address indicated by Diocese of Palm Beach Health Plan Trust.

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 Evidence of Coverage.

Proof of Coverage

Each Covered Employee will be provided with an Evidence of Coverage and an Identification Card for enrolled Covered Plan Participants as proof of coverage.

Right to Receive Necessary Information

In order to administer coverage and/or benefits, BCBSF or Diocese of Palm Beach Health Plan Trust 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 Covered Plan Participant or applicant for enrollment which BCBSF or Diocese of Palm Beach Health Plan Trust deems to be necessary.

Right to Recovery

Whenever payments are made in excess of the maximum provided for under this Evidence of Coverage, BCBSF, Diocese of Palm Beach Health Plan Trust, or the Group Health Plan shall have the right to recover any such payments, to the extent of such excess, from any Covered Plan Participant, person, plan, or other organization that received such payments.

Service Mark

Diocese of Palm Beach Health Plan Trust, on behalf of itself and its Covered Employees, acknowledges that BCBSF is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and/or Blue Shield Plans (the "Association"), permitting BCBSF to use the Blue Cross and Blue Shield Service Mark in the state of Florida and that BCBSF is not contracting as the agent of the Association. Diocese of Palm Beach Health Plan Trust further acknowledges and agrees that it has not entered into an agreement with BCBSF and that no person, entity, or organization other than BCBSF shall be held accountable or liable to Diocese of Palm Beach Health Plan Trust for any of BCBSF's obligations to Diocese of Palm Beach Health Plan Trust.

Reimbursement of Payments Made by Group Health Plan

The Group Health Plan is designed to only pay covered expenses for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a Covered Plan Participant in a time of need, however, the Group Health Plan may pay covered expenses that may be or become the responsibility of another person, provided that the Group Health Plan later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the Group Health Plan, as well as by applying for payment of covered expenses, a Covered Plan Participant is subject to, and agrees to, the following terms and conditions with respect to the amount of covered expenses paid by the Group Health Plan:

1. Assignment of Rights (Subrogation). The Covered Plan Participant automatically assigns to the Group Health Plan any rights the Covered Plan Participant may have to recover all or part of the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Group Health Plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a Covered Plan Participant or paid to another for the benefit of the Covered Plan Participant. This assignment applies on a first-dollar basis (*i.e.*, has priority over other rights), applies whether the funds paid to (or for the benefit of) the Covered Plan Participant constitute a full or a partial recovery, and even applies to funds paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the Group Health Plan to pursue any claim that the Covered Plan Participant may have, whether or not the Covered Plan Participant chooses to pursue that claim. By this assignment, the Group Health Plan's right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Equitable Lien and other Equitable Remedies. The Group Health Plan shall have an equitable lien against any rights the Covered Plan Participant may have to recover the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Group Health Plan. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the Group Health Plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

   This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the Covered Plan Participant, the Covered Plan Participant's attorney, and/or a trust) as a result of an exercise of the Covered Plan Participant's rights of recovery (sometimes referred to as "proceeds"). The Group Health Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the plan administrator, the Group Health Plan may reduce any future covered expenses otherwise available to the Covered Plan Participant under the Group Health Plan by an amount up to the total amount of Reimbursable Payments made by the Group Health Plan that is subject to the equitable lien.

   This and any other provisions of the Group Health Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court's decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, US (1/8/2002). The provisions of the Group Health Plan concerning subrogation, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

3. Assisting in Group Health Plan's Reimbursement Activities. The Covered Plan Participant has an obligation to assist

the Group Health Plan to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the Covered Plan Participant, and to provide the Group Health Plan with any information concerning the Covered Plan Participant's other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the Covered Plan Participant. The Covered Plan Participant is required to (a) cooperate fully in the Group Health Plan's exercise of its right to subrogation and reimbursement, (b) not do anything to prejudice those rights (such as settling a claim against another party without including the Group Health Plan as a co-payee for the amount of the Reimbursable Payments and notifying the Group Health Plan), (c) sign any document deemed by the plan administrator to be relevant to protecting the Group Health Plan's subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the plan administrator to enforce the Group Health Plan's rights.

Failure by a Covered Plan Participant to follow the above terms and conditions may result, at the discretion of the plan administrator, in a reduction from future benefit payments available to the Covered Plan Participant under the Group Health Plan of an amount up to the aggregate amount of Reimbursable Payments that has not been reimbursed to the Group Health Plan.

Reimbursement

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

Constructive Trust

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

Lien Rights

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

Assignment

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

First-Priority Claim

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

Applicability to All Settlements and Judgments

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

Cooperation

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

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

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

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

Interpretation

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

Jurisdiction

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

Third Party Beneficiary

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

Section 17: Glossary of Terms

For purposes of this Evidence of Coverage and any 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 Evidence of Coverage.

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

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

Administrative Services Only Agreement or **ASO Agreement** means the agreement between Diocese of Palm Beach Health Plan Trust and BCBSF. Under the Administrative Services Only Agreement, BCBSF provides claims processing and payment services, customer service, utilization review services and access to its statewide preferred provider organization ("PPO") and Traditional Insurance Providers.

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.

Adverse Benefit Determination means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under the Evidence of Coverage with respect to a Pre-Service Claim or a Post-Service Claim. Any reduction or termination of coverage, benefits, or payment in connection with a Concurrent Care Decision, as described in the Claims Processing section, shall also constitute an Adverse Benefit Determination.

Allowance and Allowed Amount means the maximum amount upon which payment will be based for Covered Services. Either the Allowance or Allowed Amount may be changed at any time without notice to, or consent of any Covered Plan Participant.

1. In the case of a BCBSF PPC[sm] Provider located in Florida, this amount will be established in accordance with the applicable agreement between that Provider and BCBSF.
2. In the case of a PPO Provider located outside of Florida, this amount will generally be established in accordance with the negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to BCBSF, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the BlueCard Program section for more details.
3. In the case of Providers located in Florida who do not participate in BCBSF's PPC Network but who participate in the Traditional Program, this amount will be established in accordance with the applicable agreement between that Provider and BCBSF.

4. In the case of Providers located outside of Florida who participate in the BlueCard Traditional Program, this amount will generally be established in accordance with the negotiated price that the Host Blue passes on to BCBSF, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the BlueCard Program section for more details.

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

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

Please specifically note that, in the case of a Provider that has not entered into an agreement with BCBSF to provide access to a discount from the billed amount of that Provider, the Allowed Amount for particular Services is often substantially below the amount billed by such Provider for such Services. The Covered Plan Participant will be responsible for any difference between such Allowed Amount and the amount billed for such Services by any such Provider.

The Covered Plan Participant may obtain an estimate of the Allowed Amount for particular Services by calling the customer service telephone number included in this Evidence of Coverage or on the BCBSF Identification Card. The fact that BCBSF may provide the Covered Plan Participant with such information does not mean that the particular Service is a Covered Service. All terms and conditions included in the Evidence of Coverage apply. You should refer to the Covered Services section of the Evidence of Coverage and the Schedule of Benefits to determine what is covered and how much BCBSF will pay.

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

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

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

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

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

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

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

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

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

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

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

Birth Center means 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, Covered Plan Participants 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 or non-ablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant, or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "Bone Marrow Transplant" includes the transplantation as well as the administration of chemotherapy and the chemotherapy drugs. The term "Bone Marrow Transplant" also includes any Services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all Hospital, Physician or other health care Provider 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.

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

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

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

Certified Nurse Midwife means a person who is 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.

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

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

Concurrent Care Decision means a decision by BCBSF and/or Diocese of Palm Beach Health Plan Trust to deny, reduce, or terminate coverage, benefits, or payment (in whole or in part) with respect to a course of treatment to be provided over a period of time, or a specific number of treatments, if BCBSF and/or Diocese of Palm Beach Health Plan Trust had previously approved or authorized in writing coverage, benefits, or payment for that course of treatment or number of treatments.

As defined herein, a Concurrent Care Decision shall not include any decision to deny, reduce, or terminate coverage, benefits, or payment under the Case Management Program as described in the Individual Benefit Utilization Management/Utilization Review Programs section.

Condition means a disease, illness, ailment, injury, bodily malfunction, or pregnancy of a Covered Plan Participant.

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

Copayment (if applicable) means the dollar amount established which is required to be paid to a health care Provider by a Covered Plan Participant 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.

Cost Share means the dollar or percentage amount established solely by us, which must be paid to a health care Provider by the Covered

Plan Participant at the time Covered Services are rendered by that Provider. Cost Share may include, but is not limited to Coinsurance, Copayment, Deductible Emergency Room Per Visit Deductible and/or Per Admission Deductible (PAD) amounts. Applicable Cost Share amounts are identified in the Schedule of Benefits.

Covered Dependent means an Eligible Dependent who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the Group Health Plan other than as a Covered Employee. (See the Eligibility Requirements for Dependents subsection of the Eligibility for Coverage section.)

Covered Employee means an Eligible Employee who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under the Group Health Plan other than as a Covered Dependent. (See the Eligibility Requirements for Covered Employees subsection of the Eligibility for Coverage section.)

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

Covered Plan Participant means the Covered Employee or Covered Dependent who meets and continues to meet the applicable eligibility requirements of Diocese of Palm Beach Health Plan Trust and is actually covered under the Group Health Plan.

Covered Services means those Medically Necessary Health Care Services described in the Covered Services section.

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

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

Detoxification means a process whereby an alcohol or drug intoxicated, or alcohol or drug dependent, Covered Plan Participant 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 Covered Plan Participant at a minimum.

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

Dialysis Center means an outpatient facility certified by the Centers for Medicare and Medicaid Services (CMMS) , and the Florida Agency for Health Care Administration (or a similar regulatory agency of another state) to

provide hemodialysis and peritoneal dialysis Services and support.

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

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

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

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

Effective Date means, with respect to individuals covered under this Evidence of Coverage, 12:01 a.m. on the date Diocese of Palm Beach Health Plan Trust specifies that coverage will commence as further described in the Enrollment and Effective Date of Coverage section of this Evidence of Coverage.

Eligible Dependent means an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility Requirements for Dependents subsection of the Eligibility for Coverage section in this Evidence of Coverage, and is eligible to enroll as a Covered Dependent.

Refer to the "Eligibility for Coverage" section for limits on eligibility.

Eligible Employee means an individual who meets all of the eligibility requirements set forth in the Eligibility Requirements for Covered Employees subsection of the Eligibility for Coverage section, and is eligible to enroll as a Covered Employee. Any individual who is an Eligible Employee is not a Covered Employee until such individual has actually enrolled with, and been accepted for coverage as a Covered Employee by Diocese of Palm Beach Health Plan Trust.

Emergency Medical Condition means a medical or psychiatric Condition or an injury manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of Section 1867(e)(1)(A) of the Social Security Act.

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

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

Employer means Diocese of Palm Beach which has established this plan for the purpose of

providing coverage and/or benefits to Covered Plan Participants.

Endorsement means any amendment to the Group Health Plan or this Evidence of Coverage.

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

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

E-Visit, for purposes of this Evidence of Coverage, means online assessment and management Services provided to an established patient by a Physician or other qualified health care professional; that does not originate from a related Physician Service rendered within the previous 7 days; using the internet or similar electronic communications network.

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 either by Diocese of Palm Beach Health Plan Trust or 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 Covered Plan Participant;
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. credible scientific evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
5. credible scientific evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
6. credible scientific evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently published Medical Literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices;
7. there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or

8. such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

"Credible scientific evidence" shall mean (as determined by Diocese of Palm Beach Health Plan Trust or BCBSF):

1. records maintained by Physicians or Hospitals rendering care or treatment to the Covered Plan Participant 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 Diocese of Palm Beach Health Plan Trust or BCBSF to be Experimental or Investigational are excluded (see the General Exclusions section). In determining whether a Health Care Service is Experimental or Investigational, BCBSF or Diocese of Palm Beach Health Plan Trust 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 Covered Employee's residence and care by the Florida Department of Health and 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 Employee means an employee actively working at least 30 hours per week or on an approved leave of absence for up to a total of six (6) months in any twelve month period.

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

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

Group Health Plan Description means the written document whereby coverage and/or

benefits will be provided to Covered Plan Participants. The Group Health Plan Description includes the Evidence of Coverage (including the Schedule of Benefits) and any Enrollment Forms and Endorsements to the Group Health Plan Description or the Evidence of Coverage.

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

Health Care Services or **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 or **Home Health Care Service** means Physician-directed professional, technical and related medical and personal care Services provided on a visiting or part-time basis directly by (or indirectly through) a Home Health Agency in the Covered Plan Participant's home or residence.

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

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

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

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

Identification (ID) Card means the card(s) issued to Covered Employees under the Group Health Plan. The card is not transferable to another person. Possession of such card in no way guarantees that a particular individual is eligible for, or covered under, the Group Health Plan.

Independent Clinical Laboratory means a laboratory properly licensed pursuant to Chapter 483 of the Florida Statutes, or a similar

applicable law of another state, where examinations are performed on materials or specimens taken from the human body to provide information or materials used in the diagnosis, prevention, or treatment of a Condition.

Independent Diagnostic Testing Facility means a facility, independent of a hospital or Physician's office, which is a fixed location, a mobile entity, or an individual non-Physician practitioner where diagnostic tests are performed by a licensed Physician or by 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.

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

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

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.

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

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

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

Note: It is important to remember that any review of Medical Necessity by BCBSF is solely for the purpose of determining coverage or benefits under this Evidence of Coverage and not for the purpose of recommending or providing medical care. In this respect, BCBSF may review specific medical facts or information pertaining to the Covered Plan Participant. Any such review, however, is strictly for the purpose

of determining, among other things, whether a Service provided or proposed meets the definition of Medical Necessity in this Evidence of Coverage as determined by BCBSF. In applying the definition of Medical Necessity in this Evidence of Coverage**,** BCBSF may apply its coverage and payment guidelines then in effect. The Covered Plan Participant is free to obtain a Service even if BCBSF denies coverage because the Service is not Medically Necessary; however, the Covered Plan Participant will be solely responsible for paying for the Service.

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

Medication Guide means, for purposes of this Evidence of Coverage, the guide then in effect issued by BCBSF which contains information about Specialty Drugs, Prescription Drugs that require prior coverage authorization and Self-Administered Prescription Drugs that may be covered under this plan.

Note: The Medication Guide is subject to change at any time. Please refer to BCBSF's website at www.floridablue.com for the most current guide or call the customer service phone number on the Covered Plan Participant's Identification Card for current information.

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

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

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

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

   or

2. December 31st of the following Calendar Year.

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.

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

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

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

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

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

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

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

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

Placed, Placement, or To Place 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 Covered Employee and includes all actions by any person or agency participating in the process, or as otherwise defined by Florida Statutes.

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

PPO means, or refers to, the network of PPO Providers available to Covered Plan Participants under this Evidence of Coverage.

PPO Provider means, or refers to, any health care Provider who or which, at the time Health Care Services were rendered to a Covered Plan Participant, 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 a Covered Plan Participant, were under contract to participate as PPC℠ Providers. A Covered Plan Participant, 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 Evidence of Coverage, 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 a Covered Plan Participant, participated as Host Plan PPO Providers under the Blue Cross and Blue Shield Association's BlueCard Program.

PPO Schedule Amount means the amount on which payment will be based 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.

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

Pre-Service Claim means any request or application for coverage or benefits for a Service that has not yet been provided to the Covered Plan Participant and with respect to which the terms of the Evidence of Coverage condition payment for the Service (in whole or in part) on approval by BCBSF and/or Diocese of Palm Beach Health Plan Trust of coverage or benefits for the Service before the Covered Plan Participant receives it. A Pre-Service Claim may be a Claim Involving Urgent Care. As defined herein, a Pre-Service Claim shall not include a request for a decision or opinion by BCBSF and/or Diocese of Palm Beach Health Plan Trust regarding coverage, benefits, or payment for a Service that has not actually been rendered to the Covered Plan Participant if the terms of the Evidence of Coverage do not require (or condition payment upon) approval by BCBSF and/or Diocese of Palm Beach Health Plan Trust of coverage or benefits for the Service before it is received.

Preventive Services Guide means the guide then in effect issued by BCBSF that contains a listing of Preventive Health Services covered under this Evidence of Coverage. **Note**: The Preventive Services Guide is subject to change Please refer to BCBSF's website at www.FloridaBlue.com/healthresources for the most current guide.

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 Evidence of Coverage.

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

Psychiatric Facility means a facility licensed to provide for the Medically Necessary care and treatment of Mental and Nervous Disorders. For purposes of this Evidence of Coverage, 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.

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 is 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.

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

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

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

- If Detoxification Services are necessary, provides access to necessary on-site medical services 24 hours per day and 7 days per week, which must be actively supervised by an attending physician;
- Ability to assess and recognize withdrawal complications that threaten life or bodily

function and to obtain needed Services either on site or externally;

- Is supervised by an on-site Physician 24 hours per day and 7 days per week with evidence of close and frequent observation.

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

Self-Administered Prescription Drug means an FDA-approved Prescription Drug that the Covered Plan Participant may administer to him or herself, as recommended by a Physician.

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

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

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

Specialty Pharmacy means a pharmacy that has signed a Participating Pharmacy Provider Agreement with BCBSF to provide specific Prescription Drug products, as determined by BCBSF. Participating Specialty Pharmacies are listed in the Medication Guide.

The fact that a pharmacy is a participating pharmacy does not mean that it is a Specialty Pharmacy.

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

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

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

Standard Reference Compendium means: 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. For purposes of this Evidence of Coverage a substance abuse facility is not a Hospital or a Psychiatric Facility, as defined herein.

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

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

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 are also known as Payment for Professional Services "PPS" or Payment for Hospital Services "PHS"), as applicable, in Florida or in certain counties outside of Florida, when such programs exist.

Urgent Care Center means a facility properly licensed that: 1) is available to provide Services to patients at least 60 hours per week with at least twenty-five (25) of those available hours after 5:00 p.m. on weekdays or on Saturday or Sunday; 2) posts instructions for individuals seeking Health Care Services, in a conspicuous public place, as to where to obtain such Services when the Urgent Care Center is closed; 3) employs or contracts with at least one or more Board Certified or Board Eligible Physicians and Registered Nurses (RNs) who are physically present during all hours of operation. Physicians, RNs, and other medical professional staff must have appropriate training and skills for the care of adults and children; and 4) maintains and operates basic diagnostic radiology and laboratory equipment in compliance with applicable state and/or federal laws and regulations.

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

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

Waiting Period means the period of time specified if any, which must follow the date an individual is initially employed by Diocese of Palm Beach Health Plan Trust before such individual may become a Covered Employee.

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.

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Diocese of Palm Beach Health Plan Trust

AMENDMENT TO PLAN DOCUMENTS

The plan document amendments provide the required assurance that Plan Sponsor will (a) appropriately safeguard and limit the use and disclosure of the Group Health Plan enrollees' protected health information (PHI) and (b) reasonably and appropriately safeguard the Group Health Plan enrollees' Electronic PHI that Plan Sponsor may receive from a health carrier. Plan Sponsor must:

1. Only use and disclose the PHI as permitted or required by the plan document or as required by law;
2. Not use or disclose the PHI for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of Plan Sponsor;
3. Ensure "adequate separation" between Group Health Plan and Plan Sponsor and ensure that the separation is supported by reasonable and appropriate security measures;
4. Ensure that Plan Sponsor's agents and subcontractors agree to abide by the same restrictions and conditions as Plan Sponsor in regard to the use and disclosure of PHI and the security of Electronic PHI received from a health carrier;
5. Report to Group Health Plan any improper use or disclosure of the PHI of which Plan Sponsor is aware or any security incident of which Plan Sponsor is aware;
6. Make available PHI in accordance with the Privacy Rule's access provisions;
7. Make available PHI for amendment and incorporate any amendments to an enrollee's PHI in accordance with the Privacy Rule's amendment provisions;
8. Collect and make available the information necessary to provide an accounting of disclosures of an enrollee's PHI in accordance with the Privacy Rule's disclosure accounting provisions;
9. Make its internal practices, books and records relating to the use and disclosure of the PHI available to U.S. Department of Health and Human Services for purposes of auditing Group Health Plan's Privacy Rule compliance;
10. Return or destroy all PHI when the PHI is no longer needed for plan administration. If return or destruction is not feasible, limit further use and disclosure of the PHI to those purposes making return or destruction not feasible; and
11. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Group Health Plan enrollees' Electronic PHI.

Plan Sponsor may use and disclose PHI only for the following plan administration functions:

- Actuarial and statistical analysis
- Claims/membership inquires
- Quality assessment and improvement activities
- Performance monitoring
- Other health care operations
- Payment activities

The following classes of employees, as designated by title, may use and disclose PHI for the performance of the plan administrative functions listed above or as required by law:

Director of Insurance & Employee Services

Benefits Coordinator

Human Resources Assistant

In the event any such employee uses or discloses PHI for any other purpose, the employee will be subject to sanction as specified in plan sponsor's employee handbook.