



Summary Plan Description for
Covered Plan Participants of
The School Board of Polk County
Health Benefits Plan

A Self-funded Group Health
Benefit Plan

Serviced by



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Section 1: How to Use This Document

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

The School Board of Polk County is also known and referred to as the Polk County School Board or PCSB.

The School Board of Polk County is the Plan Sponsor and has contracted with a Third Party Administrator (TPA), Blue Cross Blue Shield of Florida, Inc. (BCBSF), under an Administrative Services Only Agreement (“ASO Agreement”), to provide certain third party administrative services, including claims processing, customer service, and other services, and access to certain of its Provider networks. BCBSF provides certain administrative services only and does not assume any financial risk or obligation with respect to Health Care Services rendered to Covered Persons or claims submitted for processing under this plan for such Services. The payment of claims under the Group Health Plan depends exclusively upon the funding provided by The School Board of Polk County Health Benefits Plan.

Under no circumstances will BCBSF be held responsible for, nor will BCBSF accept liability relating to, the failure of The School Board of Polk County to: 1) comply with any applicable disclosure requirements; 2) provide you with this Summary Plan Description (SPD); or 3) comply with any other legal requirements.

Responsibilities for Plan Administration

Plan Sponsor: The School Board of Polk County

Type of Plan: Self-Funded Welfare Plan providing health benefits

Type of Administration: Contract administration with Third Party Administrators

Address of Plan:

1915 S Floral Avenue
Bartow, FL 33830
(863) 519-3858

Federal Tax ID Number:

Plan Effective Date: October 1, 2003

Plan Renewal Date: January 1, Annually

Named Fiduciary: The School Board of Polk County

Agent for Services of Legal Process: The School Board of Polk County

Plan Third Party Administrator: Blue Cross and Blue Shield of Florida

BCBSF is not your Group Plan’s sponsor or plan administrator.

You should read this document carefully before you need Health Care Services. It contains valuable information about:

- your medical plan benefits;
- what is covered;
- what is excluded or not covered;
- coverage and payment rules;
- Condition Management and Care Coordination Programs;
- how and when to file a claim;
- how much, and under what circumstances, payment will be made;
- what you will have to pay as your share; and

- other important information including when benefits may change; how and when coverage stops; how to continue coverage if you are no longer eligible; how benefits will be coordinated with other policies or plans; and the Group Health Plan's subrogation rights and right of reimbursement.

You will need to refer to the Schedule of Benefits to determine how much you have to pay for particular Health Care Services.

When reading the Summary Plan Description, please remember that:

- you should read the SPD in its entirety in order to determine if a particular Health Care Service is covered.
- the headings of sections contained in the SPD are for reference purposes only and shall not affect in any way the meaning or interpretation of particular provisions.
- references to "you" or "your" throughout refer to you as the Covered Plan Participant and to your Covered Dependents, unless expressly stated otherwise or unless, in the context in which the term is used, it is clearly intended otherwise. Any references which refer solely to you as the Covered Plan Participant or solely to your Covered Dependent(s) will be noted as such.
- references to "we", "us", and "our" throughout refer to the Third Party Administrator, Blue Cross and Blue Shield of Florida, Inc., which may also be referred to as "BCBSF".
- if a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If the word or phrase has a special meaning, it will either be defined in the Definitions section or defined within the particular section where it is used.

Where do you find information on.....

- **what particular types of Health Care Services are covered?**

Read the “What Is Covered?” and “What Is Not Covered?” sections.

- **how much will be paid under your Group Health Plan and how much do you have to pay?**

Read the “Understanding Your Share of Health Care Expenses” section along with the Schedule of Benefits.

- **how the amount you pay for Covered Services under the BlueCard® (Out-of-State) Program will be determined when you receive care outside the state of Florida?**

Read the “BlueCard® (Out-of-State) Program” section.

- **how to add or remove a Dependent?**

Read the “Enrollment and Effective Date of Coverage” section.

- **what happens if you are covered under this Summary Plan Description and another health plan?**

Read the “Duplication of Coverage Under Other Health Plans Programs” section.

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

Read the “Termination of Coverage” section.

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

Read the “Definitions” section.

Overview of How BlueOptions Works

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

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

Section 2: What Is Covered?

Introduction

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

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

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

1. within the Health Care Services categories in the "What Is Covered?" section;
2. actually rendered (not just proposed or recommended) by an appropriately licensed health care Provider who is recognized for payment under this plan and for which an itemized statement or description of the procedure or Service which was rendered is received, including any applicable procedure code, diagnosis code and other information required in order to process a claim for the Service;
3. Medically Necessary, as defined in this plan and determined by BCBSF or The School Board of

Polk County in accordance with BCBSF's Medical Necessity coverage criteria then in effect, except as specified in this section;

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

BCBSF or School Board of Polk County will determine whether Services are Covered Services under this plan after you have obtained the Services and a claim has been received for the Services. In some circumstances BCBSF or The School Board of Polk County may determine whether Services might be Covered Services under this plan before you are provided the Service. For example, BCBSF or The School Board of Polk County may determine whether a proposed transplant is a Covered Service under this plan before the transplant is provided. Neither BCBSF nor The School Board of Polk County are obligated to determine, in advance, whether any Service not yet provided to you would be a Covered Service unless we have specifically designated that a Service is subject to a prior authorization requirement as described in the "Blueprint for Health Programs" section. We are also not obligated to cover or pay for any Service that has not actually been rendered to you.

In determining whether Health Care Services are Covered Services under this plan, no written or verbal representation by any employee or agent of BCBSF or The School Board of Polk County, or by any other person, shall waive or otherwise modify the terms of this Summary Plan Description and, therefore, neither you, nor any health care Provider or other person should

rely on any such written or verbal representation.

Our Benefit Guidelines

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

1. Payment 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.
2. Payment is based on the Allowed Amount for the actual Service rendered (i.e., payment is not based on the Allowed Amount for a Service which is more complex than that actually rendered), and is not based on the method utilized to perform the Service or the day of the week or the time of day the procedure is performed.
3. Payment for a Service includes all components of the Health Care Service when the Service can be described by a single procedure code, or when the Service is an essential or integral part of the associated therapeutic/diagnostic Service rendered.

Covered Services Categories

Accident Care

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

Exclusion:

Health Care Services to treat an injury or illness resulting from an Accident related to your job or employment are excluded.

Allergy Testing and Treatments

Testing and desensitization therapy (e.g., injections) and the cost of hyposensitization

serum are covered. The Allowed Amount for allergy testing is based upon the type and number of tests performed by the Physician. The Allowed Amount for allergy immunotherapy treatment is based upon the type and number of doses.

Ambulance Services

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

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

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

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

Ambulatory Surgical Centers

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

1. use of operating and recovery rooms;
2. respiratory, or inhalation therapy (e.g., oxygen);
3. drugs and medicines administered (except for take home drugs) at the Ambulatory Surgical Center;

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

Anesthesia Administration Services

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

Exclusion:

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

Autism Spectrum Disorder

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;

Payment Guidelines for Autism Spectrum Disorder

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

Note: In order to determine whether such Services are covered under this plan, 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.

You or your Physician will be required to obtain prior coverage authorization from us for Autism Spectrum Disorder Services before such Services are rendered. Refer to the “Blueprint for Health Programs” section of this SPD for additional information.

Breast Reconstructive Surgery

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

Child Cleft Lip and Cleft Palate Treatment

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

Concurrent Physician Care

Concurrent Physician care Services are covered, provided: (a) the additional Physician actively participates in your 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 your attending Physician requests the consultation and the consulting Physician prepares a written report.

Contraceptive Injections and Devices

1. Medication by injection is covered when provided and administered by a Physician or other health care professionals licensed to perform such services; and

2. The Mirena IUD is covered, including insertion, removal and the device. Other Intrauterine Devices (IUD) are not covered; however, the physician services required for the insertion and removal are covered when performed by a Physician or other health care professionals licensed to perform such services.

Dental Services

Dental Services are limited to the following:

1. Care and stabilization treatment rendered within 62 days of an Accidental Dental Injury to Sound Natural Teeth.
2. Extraction of teeth required prior to radiation therapy when you have a diagnosis of cancer of the head and/or neck.
3. Anesthesia Services for dental care including general anesthesia and hospitalization Services necessary to assure the safe delivery of necessary dental care provided to you or your Covered Dependent in a Hospital or Ambulatory Surgical Center if:
 - a) the Covered Dependent is under 8 years of age and it is determined by a dentist and the Covered Dependent's Physician that:
 - i. dental treatment is necessary due to a dental Condition that is significantly complex; or
 - ii. the Covered Dependent has a developmental disability in which patient management in the dental office has proven to be ineffective; or
 - b) you or your Covered Dependent have one or more medical Conditions that would create significant or undue medical risk for you in the course of delivery of any necessary dental treatment or surgery if not rendered in a Hospital or Ambulatory Surgical Center.

Exclusion:

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

Diabetic Equipment

Medically Necessary equipment used to treat diabetes (e.g. infusion pumps and pump supplies including pre-filled insulin cartridges).

Exclusion:

The following Supplies and equipment used in the treatment of diabetes are excluded under the medical portion of this plan: insulin, blood glucose testing strips and tablets, lancets, blood glucose meters, and acetone test tablets and syringes and needles.

Diagnostic Services

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

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

Exclusion:

Genetic screening when signs or symptoms do not exist.

Dialysis Services

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

Durable Medical Equipment

Durable Medical Equipment when provided by a Durable Medical Equipment Provider and when prescribed by a Physician, limited to the most cost-effective equipment as determined by BCBSF or The School Board of Polk County is covered.

Payment Guidelines for Durable Medical Equipment

Supplies and service to repair medical equipment may be Covered Services only if you own the equipment or you are purchasing the equipment. Payment for Durable Medical Equipment will be based on the lowest of the following: 1) the purchase price; 2) the lease/purchase price; 3) the rental rate; or 4) the Allowed Amount. The Allowed Amount for such rental equipment will not exceed the total purchase price. Durable Medical Equipment includes, but is not limited to, the following: wheelchairs, crutches, canes, walkers, hospital beds, and oxygen equipment.

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

Exclusion:

Equipment which is primarily for convenience and/or comfort; modifications to motor vehicles and/or homes, including but not limited to, wheelchair lifts or ramps; water therapy devices such as Jacuzzis, hot tubs, swimming pools or

whirlpools; exercise and massage equipment, electric scooters, hearing aids, air conditioners and purifiers, humidifiers, water softeners and/or purifiers, pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails and grab bars, heat appliances, dehumidifiers, and the replacement of Durable Medical Equipment solely because it is old or used are excluded.

Emergency Services

Emergency Services for an Emergency Medical Condition are covered when rendered In-Network and Out-of-Network without the need for any prior authorization determination by us.

When Emergency Services and care for an Emergency Medical Condition are rendered by an Out-of-Network Provider, any Copayment and/or Coinsurance amount applicable to In-Network Providers for Emergency Services will also apply to such Out-of-Network Provider.

Enteral Formulas

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

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

Eye Care

Coverage includes the following Services:

1. Physician Services, soft lenses or sclera shells, for the treatment of aphakic patients;

2. initial glasses or contact lenses following cataract surgery; and
3. Physician Services to treat an injury to or disease of the eyes.

Exclusion:

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

Hearing Aids

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

Exclusion:

Hearing aids or related services and exams not required due to a medical condition.

Home Health Care

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

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

Physician every 30 days. In order to determine whether such Services are covered under this Booklet, you may be required to provide a copy of any written treatment plan;

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

Home Health Care Services are limited to:

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

Exclusions:

1. homemaker or domestic maid services;
2. sitter or companion services;
3. Services rendered by an employee or operator of an adult congregate living facility; an adult foster home; an adult day care center, or a nursing home facility;

4. Speech Therapy provided for a diagnosis of developmental delay;
5. Custodial Care except for any such care covered under this subsection when provided on a part-time or intermittent basis (as defined above) by a home health aide;
6. food, housing, and home delivered meals; and
7. Services rendered in a Hospital, nursing home, or intermediate care facility.

Hospice Services

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

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

Recertification is required every six months.

Hospital Services

Covered Hospital Services include:

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

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

Exclusion:

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

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

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

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

Inpatient Rehabilitation

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

1. Services must be provided under the direction of a Physician and must be provided by a Medicare certified facility in accordance with a comprehensive rehabilitation program;

2. a plan of care must be developed and managed by a coordinated multi-disciplinary team;
3. coverage is limited to the specific acute, catastrophic target diagnoses of severe stroke, multiple trauma, brain/spinal injury, severe neurological motor disorders, and/or severe burns;
4. the individual must be able to actively participate in at least 2 rehabilitative therapies and be able to tolerate at least 3 hours per day of skilled Rehabilitation Services for at least 5 days a week and their Condition must be likely to result in significant improvement; and
5. the Rehabilitation Services must be required at such intensity, frequency and duration as to make it impractical for the individual to receive services in a less intensive setting.

Inpatient Rehabilitation Services are subject to the inpatient facility Copayment, if applicable, and the 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 may not be subject to the Deductible, Coinsurance, or Copayment (if applicable). Please refer to your Schedule of Benefits for more information.

Mastectomy Services

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

Outpatient post-surgical follow-up care for Mastectomy Services shall be covered when 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 your home. The treating Physician, after consultation with you, may choose the appropriate setting.

Maternity Services

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

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

Under Federal law, your 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, your Group Plan can only require that a provider obtain authorization for prescribing an inpatient hospital stay that exceeds 48 hours (or 96 hours).

Exclusion:

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

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

Mental Health Services

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

Partial Hospitalization is a Covered Service when provided under the direction of a Physician and in lieu of inpatient hospitalization.

Exclusion:

1. Services rendered in connection with a Condition not classified in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM) or their equivalents in the most recently published version of the American

Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder;

2. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or for mental retardation;
3. Services extended beyond the period necessary for evaluation and diagnosis of learning disabilities or for mental retardation;
4. Services for marriage counseling, when not rendered in connection with a Condition classified in 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;
5. Services for pre-marital counseling;
6. Services for court-ordered care or testing, or required as a condition of parole or probation;
7. Services for testing of aptitude, ability, intelligence or interest except as covered under the Autism Spectrum Disorder subsection;
8. Services for testing and evaluation for the purpose of maintaining employment;
9. Services for cognitive remediation;
10. inpatient confinements that are primarily intended as a change of environment; or
11. inpatient (over night) mental health Services received in a residential treatment facility.

Newborn Care

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

Newborn Assessment:

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

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

Under Federal law, your 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, your 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 are covered when prescribed by a Physician and designed and fitted by an Orthotist.

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

Payment for splints for the treatment of temporomandibular joint ("TMJ") dysfunction is limited to payment for one splint in a six-month period unless a more frequent replacement is determined by BCBSF or The School Board of Polk County 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 is covered, including, but not limited to:

1. estrogen-deficient individuals who are at clinical risk for osteoporosis;
2. individuals who have vertebral abnormalities;
3. individuals who are receiving long-term glucocorticoid (steroid) therapy; or
4. individuals who have primary hyperparathyroidism, and individuals who have a family history of osteoporosis.

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

Outpatient therapies listed below may be Covered Services when ordered by a Physician or other health care professional licensed to perform such Services. The outpatient therapies listed in this category are in addition to the Cardiac, Occupational, Physical and Speech Therapy benefits listed in the Home Health Care, Hospital, and Skilled Nursing Facility categories herein.

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

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

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

Physical Therapy Services provided by a Physician or Physical Therapist for the purpose

of aiding in the restoration of normal physical function lost due to a Condition are covered.

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

Payment Guidelines for Massage and Physical Therapy

1. Payment 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. Payment 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. Payment 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.

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

Payment Guidelines for Spinal Manipulation

1. Payment 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. Payment 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.

Your Schedule of Benefits sets forth the maximum number of visits covered under this plan for any combination of the outpatient therapies and spinal manipulation Services listed above. For example, even if you 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 you have 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

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

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

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

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

The term “established patient,” as used herein, shall mean that the covered individual has received professional services from the Physician who provided the online medical Services, or another physician of the same specialty who belongs to the same group practice as that Physician, within the past three years.

Exclusion:

Expenses for online medical Services provided electronically through a computer by a Physician via the Internet other than through a healthcare communication services vendor that has entered into contract with BCBSF are excluded. Expenses for online medical Services provided by a health care provider that is not a Physician and expenses for Health Care Services rendered by telephone are also excluded.

Preventive Adult Wellness Services

Preventive adult wellness Services are covered under your plan. For purposes of this benefit, an adult is 17 years or older.

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; and
3. with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Exclusion:

Routine vision and hearing examinations and screenings are not covered, except as required under paragraph number one above.

Preventive Child Health Supervision Services

Preventive Child Health Supervision Services from the moment of birth up to the 17th birthday are covered.

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; and
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.

Prosthetic Devices

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

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

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

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

Exclusion:

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

Self-Administered Injectable Prescription Drugs

Only Self-Administered Injectable Prescription Drugs used in the treatment of diabetes, cancer, conditions requiring immediate stabilization (e.g.

anaphylaxis), or in the administration of dialysis are covered.

Skilled Nursing Facilities

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

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

A treatment plan from your Physician may be required in order to determine coverage and payment.

Exclusion:

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

Substance Dependency Care and Treatment

Care and treatment for Substance Dependency includes the following:

1. Health Care Services (inpatient and outpatient or any combination thereof) provided by a Physician, Psychologist or Mental Health Professional in a program accredited by the Joint Commission on the Accreditation of Healthcare Organizations or approved by the state of Florida (or another state) for Detoxification or Substance Dependency.
2. Physician, Psychologist and Mental Health Professional outpatient visits for the care and treatment of Substance Dependency as listed in the Schedule of Benefits.

Exclusion:

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

Surgical Assistant Services

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

Surgical Procedures

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

1. sterilization (tubal ligations and vasectomies), regardless of Medical Necessity;
2. surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes;
3. oral surgical procedures for excisions of tumors, cysts, abscesses, and lesions of the mouth;

4. surgical procedures involving bones or joints of the jaw (e.g., temporomandibular joint [TMJ]) and facial region if, under accepted medical standards, such surgery is necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury; and
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.

Payment Guidelines for Surgical Procedures

1. Payment for multiple surgical procedures performed in addition to the primary surgical procedure, on the same or different areas of the body, during the same operative session will be based on 50 percent of the Allowed Amount for any secondary surgical procedure(s) performed. In addition, Coinsurance or Copayment (if any) indicated in your Schedule of Benefits will apply. This guideline is applicable to all bilateral procedures and all surgical procedures performed on the same date of service.
2. Payment for incidental surgical procedures is limited to the Allowed Amount for the primary procedure, and there is no additional payment for any incidental procedure. An "incidental surgical procedure" includes surgery where one, or more than one, surgical procedure is performed through the same incision or operative approach as the primary surgical procedure which, in BCBSF's or The School Board of Polk County's opinion, is not clearly identified and/or does not add significant time or complexity to the surgical session. For example, the removal of a normal appendix performed in conjunction with a Medically Necessary hysterectomy is an incidental surgical procedure (i.e., there is no payment for the removal of the normal appendix in the example).
3. Payment for surgical procedures for fracture care, dislocation treatment, debridement, wound

repair, unna boot, and other related Health Care Services, is included in the Allowed Amount of the surgical procedure.

Transplant Services

Transplant Services, limited to the procedures listed below, may be covered when performed at a facility acceptable to BCBSF or The School Board of Polk County, 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 provided in connection with a:

1. Bone Marrow Transplant, as defined herein, which is specifically listed in the rule 59B-12.001 of the *Florida Administrative Code* or any successor or similar rule or covered by Medicare as described in the most recently published *Medicare Coverage Issues Manual* issued by the Centers for Medicare and Medicaid Services. Coverage will be provided for the expenses incurred for the donation of bone marrow by a donor to the same extent such expenses would be covered for you and will be subject to the same limitations and exclusions as would be applicable to you. Coverage for the reasonable expenses of searching for the donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program. The costs of bone marrow donor searches are excluded from the \$10,000 procurement max. The \$10,000 procurement maximum does not apply to Bone Marrow Transplants.
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;
8. pancreas transplant performed simultaneously with a kidney transplant; or
9. lung-whole single or whole bilateral transplant.

Coverage will be provided for donor costs and organ acquisition for transplants, other than Bone Marrow Transplants. If these costs are covered by any other insurance carrier, organization, person or person's estate, the plan will coordinate benefits with the other coverage. Payment will not exceed the amount the plan would normally have paid if no other coverage existed and will not exceed the organ procurement benefit limitation of \$10,000.

Coverage under this health plan will for donor and acquisition costs will always pay secondary to any other applicable coverage, unless otherwise required by law to pay primary.

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

Exclusions:

Expenses for the following are excluded:

1. transplant procedures not included in the list above, or otherwise excluded under this Booklet (e.g., Experimental or Investigational transplant procedures);
2. transplant procedures involving the transplantation or implantation of any non-human organ or tissue;
3. transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered under this 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;
6. any Bone Marrow Transplant, as defined herein, which is not specifically listed in rule 59B-12.001 of the Florida Administrative Code or any successor or similar rule or covered by Medicare pursuant to a national coverage decision made by the Centers for Medicare and Medicaid Services as evidenced in the most recently published Medicare Coverage Issues Manual;
7. any Service in connection with the identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant;
8. any non-medical costs, including but not limited to, temporary lodging or transportation costs for you and/or your family to and from the approved facility; and
9. any artificial heart or mechanical device that replaces either the atrium and/or the ventricle.

Wigs and/or cranial prosthesis

Covered following Chemotherapy and/or Radiation treatment up to the benefit maximum listed on your Schedule of Benefits.

Section 3: What Is Not Covered?

Introduction

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

Abortions which are elective.

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

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

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

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

Complementary or Alternative Medicine

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

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

Contraceptive medications, devices, appliances, or other Health Care Services when provided for contraception, except when indicated as covered, under the adult wellness benefit, on the Schedule of Benefits (when selected by the Group), or otherwise covered in the “What Is Covered?” section.

Cosmetic Services, including any Service to improve the appearance or self-perception of an individual (except as covered under the Breast

Reconstructive Surgery category), including and without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A), and hair implants/transplants.

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

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

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

Diabetic Equipment and Supplies used for the treatment of diabetes except for insulin pumps and pump-related supplies.

Drugs

1. All drugs dispensed to, or purchased by, you from a pharmacy. See the separate Prescription Drug Plan Summary Plan Description. This

exclusion does not apply to drugs dispensed to you when:

- a) you are an inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility or a Hospice facility;
 - b) you are in the outpatient department of a Hospital;
 - c) dispensed with prior authorization by a pharmacy under contract with BCBSF to provide physician-administered speciality medications, to your Physician for administration to you in the Physician's office; or
 - d) you are receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills for such drugs, including Self-Administered Prescription Drugs that are rendered in connection with a nursing visit.
2. Any non-Prescription medicines, remedies, vaccines, biological products, pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, over-the-counter drugs, products, or health foods.
 3. Any Self-Administered Prescription Drug unless it is medically necessary that it be administered in the Physician's Office or by a Home Health Provider.
 4. Drugs, which require prior coverage authorization when prior coverage authorization is not obtained.

Education, Training and Counseling including nutritional or genetic of any type, regardless of diagnosis, except as provided under the following sections of this SPD: Home Health Care, Child Cleft Lip & Cleft Palate Treatment, and Mental Health Services.

Experimental or Investigational Services, except as otherwise covered under the Bone

Marrow Transplant provision of the Transplant Services category.

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

General Exclusions include, but are not limited to:

1. any Health Care Service received prior to your Effective Date or after the date your coverage terminates;
2. any Service to diagnose or treat any Condition resulting from or in connection with your job or employment;
3. any Health Care Services not within the service categories described in the "What is Covered?" section, any rider, or Endorsement attached hereto, unless such services are specifically required to be covered by applicable law;
4. any Health Care Services provided by a Physician or other health care Provider related to you by blood or marriage;
5. any Health Care Service which is not Medically Necessary as determined by us or The School Board of Polk County and defined in this Booklet. The ordering of a Service by a health care Provider does not in itself make such Service Medically Necessary or a Covered Service;
6. any Health Care Services rendered at no charge;
7. expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage;
8. any Health Care Services to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with:

- a) war or an act of war, whether declared or not;
- b) your participation in, or commission of, any act punishable by law as a misdemeanor or felony, or which constitutes riot, or rebellion;
- c) your engaging in an illegal occupation;
- d) Services received at military or government facilities; or
- e) Services received to treat a Condition arising out of your service in the armed forces, reserves and/or National Guard;
- f) Services that are not patient-specific, as determined solely by us.

9. Health Care Services rendered because they were ordered by a court, unless such Services are Covered Services under this Benefit Booklet; and
10. any Health Care Services rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group; or
11. Health Care Services that are not direct, hands-on, and patient specific, including, but not limited to the oversight of a medical laboratory to assure timeliness, reliability, and/or usefulness of test results, or the oversight of the calibration of laboratory machines, equipment, or laboratory technicians.

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

Hearing Aids (implantable) and Services related to the fitting or provision of hearing aids, including tinnitus maskers, batteries, and cost of repair except as described in the "What is Covered?" section.

Immunizations except those covered under the Preventive Child Health Supervision Services or

Preventive Adult Wellness Services categories of the “What Is Covered?” section.

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

For the definition of Gestational Surrogate and Gestational Surrogacy Contract see the Definitions section of this SPD.

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

Orthomolecular Therapy including nutrients, vitamins, and food supplements.

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

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

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

1. beauty and barber services;
2. clothing including support hose;

3. radio and television;
4. guest meals and accommodations;
5. telephone charges;
6. take-home supplies;
7. travel expenses (other than Medically Necessary Ambulance Services);
8. motel/hotel accommodations;
9. air conditioners, furnaces, air filters, air or water purification systems, water softening systems, humidifiers, dehumidifiers, vacuum cleaners or any other similar equipment and devices used for environmental control or to enhance an environmental setting;
10. hot tubs, Jacuzzis, heated spas, pools, or memberships to health clubs;
11. heating pads, hot water bottles, or ice packs;
12. physical fitness equipment;
13. hand rails and grab bars; and
14. Massages except as covered in the “*What Is Covered?*” section of this SPD.

Private Duty Nursing Care rendered at any location.

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

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

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

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

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

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

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

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

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

Wigs and/or cranial prosthesis except as described in the "What is Covered?" section.

Section 4: Medical Necessity

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

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

All decisions that require or pertain to independent professional medical/clinical judgement or training, or the need for medical services, are solely your responsibility and that of your treating Physicians and health care Providers. You and your Physicians are responsible for deciding what medical care should be rendered or received and when that care should be provided. The School Board of Polk County is ultimately responsible for determining whether expenses incurred for medical care are covered under this plan. In making coverage decisions, neither BCBSF nor The School Board of Polk County will be deemed to participate in or override your decisions concerning your health or the medical decisions of your health care Providers.

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

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

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

Section 5: Understanding Your Share of Health Care Expenses

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

Deductible Requirement

Individual Deductible

This amount, when applicable, must be satisfied by you and each of your Covered Dependents each Benefit Period, before any payment will be made by the Group Health Plan. Only those charges indicated on claims received for Covered Services will be credited toward the individual Deductible and only up to the applicable Allowed Amount. Please see your Schedule of Benefits for more information.

Family Deductible

Your plan includes a family Deductible. After the family Deductible has been met by your family, neither you nor your Covered Dependents will have any additional Deductible responsibility for the remainder of that Benefit Period. The maximum amount that any one Covered Person in your family can contribute toward the family Deductible is the amount applied toward the individual Deductible. Please see your Schedule of Benefits for more information.

Copayment Requirements

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

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

Office Services Copayment

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

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

Coinsurance Requirements

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

Out-of-Pocket Maximums

Individual out-of-pocket maximum

Once you have reached the individual out-of-pocket maximum amount listed in the Schedule of Benefits, you will have no additional out-of-pocket responsibility for the remainder of that Benefit Period and we will pay 100 percent of the Allowed Amount for Covered Services rendered during the remainder of that Benefit Period. This applies to all covered services except were specifically excluded in the Schedule of Benefits.

Family out-of-pocket maximum

If your plan includes a family out-of-pocket maximum, once your family has reached the family out-of-pocket maximum amount listed in the Schedule of Benefits, neither you nor your covered family members will have any additional out-of-pocket responsibility for the remainder of that Benefit Period and we will pay 100 percent of the Allowed Amount for Covered Services rendered during the remainder of that Benefit Period. This applies to all covered services except where specifically excluded in the Schedule of Benefits. The maximum amount any one Covered Person in your family can contribute toward the family out-of-pocket maximum, if applicable, is the amount applied toward the individual out-of-pocket maximum. Please see your Schedule of Benefits for more information.

Note: The Deductible, any applicable Copayments and Coinsurance amounts will accumulate toward the out-of-pocket maximums. Any benefit penalty reductions, non-covered charges or any charges in excess of the Allowed Amount will not accumulate toward the out-of-pocket maximums. Prescription drugs covered by the Group Health Plan Pharmacy Benefit Administrator (PBA) do not accumulate toward the BCBSF Deductible or Out-of-Pocket Maximums.

Additional Expenses You Must Pay

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

1. any applicable Copayments;
2. expenses incurred for non-covered Services;
3. charges in excess of any maximum benefit limitation listed in the Schedule of Benefits (e.g., Benefit Period maximums);
4. charges in excess of the Allowed Amount for Covered Services rendered by Providers who have not agreed to accept the Allowed Amount as payment in full;
5. any benefit reductions;
6. payment of expenses for claims denied because we did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage; and
7. charges for Health Care Services which are excluded.

Additionally, you are responsible for any contribution amount required by the School Board of Polk County.

How Benefit Maximums Will Be Credited

Only amounts actually paid for Covered Services will be credited towards any applicable benefit maximum. The amounts paid which are credited towards your benefit maximums will be based on the Allowed Amount for the Covered Services provided.

Section 6: Physicians, Hospitals and Other Provider Options

Introduction

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

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

You are entitled to preferred provider type benefits when you receive Covered Services from In-Network Providers. You are entitled to traditional program type benefits at the point of service when you receive Covered Services from Traditional Program Providers or BlueCard[®] (Out-of-State) Traditional Program Providers, in conformity with Section 7: BlueCard[®] (Out-of-State) Program.

Provider Participation Status

With BlueOptions, you may choose to receive Services from any Provider. However, you may be able to lower the amount you have to pay for Covered Services by receiving care from an In-Network Provider. Although you have the option to select any Provider you choose, you are encouraged to select and develop a relationship with an In-Network Family Physician. There are several advantages to selecting a Family Physician. Family Physicians are trained to provide a broad range of medical care and can be a valuable resource to coordinate your overall healthcare needs. Developing and

continuing a relationship with a Family Physician allows the physician to become knowledgeable about you and your family’s health history. A Family Physician can help you determine when you need to visit a specialist and also help you find one based on their knowledge of you and your specific healthcare needs. Types of Family Physicians are Family Practitioners, General Practitioners, Internal Medicine doctors and Pediatricians. Additionally, care rendered by Family Physicians usually results in lower out-of-pocket expenses for you. Whether you select a Family Physician or another type of Physician to render Health Care Services, please remember that using In-Network Providers may result in lower out-of-pocket expenses for you. You should always determine whether a Provider is In-Network or Out-of-Network prior to receiving Services to determine the amount you are responsible for paying out-of-pocket.

Location of Service

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

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

1. If in Florida, review your current BlueOptions Provider Directory;
2. If in Florida, access the BlueOptions Provider directory at BCBSF's web-site at www.bcbsfl.com; and/or
3. If outside of Florida, access the on-line BlueCard[®] Doctor and Hospital Finder at www.bcbs.com; and/or
4. Call the customer service phone number in this SPD or on your Identification Card.

Please remember that changes to Provider network participation can occur at any time. Consequently, it is your responsibility to determine whether a specific Provider is In-Network at the time you receive Covered Services.

In-Network Providers

When you use In-Network Providers, your out-of-pocket expenses for Covered Services may be lower. Payment will be based on the Allowed Amount and your share of the cost will be at the In-Network benefit level listed in the Schedule of Benefits.

Out-of-Network Providers

When you use Out-of-Network Providers your out-of-pocket expenses for Covered Services will be higher. We will base our payment on the Allowed Amount at the Coinsurance percentage listed in the Schedule of Benefits. Further, if the Out-of-Network Provider is a Traditional Program Provider or a BlueCard[®] (Out-of-State) Traditional Program Provider, our payment to such Provider may be under the terms of that Provider's contract. If your Schedule of Benefits and BlueOptions Provider directory do not

include a Provider as In-Network under your benefit plan, the Provider is considered Out-of-Network.

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

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

Physicians

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

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

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

Hospitals

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

In-Network Hospitals have been divided into two groups that are referred to as "options" on the Schedule of Benefits. The amount you are responsible for paying out-of-pocket is different for each of these options. Remember that there are also different out-of-pocket expenses for Out-of-Network Hospitals.

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

This will provide you with information that will help you determine a portion of what your out-of-pocket costs may be in the event you are hospitalized.

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

Specialty Pharmacy

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

Using the Specialty Pharmacy to provide these Specialty Drugs should lower the amount you have to pay for these medications, while helping to preserve your benefits.

Medical Pharmacy, both speciality and non-specialty, which require physician administration are covered under the Medical portion of your Group Health Plan.

Self-Administered medications, both speciality and non-speciality, are covered under your Pharmacy benefit and are processed by the Pharmacy Benefit Administrator for your Group Health Plan, not BCBSF. Self-Administered medications are only covered under the Medical portion of your Group Health Plan when they are required to be administered by a health care professional or when they are provided as part of Home Health treatment and billed by the Home Health Care agency.

Other Providers

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

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

Remember that the location of service can impact the amount you are responsible for paying out-of-pocket. After you and your Physician have determined the plan of treatment most appropriate for your care, you should refer to the Schedule of Benefits and consult with your Physician to determine the most appropriate setting based on your health care and financial needs. When Services are rendered at an outpatient facility other than a Hospital there may be an out-of-pocket expense for the facility Provider as well as an out-of-pocket expense for other types of Providers.

Assignment of Benefits to Providers

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

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

We specifically reserve the right to honor an assignment of benefits or payment by you to a Provider who: 1) is In-Network under your plan of coverage; 2) is a NetworkBlue Provider even if that Provider is not in the panel for your plan of coverage; 3) is a Traditional Program Provider; 4) is a BlueCard® (Out-of-State) PPO Program Provider; 5) is a BlueCard® (Out-of-State) Traditional Program Provider; 6) is a licensed Hospital, Physician, or dentist and the benefits which have been assigned are for care provided pursuant to section 395.1041, *Florida Statutes*; or 7) 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.

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

Providers Outside the State of Florida

When you obtain Health Care Services from BlueCard[®] participating Providers outside the state of Florida, the amount you pay for Covered Services is calculated on the **lower** of:

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

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

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

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

Section 8: Blueprint for Health Programs

Introduction

BCBSF has established (and from time to time establishes) various customer-focused health education and information programs as well as benefit utilization management and utilization review programs. Under the terms of the ASO Agreement between BCBSF and The School Board of Polk County, BCBSF has agreed to make these programs available to you. These programs, collectively called the Blueprint for Health Programs, are designed to 1) provide you with information that will help you make more informed decisions about your health, 2) help facilitate the management and review of coverage and benefits provided under this plan and 3) present opportunities, as explained below, to mutually agree upon alternative benefits or payment alternatives for cost-effective medically appropriate Health Care Services. **Some BluePrint For Health Programs may not be available outside the state of Florida.**

Admission Notification

The admission notification requirements vary depending on whether you are admitted to a Hospital, Psychiatric Facility, Substance Abuse Facility or Skilled Nursing Facility which is In-Network or Out-of-Network.

In-Network

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

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

Out-of-Network

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

Inpatient Facility Program

Under the inpatient facility program, we may review Hospital stays, Hospice, Inpatient Rehabilitation, LTAC and Skilled Nursing Facility (SNF) Services, and other Health Care Services rendered during the course of an inpatient stay or treatment program. We may conduct this

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

Provider Focused Utilization Management Program

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

or collect, any payment whatsoever from you or us, or any other person or entity, with respect to a specific Health Care Service if:

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

Exception for Certain NetworkBlue Physicians

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

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

Prior Coverage Authorization/Pre-Service Notification Programs

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

You or your Provider will be required to obtain prior coverage authorization from us for:

1. certain **Physician-Administered Specificity Medications**;
2. **advanced diagnostic imaging Services**, such as CT scans, MRIs, MRA and nuclear imaging;
3. **Autism Spectrum Disorder; Mental Health; and Substance Dependency Services**; and
4. **Other Health Care Services** that are or may become subject to a prior coverage authorization program or a pre-service notification program as defined and administered by BCBSF.

Prior coverage authorization requirements vary, depending on whether Services are rendered by an In-Network Provider or an Out-of-Network Provider, as described below:

In-Network Providers

It is the In-Network Provider's sole responsibility to comply with our prior coverage authorization requirements, and therefore you will not be responsible for any benefit reductions if prior coverage authorization is not obtained before Medically Necessary Services are rendered.

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

Out-of-Network Providers

1. In the case of **Medical Pharmacy Drugs** which require prior authorization, it is your sole responsibility to comply with our prior coverage authorization requirements when you use an Out-of-Network Provider **before** the Prescription Drug is purchased or administered. **Your failure to obtain prior coverage authorization will result in denial of coverage for such Drug,**

including any Service related to the Drug or its administration.

2. In the case of advanced diagnostic imaging Services such as CT scans, MRIs, MRA and nuclear imaging, it is your sole responsibility to comply with our prior coverage authorization requirements when rendered or referred by an Out-of-Network Provider before the advanced diagnostic imaging Services are provided. Your 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, please call the customer service phone number on the back of your ID Card.

3. In the case of **Autism Spectrum Disorder, Mental Health, and Substance Dependency Services** under a prior coverage authorization or pre-service notification program, it is your sole responsibility to comply with our prior coverage authorization or pre-service notification requirements when rendered or referred by an Out-of-Network Provider, **before** the Services are provided. **Failure to obtain prior coverage authorization will result in denial of coverage for such Services.**

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

See the "Claims Processing" section for information on what you can do if prior coverage authorization is denied.

Note: Prior coverage authorization is not required when Covered Services are provided

for the treatment of an Emergency Medical Condition.

Member Focused Programs

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

Personal Case Management Program

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

Under the personal case management program, you may be offered alternative benefits or payment for cost-effective Health Care Services. These alternative benefits or payments may be made available on a case-by-case basis when you meet BCBSF's case management criteria then in effect. Such alternative benefits or payments, if any, will be made available in accordance with a treatment plan with which you, or your representative, and your Physician agree to in writing. In addition, The School Board of Polk County will be required to specifically agree to such treatment plan and the alternative benefits or payment.

The fact that certain Health Care Services under the personal case management program have been provided or payment has been made in no

way obligates BCBSF, The School Board of Polk County, or the Group Health Plan to continue to provide or pay for the same or similar Services. Nothing contained in this section shall be deemed a waiver of The School Board of Polk County's right to enforce this plan in strict accordance with its terms. The terms of this SPD will continue to apply, except as specifically modified in writing in accordance with the personal case management program rules then in effect.

Health Information, Promotion, Prevention and Illness Management Programs

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

IMPORTANT INFORMATION RELATING TO BCBSF'S BLUEPRINT FOR HEALTH PROGRAMS

All decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical services, are solely your responsibility and the responsibility of your Physicians and other health care Providers. You and your Physicians

are responsible for deciding what medical care should be rendered or received, and when and how that care should be provided. The School Board of Polk County is ultimately responsible for determining whether expenses, which have been or will be incurred for medical care are, or will be, covered under this plan. In fulfilling this responsibility, neither BCBSF nor The School Board of Polk County will be deemed to participate in or override the medical decisions of your health care Provider.

Please note that the Hospital admission notification requirement and any Blueprint For Health Program may be discontinued or modified at any time without notice to you or your consent.

Section 9: Pre-existing Conditions Exclusion Period

Introduction

Generally, there is no coverage under this plan for Health Care Services to treat a Pre-existing Condition, or Conditions arising from a Pre-existing Condition, until you have been continuously covered under this plan for a 12-month period. This 12-month Pre-existing Condition exclusionary period begins on the first day of the Waiting Period if you are an initial enrollee; or your Effective Date of coverage under the plan if you are a special or annual enrollee. This exclusionary period also applies to any prescription drug that is prescribed in connection with a Pre-existing Condition.

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

1. the Covered Employee and each Covered Dependent who was covered under The School Board of Polk County's prior medical plan on the date immediately preceding the Effective Date of coverage under this SPD;
2. you if you were enrolled during the Initial Enrollment Period prior to the Effective Date of The School Board of Polk County; or
3. you when The School Board of Polk County has elected to waive, in writing, the Pre-existing Conditions exclusionary period for all subsequent Eligible Employees and/or Eligible Dependents
4. any Condition for a Covered Person who is under the age of 19 as of the effective date of this SPD, or if enrolled thereafter, is under the age of 19 at the time of enrollment;
5. pregnancy;
6. genetic Information in the absence of a diagnosis of the Condition;
7. routine follow-up care of breast cancer after the person was determined to be free of breast cancer;
8. conditions arising from domestic violence; or
9. 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.

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

Pre-existing Condition Definition

A Pre-existing Condition means any Condition related to a physical or mental Condition, regardless of the cause of the Condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the six-month period immediately preceding:

1. the first day of your Waiting Period for initial enrollees; or
2. your Effective Date of coverage under the Group Health Plan for special and annual enrollees.

Reducing the Pre-existing Conditions Exclusionary Period

No matter whether you enroll when first eligible or at a later date (such as an Annual Open Enrollment

Period or as a result of Special Enrollment), you may be able to reduce or even eliminate the Pre-existing Conditions exclusionary period if you have prior Creditable Coverage.

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

If, on the other hand, you are enrolling under this plan at any other time as allowed under its terms, such as during an Annual Open Enrollment Period or a Special Enrollment Period, your Pre-existing Conditions exclusionary period will be reduced by the amount of any Creditable Coverage you have; provided there is no more than a 63 day break in coverage prior to your Enrollment Date in this plan.

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

Creditable Coverage

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

1. a group health insurance plan;
2. individual health insurance;
3. Medicare Part A and Part B;
4. Medicaid;
5. benefits to members and certain former members of the uniformed services and their dependents;
6. a medical care program of the Indian Health Service or of a tribal organization;

7. a State health benefits risk pool;
8. a health plan offered under chapter 89 of Title 5, United States Code;
9. a public health plan;
10. a health benefit plan of the Peace Corps;
11. State Children's Health Insurance Program (CHIP);
12. public health plans established by the federal government; or
13. public health plans established by foreign governments.

Proving Creditable Coverage

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

Section 10: Eligibility for Coverage

Each employee or other individual who is eligible to participate in the Group Health Plan, and who meets and continues to meet the eligibility requirements described in this SPD, shall be entitled to apply for coverage under this plan. These eligibility requirements are binding upon you and/or your eligible family members. No changes in the eligibility requirements will be permitted except as permitted by The School Board of Polk County. Acceptable documentation may be required as proof that an individual meets and continues to meet the eligibility requirements such as a court order naming the Eligible Employee as the legal guardian or appropriate adoption documentation described in the "Enrollment and Effective Date of Coverage" section.

Covered Employment Classification

Employees who work at least 3 hours and 45 minutes per day and 18 hours and 45 minutes per week in a regular position, including those active employees eligible for coverage under Medicare, will be eligible to receive the benefits described in this SPD, subject to the terms and conditions of the plan, and are referred to as Employees.

Retirees

Employees described above who retired from The School Board of Polk County and elected to continue health insurance coverage will be referred to as Retirees.

1. Retirees not eligible for Medicare
2. Retirees eligible for Medicare - All retired employees and their spouses age sixty-five (65) or over and disabled retirees who are eligible for

Medicare, regardless of cost, shall have Medicare as the primary payer and this Plan shall be secondary. If you are Eligible for Medicare Part B and do not elect Medicare Part B, this plan pays benefits as though Medicare was primary. The plan will not pay anymore than it would have paid if the eligible retiree or dependent had been enrolled in both Medicare Part A and B.

3. The School Board of Polk County is responsible for determining eligibility and notifying BCBSF when a retiree or dependent is eligible for and does not elect Medicare Part B.

Once you become age sixty-five (65), you are eligible for Medicare Part B. Medicare Part B is not automatic; you **must apply through the Social Security Administration**. Expect to receive a letter from the Social Security Administration prior to your sixty-fifth (65th) birthday with an application to be completed. It is **strongly recommended** that you complete this application in order to receive optimal medical coverage.

Eligibility Requirements for Covered Plan Participants

In order to be eligible to enroll as a Covered Employee, an individual must be an Eligible Employee. An Eligible Employee must meet each of the following requirements:

1. The employee must be a bona fide employee of The School Board of Polk County;
2. The employee's job must fall within a job classification identified by The School Board of Polk County;

3. The employee must have completed any applicable Waiting Period determined by The School Board of Polk County; and
4. The employee must meet any additional eligibility requirement(s) required by The School Board of Polk County.

The School Board of Polk County's coverage eligibility classifications may be expanded to include other individuals as determined by The School Board of Polk County.

The School Board of Polk County shall have sole discretion concerning the expansion of eligibility classifications.

Eligibility Requirements for Dependent(s)

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

1. The Covered Employee's spouse under a legally valid existing marriage.
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 month in which he or she reaches age 26 (or in the case of a Foster Child, is no longer eligible under the Foster Child Program), regardless of the dependent child's student or marital status, financial dependency on the Covered Employee, whether the dependent child resides with the Covered Employee, or whether the dependent child is eligible for or enrolled in any other group health plan.
3. The newborn child of a Covered Dependent child. Coverage for such newborn child will automatically terminate 18 months after the birth of the newborn child.

Note: It is the Covered Employee's sole responsibility to establish that a child meets the applicable requirements for eligibility. Eligibility will terminate on the last day of the month in which the dependent child reaches the age of 26.

Handicapped Children

In the case of a handicapped dependent child, such child is eligible to continue coverage as a Covered Dependent, beyond the age of 26 if the child is:

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

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

Section 11: Enrollment and Effective Date of Coverage

Benefit Eligibility Date for Employees, Dependents and Retirees

Eligible Employees, Dependents and Retirees may enroll for coverage according to the provisions below.

Any Eligible Employee will be automatically enrolled in this plan on their initial Date of Eligibility. The Initial Benefit Eligibility Date will be the first of the month after ninety (90) days of continuous active employment, in a covered employment classification, with The School Board of Polk County, unless they waive coverage under the plan in writing. Eligible Dependents who are not properly enrolled will not be covered under this plan.

Retirees will have a Benefit Eligibility Date beginning on the first of the month after termination of coverage as an Employee. Retirees who are not properly enrolled will not be covered under this plan.

Neither BCBSF nor The School Board of Polk County will have any obligation whatsoever to any individual who does not properly waive or enroll.

Enrollment Forms/Electing Coverage

Outside of the automatic enrollment of new employees, all other eligible employees and retirees must apply for coverage under this plan according to the provisions set forth below.

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

1. complete and submit, through The School Board of Polk County, the Change of Status Form;

2. provide any additional information needed to determine eligibility, at the request of BCBSF or The School Board of Polk County;
3. pay any required contribution; and
4. complete and submit, through The School Board of Polk County, a Change of Status Form to add Eligible Dependents.

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

Employee Only Coverage - This type of coverage provides coverage for the Employee only.

Employee/Spouse Coverage - This type of coverage provides coverage for the Employee and the employee's spouse under a legally valid existing marriage.

Employee/Board Spouse - This type of coverage provides coverage for the Employee and the employee's spouse, who is also an eligible employee of The School Board of Polk County, under a legally valid existing marriage.

Employee/Child Coverage – This type of coverage provides coverage for the Employee and one eligible child only.

Employee/Two Children Coverage - This type of coverage provides coverage for the Employee and two eligible children only.

Employee/Three or more Children Coverage - This type of coverage provides coverage for the Employee and three or more of the employee's eligible children.

Employee/Spouse/Child - This type of coverage provides coverage for the Employee,

the employee's spouse under a legally valid existing marriage and one eligible child only.

Employee/Spouse/Two Children Coverage -

This type of coverage provides coverage for the Employee, the employee's spouse under a legally valid existing marriage and two eligible children only.

Employee/Spouse/Three or more Children Coverage -

This type of coverage provides coverage for the Employee, the employee's spouse under a legally valid existing marriage and three or more eligible children.

There may be additional contribution amounts for each Covered Dependent based on the coverage selected by School Board of Polk County.

Enrollment Periods

The enrollment periods for applying for coverage are as follows:

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 Eligibility Date and ends no less than 30 days later.

Annual Open Enrollment Period is the period of time during which each Eligible Employee is given an opportunity to elect or change coverage in The School Board of Polk County's health benefit program. The period is established by The School Board of Polk County, occurs annually, and will take place when specified by The School Board of Polk County.

Special Enrollment Period is the 31-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

An Eligible Employee who fails to waive coverage during the Initial Enrollment Period will be automatically enrolled with Employee Only coverage.

Dependent Enrollment

An Eligible Employee who fails to enroll their Eligible Dependents during the Initial Enrollment Period may only enroll their Eligible Dependents under this plan during the next Annual Open Enrollment Period established by The School Board of Polk County, or in the case of a Special Enrollment event, during the Special Enrollment Period. The Effective Date will be the date specified by The School Board of Polk County.

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

Newborn Child – To enroll a newborn child who is an Eligible Dependent, the Covered Plan Participant must submit an Enrollment Form to The School Board of Polk County during the 31-day period immediately following the date of birth. The Effective Date of coverage for a newborn child will be the date of birth.

If timely notice is given, no additional contribution will be charged for coverage of the newborn child for not less than 31 days after the birth of the child. If timely notice is not received, the applicable contribution will be charged from the date of birth. The applicable contribution for the child will be charged after the initial 31-day period in either case. Coverage will not be denied for a newborn child if the Covered Plan Participant provides notice to The School Board

of Polk County and a Change of Status Form is received within the 60-day period following the birth of the child and any applicable contribution is paid back to 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 plan during an Annual Open Enrollment Period, or in the case of a Special Enrollment event, during the Special Enrollment Period.

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

Adopted Newborn Child – To enroll an adopted newborn child, the Covered Plan Participant must submit a Change of Status Form through The School Board of Polk County during the 31-day period immediately following the date of birth. The Effective Date of coverage for an adopted newborn child, eligible for coverage, will be the moment of birth, provided that a written agreement to adopt such child has been entered into by the Covered Plan Participant prior to the birth of such child, whether or not such an agreement is enforceable. The Covered Plan Participant may be required to provide any information and/or documents that are deemed necessary in order to administer this provision.

If timely notice is given, no additional contribution will be charged for coverage of the adopted newborn child for not less than 30 days after the birth of the child. If timely notice is not received, the applicable contribution will be charged from the date of birth. The applicable contribution for the child will be charged after the initial 30-day period in either case. Coverage will not be denied for an adopted newborn child if the Covered Plan Participant provides notice to The School Board of Polk County and a Change of Status form is received within the 60-

day period of the birth of the adopted newborn child and any applicable contribution is paid back to the date of birth.

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 plan 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 Plan Participant, there shall be no coverage for the adopted newborn child. It is your responsibility as the Covered Plan Participant to notify The School Board of Polk County within ten calendar days of the date that placement was to occur if the adopted newborn child is not placed in your residence.

Adopted/Foster Children – To enroll an adopted or Foster Child, the Covered Plan Participant must submit a Change of Status Form during the 31-day period immediately following the date of placement. The Effective Date for an adopted or Foster child (other than an adopted newborn child) will be the date such adopted or Foster child is placed in the residence of the Covered Plan Participant in compliance with applicable law. The Covered Plan Participant may be required to provide any information and/or documents deemed necessary in order to properly administer this section.

In the event The School Board of Polk County is not notified within 31 days of the date of placement, the child will be added as of the date of placement so long as Covered Plan Participant provides notice to The School Board of Polk County, and we receive the Change of Status Form within 60 days of the placement. If the adopted or Foster Child is not enrolled within sixty days of the date of placement, the adopted or Foster Child will not be covered, and may

only be enrolled under this plan during an Annual Open Enrollment Period, or in the case of a Special Enrollment event, during the Special 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 The School Board of Polk County. It is the responsibility of the Covered Plan Participant to notify The School Board of Polk County if the adoption does not take place. Upon receipt of this notification, we will terminate the coverage of the child as of the Effective Date of the adopted child upon receipt of the written notice.

If the Covered Plan Participant's status as a foster parent is terminated, coverage will end for any Foster Child. It is the responsibility of the Covered Plan Participant to notify The School Board of Polk County that the Foster Child is no longer in the Covered Plan Participant's care. Upon receipt of this notification, coverage for the child will be terminated on the date the Covered Plan Participant's status as a foster parent terminated.

Marital Status –The Covered Plan Participant may apply for coverage of an Eligible Dependent due to a legally valid marriage. To apply for coverage, the Covered Plan Participant must complete the Enrollment Form or Change of Status Form through The School Board of Polk County. The Covered Plan Participant must make application for enrollment within 31 days of the marriage. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of marriage is the date of the marriage.

Court Order – The Covered Plan Participant 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 their group coverage. To apply for coverage, the Covered Plan Participant must complete an Enrollment Form or Change of Status Form through The School Board of

Polk County. The Covered Plan Participant must make application for enrollment within 31 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 the Enrollment Form during the Annual Open Enrollment Period.

The effective date of coverage for an Eligible Employee and any Eligible Dependent(s) will be the date established by The School Board of Polk County.

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 the 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 Dependent(s) 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 Dependent(s) must complete the applicable Enrollment Form or Change of Status Form and through The School Board of Polk County within the time periods noted below for each special enrollment event.

An Eligible Employee and/or the Employee's Eligible Dependent(s) may apply for coverage if

one of the following special enrollment events occurs and the applicable Enrollment Form or Change of Status Form is submitted to The School Board of Polk County within the indicated time periods:

1. If you lose your 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 you were covered under at the time of initial enrollment provided that:
 - a) when offered coverage under this plan at the time of initial eligibility, you stated, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment; and
 - b) you lost your 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 you work, reaching or exceeding the maximum lifetime of all benefits under other health coverage, the employer ceased offering group health coverage, death of your spouse, divorce, legal separation or employer contributions toward such coverage was terminated; and
 - c) you submit the applicable Enrollment Form or Change of Status Form to The School Board of Polk County within 31 days of the date your coverage was terminated

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

or

2. If when offered coverage under this plan at the time of initial eligibility, you stated, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment; and you get married or obtain a dependent through birth, adoption or placement in anticipation of adoption and you submit the applicable Enrollment Form or Change of Status Form to The School Board of Polk County within 31 days of the date of the event.

or

3. If you or your Eligible Dependent(s) 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 you submit the applicable Enrollment Form or Change of Status Form to The School Board of Polk County within 60 days of the date such coverage was terminated or the date you become eligible for the optional state premium assistance program.

The Effective Date of coverage for you and your Eligible Dependents added as a result of a special enrollment event is the date of the special enrollment event. Eligible Employees or Eligible Dependents who do not enroll or change their coverage selection during the Special Enrollment Period must wait until the next Annual Open Enrollment Period (See the Dependent Enrollment subsection of this section for the rules relating to the enrollment of Eligible Dependents of a Covered Plan Participant).

Other Provisions Regarding Enrollment and Effective Date of Coverage

Individuals who are rehired as employees of The School Board of Polk County are considered newly hired employees for purposes of this section. The provisions of this SPD which are applicable to newly hired employees and their

Eligible Dependents (e.g., enrollment, Effective Dates of coverage, Pre-existing Condition exclusionary period, and Waiting Period) are applicable to rehired employees and their Eligible Dependents.

Section 12: Termination of Coverage

Termination of a Covered Plan Participant's Coverage

A Covered Plan Participant's coverage under this plan 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 The School Board of Polk County terminates;
3. on the last day of the first month that the Covered Plan Participant fails to continue to meet any of the applicable eligibility requirements;
4. on the date the Covered Plan Participant's coverage is terminated for cause (see the Termination of an Individual Coverage for Cause subsection); or
5. on the date specified by The School Board of Polk County that the Covered Plan Participant's coverage terminates.

Termination of a Covered Dependent's Coverage

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

1. the Group Health Plan terminates;
2. the Covered Plan Participant'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 Health Plan;

4. last day of the month that the Covered Dependent child no longer meets any of the applicable eligibility requirements;
5. the Dependent's coverage is terminated for cause (see the Termination of Individual Coverage for Cause subsection).

In the event you as the Covered Plan Participant wish to delete a Covered Dependent from coverage, a Change of Status Form must be forwarded to the Risk Management Department of The School Board of Polk County.

In the event you as the Covered Plan Participant wish to terminate a spouse's coverage, (e.g., in the case of divorce), you must submit a Change of Status Form to the Risk Management Department of The School Board of Polk County within 30 days of the date the divorce is final.

Termination of a Retiree's Coverage

At the time of retirement, a Covered Employee may elect to continue coverage under this plan or another plan sponsored by The School Board or Polk County. If a retiree terminates their retiree coverage and is no longer covered by any plan sponsored by The School Board of Polk County, that retiree may not re-enroll, for any reason or at any time, under a plan sponsored by The School Board of Polk County.

Termination of an Individual's Coverage for Cause

In the event any of the following occurs, The School Board of Polk County may terminate an individual's coverage for cause:

1. fraud, material misrepresentation or omission in applying for coverage or benefits; or

2. the knowing misrepresentation, omission or the giving of false information on Enrollment Forms or other forms completed, by or on your behalf.

Notice of Termination

It is The School Board of Polk County's responsibility to immediately notify you of your termination or that of your Covered Dependents for any reason.

Certification of Creditable Coverage

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

The certification of Creditable Coverage will indicate the period of time you were enrolled under The School Board of Polk County's Group Health Plan. Creditable Coverage may reduce the length of any Pre-existing Condition exclusionary period by the length of time you had prior Creditable Coverage.

Upon request, another certification of Creditable Coverage will be sent to you within a 24-month period after termination of coverage. You may call the customer service phone number indicated in this SPD or on your ID Card to request the certification.

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

Section 13: Continuing Coverage Under COBRA

A federal continuation of coverage law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, may apply to your Group Health Plan. If COBRA applies, you or your Covered Dependents may be entitled to continue coverage for a limited period of time, if you meet the applicable requirements, make a timely election, and pay the proper amount required to maintain coverage.

You must contact The School Board of Polk County to determine if you or your Covered Dependent(s) are entitled to COBRA continuation of coverage. The School Board of Polk County is solely responsible for meeting all of the obligations under COBRA, including the obligation to notify all Covered Persons of their rights under COBRA. If you fail to meet your obligations under COBRA and this SPD, The School Board of Polk County will not be liable for any claims incurred by you or your Covered Dependent(s) after termination of coverage.

A summary of your COBRA rights and the general conditions for qualification for COBRA continuation coverage is provided below.

The following is a summary of what you may elect, if COBRA applies to The School Board of Polk County and you are eligible for such coverage:

1. You may elect to continue this coverage for a period not to exceed 18 months* in the case of:
 - a) termination of employment of the Covered Plan Participant other than for gross misconduct; or
 - b) reduced hours of employment of the Covered Plan Participant.

***Note:** You and/or your Covered Dependent(s) are eligible for an 11 month extension of the 18 month COBRA continuation option above (to a total of 29 months) if you or your Covered Dependent(s) is/are totally disabled (as defined by the Social Security Administration (SSA)) at the time of your termination, reduction in hours or within the first 60 days of COBRA continuation coverage. The Covered Person must supply notice of the disability determination to The School Board of Polk County within 18 months of becoming eligible for continuation coverage and no later than 60 days after the SSA's determination date.

2. Your Covered Dependent(s) may elect to continue their coverage for a period not to exceed 36 months in the case of:
 - a) the Covered Plan Participant's entitlement to Medicare;
 - b) divorce or legal separation of the Covered Plan Participant;
 - c) death of the Covered Plan Participant;
 - d) the employer files bankruptcy (subject to bankruptcy court approval); or
 - e) a dependent child may elect the 36 month extension if the dependent child ceases to be an Eligible Dependent under the terms of The School Board of Polk County's coverage.

Children born to or placed for adoption with the Covered Plan Participant during the continuation coverage periods noted above are also eligible for the remainder of the continuation period.

Additional requirements applicable to continuation of coverage under COBRA are set forth below:

1. The School Board of Polk County must notify you of your continuation of coverage rights under COBRA within 14 days of the event which creates the continuation option. If coverage would be lost due to Medicare entitlement, divorce, legal separation or the failure of a Covered Dependent child to meet eligibility requirements, you or your Covered Dependent must notify The School Board of Polk County, in writing, within 60 days of any of these events. The School Board of Polk County's 14-day notice requirement runs from the date of receipt of such notice.
2. You must elect to continue the coverage within 60 days of the later of:
 - a) the date that the coverage terminates; or
 - b) the date the notification of continuation of coverage rights is sent by The School Board of Polk County.
3. COBRA coverage will terminate if you become covered under any other group health insurance plan. However, COBRA coverage may continue if the new group health insurance plan contains exclusions or limitations due to a Pre-existing Condition that would affect your coverage.
4. COBRA coverage will terminate if you become entitled to Medicare.
5. If you are totally disabled and eligible and elect to extend your continuation of coverage, you may not continue such extension of coverage more than 30 days after a determination by the Social Security Administration that you are no longer disabled. You must inform The School Board of Polk County of the Social Security Administration's determination within 30 days of such determination.
6. You must meet all contribution requirements, and all other eligibility requirements described in COBRA, and, to the extent not inconsistent with COBRA, in the Group Health Plan.

7. COBRA coverage will terminate on the date The School Board of Polk County ceases to provide group health coverage to its employees.

An election by a Covered Plan Participant or Covered Dependent spouse shall be deemed to be an election for any other qualified beneficiary related to that Covered Plan Participant or Covered Dependent spouse, unless otherwise specified in the election form.

Note: This section shall not be interpreted to grant any continuation rights in excess of those required by COBRA and/or Section 4980B of the Internal Revenue Code. Additionally, this Benefit Booklet shall be deemed to have been modified, and shall be interpreted, so as to comply with COBRA and changes to COBRA that are mandatory with respect to The School Board of Polk County.

Section 14: Conversion Privilege

Eligibility Criteria for Conversion

You are entitled to apply for a BCBSF individual insurance conversion policy (hereinafter referred to as a “converted policy” or “conversion policy”) if:

1. you were continuously covered for at least three months under the Group Health Plan, and/or under another group policy that provided similar benefits immediately prior to the Group Health Plan; and
2. your coverage was terminated for any reason, including discontinuance of the Group Health Plan in its entirety and termination of continued coverage under COBRA.

Notify us in writing or by telephone if you are interested in a conversion policy. Within 14 days of such notice, we will send you a conversion policy application, premium notice and outline of coverage. The outline of coverage will contain a brief description of the benefits and coverage, exclusions and limitations, and the applicable Deductible(s) and Coinsurance provisions.

We must receive a completed application for a converted policy, and the applicable premium payment, within the 63-day period beginning on the date the coverage under the Group Health Plan terminated. If coverage has been terminated, due to the non-payment of employee contribution by The School Board of Polk County, we must receive the completed converted policy application and the applicable premium payment within the 63-day period beginning on the date notice was given that the Group Health Plan terminated.

In the event we do not receive the converted policy application and the initial premium payment within such 63-day period, your converted policy application will be denied and you will not be entitled to a converted policy.

Additionally, you are not entitled to a converted policy if:

1. you are eligible for or covered under the Medicare program;
2. you failed to pay, on a timely basis, the contribution required for coverage under the Group Health Plan;
3. the Group Health Plan was replaced within 31 days after termination by any group policy, contract, plan, or program, including a self-insured plan or program, that provides benefits similar to the benefits provided under this plan; or
4. a) you fall under one of the following categories and meet the requirements of 4.b. below:
 - i. you are covered under any Hospital, surgical, medical or major medical policy or contract or under a prepayment plan or under any other plan or program that provides benefits which are similar to the benefits provided under this plan; or
 - ii. you are eligible, whether or not covered, under any arrangement of coverage for individuals in a group, whether on an insured, uninsured, or partially insured basis, for benefits similar to those provided under this plan; or
 - iii. benefits similar to the benefits provided under this plan are provided for or are available to you pursuant to or in accordance with the requirements of any state or federal law (e.g., COBRA, Medicaid); and
- b) the benefits provided under the sources referred to in paragraph 4.a.i or the benefits provided or available under the source referred to in paragraph 4.a.ii. and 4.a.iii.

above, together with the benefits provided by our converted policy would result in over-insurance in accordance with our over-insurance standards, as determined by us.

Neither The School Board of Polk County nor BCBSF has any obligation to notify you of this conversion privilege when your coverage terminates or at any other time. It is your sole responsibility to exercise this conversion privilege by submitting a BCBSF converted policy application and the initial premium payment to us within 63 days of the termination of your coverage under this plan. The converted policy may be issued without evidence of insurability and shall be effective the day following the day your coverage under this plan terminated.

Note: Our converted policies are not a continuation of coverage under COBRA or any other states' similar laws. Coverage and benefits provided under a converted policy will not be identical to the coverage and benefits provided under this plan. When applying for our converted policy, you have two options: 1) a converted policy providing major medical coverage meeting the requirements of 627.6675(10) Florida Statutes or 2) a converted policy providing coverage and benefits identical to the coverage and benefits required to be provided under a small employer standard health benefit plan pursuant to Section 627.6699(12) Florida Statutes. In any event, we will not be required to issue a converted policy unless required to do so by Florida law. We may have other options available to you. Call the telephone number on your Identification card for more information.

Section 15: Extension of Benefits

Extension of Benefits

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

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

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

For purposes of this section, you will be considered "totally disabled" only if, in our or The School Board of Polk County's opinion, you are unable to work at any gainful job for which you are suited by education, training, or experience, and you require regular care and attendance by a Physician. You are totally disabled only if, in our or The School Board of Polk County's opinion, you are unable to perform those normal day-to-day activities which

you would otherwise perform and you require regular care and attendance by a Physician.

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

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

Please refer to the Dental Care category of the "What Is Covered?" section for a description of the dental care Services covered under this plan.

3. In the event you are pregnant as of the termination date of the Group Health Plan, a limited extension of the maternity expense benefits included in this plan will be available, provided the pregnancy commenced while the pregnant individual was covered under the Group Health Plan, as determined by us or The School Board of Polk County. This extension of benefits is for Covered Services necessary to treat the pregnancy only. This extension of benefits will automatically terminate on the date of the birth of the child. You are not required to be Totally Disabled in order to be eligible for this extension of benefits.

Section 16: The Effect of Medicare Coverage/Medicare Secondary Payer Provisions

For active employees, when you become covered under Medicare and continue to be eligible and covered under this plan, coverage under this plan will be primary and the Medicare benefits will be secondary, but only to the extent required by law. In all other instances, coverage under this plan will be secondary to any Medicare benefits. To the extent the benefits under this plan are primary, claims for Covered Services should be filed with BCBSF first.

For active employees only covered under Medicare, The School Board of Polk County MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you. Also, School Board of Polk County MAY NOT induce you to decline or terminate your group health insurance coverage and elect Medicare as primary payer.

If you are a retiree on the plan:

1. You must elect Part B coverage upon Medicare eligibility
2. You must NOT elect Part D coverage

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

Individuals With End Stage Renal Disease

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

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

If Medicare was primary prior to the time you became 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 coverage under this plan was primary prior to ESRD entitlement, then coverage hereunder will remain primary for the ESRD coordination period. If you become eligible for Medicare due to ESRD, coverage will be provided, as described in this section, on a primary basis for 30 months.

Individuals enrolled in Medicare due to age, who subsequently develop ESRD, must immediately notify Medicare of their ESRD status. If coverage under this plan was primary prior to ESRD entitlement, then coverage hereunder will remain primary for the ESRD coordination period.

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

Disabled Active Individuals

If you are entitled to Medicare coverage because of a disability other than ESRD, Medicare benefits will be secondary to the benefits provided under this plan provided that:

The School Board of Polk County employed at least 100 or more full-time or part-time employees on 50% or more of its regular business days during the previous Calendar Year. If the Group Health Plan is a multi-

employer plan, as defined by Medicare, Medicare benefits will be secondary if at least one employer participating in the plan covered 100 or more employees under the plan on 50% or more of its regular business days during the previous Calendar Year.

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 this plan.
2. BCBSF will not be liable to The School Board of Polk County or to any individual covered under this plan on account of any nonpayment of primary benefits resulting from any failure of performance of The School Board of Polk County's obligations as described in this section.

Section 17: 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 this plan.

COB determines the manner in which expenses will be paid when you are covered under more than one health plan, program, or policy providing benefits for Health Care Services. COB is designed to avoid the costly duplication of payment for Covered Services. It is your responsibility to provide BCBSF and The School Board of Polk County information concerning any duplication of coverage under any other health plan, program, or policy you or your Covered Dependents may have. This means you must notify BCBSF and The School Board of Polk County in writing if you have other applicable coverage or if there is no other coverage. You may be requested to provide this information at initial enrollment, by written correspondence annually thereafter, or in connection with a specific Health Care Service you receive. If the information is not received, claims may be denied and you 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, when benefits are coordinated under this section, is based on whether or not the benefits under this plan are primary. When primary, payment will be made for Covered Services without regard to coverage under other plans. When the benefits under this plan are not primary, payment for Covered Services may be reduced so that total benefits under all your plans will not exceed 100 percent of the total reasonable expenses actually incurred for Covered Services. For purposes of this section, in the event you receive Covered Services from an In-Network Provider or an Out-of-Network Provider who participates in the Traditional Program, "total reasonable expenses" shall mean the total amount required to be paid to the Provider pursuant to the applicable agreement BCBSF or another Blue Cross and/or Blue Shield organization 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. When you are covered as a Covered Dependent and the other plan covers you as other than a dependent, the Group Health Plan will be secondary.
2. When the Group Health Plan covers a dependent child whose parents are not separated or divorced:

- a) the plan of the parent whose birthday, excluding year of birth, falls earlier in the year will be primary; or
 - b) if both parents have the same birthday, excluding year of birth, and the other plan has covered one of the parents longer than us, the Group Health Plan will be secondary.
3. When the Group Health Plan covers a dependent child whose parents are separated or divorced:
- a) if the parent with custody is not remarried, the plan of the parent with custody is primary;
 - b) if the parent with custody has remarried, the plan of the parent with custody is primary; the stepparent's plan is secondary; and the plan of the parent without custody pays last;
 - c) regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is primary.
4. When the Group Health Plan covers a dependent child and the dependent child is also covered under another plan:
- a) the plan of the parent who is neither laid off nor retired will be primary; or
 - b) if the other plan is not subject to this rule, and if, as a result, such plan does not agree on the order of benefits, this paragraph shall not apply.
5. When rules 1, 2, 3, and 4 above do not establish an order of benefits, the plan which has covered you the longest shall be primary.

The Group Health Plan 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.

6. If you are covered under a COBRA continuation plan as a result of the purchase of coverage as

provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and also under another group plan, the following order of benefits applies:

- a) first, the plan covering the person as an employee, or as the employee's Dependent; and
 - b) second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's Dependent provided according to the provisions of COBRA.
7. If the other plan does not have rules that establish the same order of benefits as under this plan, the benefits under the other plan will be determined primary to the benefits under this plan.

Coordination of benefits shall not be permitted against an indemnity-type policy, an excess insurance policy as defined in *Florida Statutes* Section 627.635, a policy with coverage limited to specified illnesses or accidents, or a Medicare supplement policy.

Non-Duplication of Government Programs and Worker's Compensation

The benefits under this plan shall not duplicate any benefits to which you or your Covered Dependents are entitled to or eligible for under government programs (e.g., Medicare, Medicaid, Veterans Administration) or Worker's Compensation 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 18: Subrogation

In the event payment is made under this plan to you or on your behalf for any claim in connection with or arising from a Condition resulting, directly or indirectly, from an intentional act or from the negligence or fault of any third person or entity, The School Board of Polk County and/or the Group Health Plan, to the extent of any such payment, shall be subrogated to all causes of action and all rights of recovery you have against any person or entity. Such subrogation rights shall extend and apply to any settlement of a claim, regardless of whether litigation has been initiated. BCBSF may recover, on behalf of The School Board of Polk County and/or the Group Health Plan, the amount of any payments made on your behalf minus BCBSF or The School Board of Polk County's pro rata share for any costs and attorney fees incurred by you in pursuing and recovering damages. BCBSF may subrogate, on behalf of The School Board of Polk County and/or the Group Health Plan, against all money recovered regardless of the source of the money including, but not limited to, uninsured motorist coverage. Although The School Board of Polk County may, but is not required to, take into consideration any special factors relating your specific case in resolving the subrogation claim, The School Board of Polk County will have the first right of recovery out of any recovery or settlement amount you are able to obtain even if you or your attorney believes that you have not been made whole for your losses or damages by the amount of the recovery or settlement.

You must promptly execute and deliver such instruments and papers pertaining to such settlement of claims, settlement negotiations, or litigation as may be requested by BCBSF or The School Board of Polk County, and shall do whatever is necessary to enable BCBSF or The School Board of Polk County to exercise The School Board of Polk County's subrogation

rights and shall do nothing to prejudice such rights. Additionally, you or your legal representative shall promptly notify BCBSF in writing of any settlement negotiations prior to entering into any settlement agreement, shall disclose to BCBSF any amount recovered from any person or entity that may be liable, and shall not make any distributions of settlement or judgement proceeds without The School Board of Polk County's prior written consent. No waiver, release of liability, or other documents executed by you without such notice to BCBSF shall be binding upon The School Board of Polk County.

Section 19: Right of Reimbursement

If any payment under this plan is made to you or on your behalf with respect to any injury or illness resulting from the intentional act, negligence, or fault of a third person or entity, The School Board of Polk County and/or the Group Health Plan will have a right to be reimbursed by you (out of any settlement or judgment proceeds you recover) one dollar (\$1.00) for each dollar paid under the terms of the Group Health Plan minus a pro rata share for any costs and attorney fees incurred in pursuing and recovering such proceeds.

The School Board of Polk County's and/or the Group Health Plan's right of reimbursement will be in addition to any subrogation right or claim available to The School Board of Polk County, and you must execute and deliver such instruments or papers pertaining to any settlement or claim, settlement negotiations, or litigation as may be requested by BCBSF on behalf of The School Board of Polk County, and/or the Group Health Plan, to exercise The School Board of Polk County's and/or the Group Health Plan's right of reimbursement hereunder. You or your lawyer must notify us, by certified or registered mail, if you intend to claim damages from someone for injuries or illness. You must do nothing to prejudice The School Board of Polk County's and/or the Group Health Plan's right of reimbursement hereunder and no waiver, release of liability, or other documents executed by you, without notice to us and our written consent, acting on behalf of The School Board of Polk County, will be binding upon The School Board of Polk County.

Section 20: Claims Processing

Introduction

This section is intended to:

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

Types of Claims

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

Post-Service Claims

How to File a Post-Service Claim

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

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

We must receive a Post-Service Claim within 90 days of the date the Health Care Service was

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

For Post-Service Claims, we must receive an itemized statement 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 Plan Participant's name and contract number as they appear on the ID Card.

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

Note: Special claims processing rules may apply for Health Care Services you receive outside the state of Florida under the BlueCard® Program (See the "BlueCard® (Out-of-State) Program" section of this Booklet).

The Processing of Post-Service Claims

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

contested, or denied within the timeframes described below.

- **Payment for Post-Service Claims**

When payment is due under the terms of this plan, we will use our best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt.

Likewise, we will use our best efforts to pay (in whole or in part) for paper Post-Service Claims within 40 days of receipt. You may receive notice of payment for paper claims within 30 days of receipt. If we are unable to determine whether the claim or a portion of the claim is payable because we need more or additional information, we may contest the claim within the timeframes set forth below.

- **Contested Post-Service Claims**

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

Service Claim within 15 days of receipt of the information.

- **Denial of Post-Service Claims**

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

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

We will investigate any allegation of improper billing by a Provider upon receipt of written notification from you. If we determine that you were billed for a Service that was not actually performed, any payment amount will be adjusted

and, if applicable, a refund will be requested. In such a case, if payment to the Provider is reduced due solely to the notification from you, we will pay you 20 percent of the amount of the reduction, up to a total of \$500.

Pre-Service Claims

How to File a Pre-Service Claim

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

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

Benefit Determinations on Pre-Service Claims Involving Urgent Care

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

within 48 hours after the earlier of: 1) receipt of the requested information; or 2) the end of the period you were afforded to provide the specified additional information as described above.

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

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

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

A Pre-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Benefit Determination standards 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:

- we have approved in writing coverage or benefits for an ongoing course of Services to be provided over a period of time or a number of Services to be rendered; and
- 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 us was not due to an amendment of this SPD or termination of your coverage as provided by this SPD.

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

Requests for Extension of Services

Your Provider may request an extension of coverage or benefits for a Service beyond the approved period of time or number of approved Services. If the request for an extension is for a Claim Involving Urgent Care, we will use our best efforts to notify you of the approval or denial of such requested extension within 24 hours after receipt of your request, provided it is received at least 24 hours prior to the expiration of the previously approved number or length of coverage for such Services. We will use our best efforts to notify you within 24 hours if: 1) we need additional information; or 2) you or your representative failed to follow proper procedures in your request for an extension. If we request additional information, you will have 48 hours to provide the requested information. We may

notify you orally or in writing, unless you or your representative specifically request that it be in writing. A denial of a request for 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

Manner and Content of a Notification of an Adverse Benefit Determination:

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

1. the date the Service or supply was provided;
2. the Provider's name
3. the dollar amount of the claim, if applicable;
4. the diagnosis codes included on the claim (e.g., ICD-9, 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 description of the specific plan 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;
10. if the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling you how to obtain the specific explanation of the scientific or clinical judgment for the determination; and
11. You have the right to an independent external review through an external review organization for certain appeals, as provided in the Patient Protection and Affordable Care Act of 2010.

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

How to Appeal an Adverse Benefit Determination

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

- We must receive your appeal of an Adverse Benefit Determination in person or in writing;
- You may request to review pertinent documents, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing;

- If the Adverse Benefit Determination is based on the lack of Medical Necessity of a particular Service or the Experimental or Investigational exclusion, you may request, free of charge, an explanation of the scientific or clinical judgment relied upon, if any, for the determination, that applies the terms of this SPD to your medical circumstances;
- During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination;
- We may consult with appropriate Physicians, as necessary;
- Any independent medical consultant who reviews your Adverse Benefit Determination on our behalf will be identified upon request; and
- If your claim is a Claim Involving Urgent Care, you may request an expedited appeal orally or in writing in which case all necessary information on review may be transmitted between you and us by telephone, facsimile or other available expeditious method;
- If you wish to give someone else permission to appeal an Adverse Benefit Determination on your behalf, we must receive a completed Appointment of Representative form signed by you indicating the name of the person who will represent you with respect to the appeal. An Appointment of Representative form is not required if your Physician is appealing an Adverse Benefit Determination relating to a Claim Involving Urgent Care. Appointment of Representative forms are available at www.bcbsfl.com or by calling the number on the back of your BCBSF ID Card.

Timing of Our Appeal Review on Adverse Benefit Determinations

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

- Pre-Service Claims-- within 30 days of the receipt of your appeal; or

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

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

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

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

How to Request External Review of Our Appeal Decision

If you are not satisfied with our internal review of your appeal of an Adverse Benefit Determination, please refer to the Adverse Benefit Determination notice or call the customer service phone number on your ID Card for information on how to request an external review.

Additional Claims Processing Provisions

1. Release of Information/Cooperation:

In order to process claims, we may need certain information, including information regarding other health care coverage you may have. You must cooperate with us in our effort to obtain such information by, among other ways, signing any release of information form at our request. Failure by you to fully cooperate with us may result in a denial of the pending claim and we will have no liability for such claim.

2. Physical Examination:

In order to make coverage and benefit decisions, we may, at our expense, require you to be examined by a health care Provider of our choice as often as is reasonably necessary while a claim is pending. Failure by you to fully cooperate with such examination shall result in a denial of the pending claim and we shall have no liability for such claim.

3. Legal Actions:

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

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

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

of the claim or cancellation or rescission of your coverage.

5. Explanation of Benefits Form:

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

- a) The specific reason or reasons for the Adverse Benefit Determination;
- b) Reference to the specific SPD 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;
- c) A description of any additional information that would change the initial determination and why that information is necessary;
- d) A description of the applicable Adverse Benefit Determination review procedures and the time limits applicable to such procedures; and
- e) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational limitations and exclusions, a statement telling you how you can obtain the specific explanation of the scientific or clinical judgment for the determination.

6. Circumstances Beyond Our Control:

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

good faith effort to make payment for such Services, taking into account the impact of the event. For the purposes of this paragraph, an event is not within our control if we cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

Section 21: Relationship Between the Parties

BCBSF/The School Board of Polk County and Health Care Providers

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

Non Liability of BCBSF and the School Board of Polk County

Neither The School Board of Polk County nor any person covered under this SPD is BCBSF's agent or representative, and neither shall be liable for any acts or omissions by BCBSF's

agents, servants, employees, or us.

Additionally, neither BCBSF nor The School Board of Polk County will 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 your agent, servant, or representative nor is BCBSF an agent, servant, or representative of The School Board of Polk County and BCBSF will not be liable for any acts or omissions, or those of The School Board of Polk County, its agents, servants, employees, or any person or organization with which The School Board of Polk County has entered into any agreement or arrangement. By acceptance of coverage and benefits hereunder, you agree to the foregoing.

Medical Treatment Decisions - Responsibility of Your Physician, Not BCBSF

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

Section 22: General Provisions

Access to Information

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

Right to Receive Necessary Information

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

Right to Recovery

Whenever the Group Health Plan has made payments in excess of the maximum provided for under this plan, BCBSF or The School Board of Polk County will have the right to recover any such payments, to the extent of such excess, from you or any person, plan, or other organization that received such payments.

Compliance with State and Federal Laws and Regulations

The terms of coverage and benefits to be provided under this SPD shall be deemed to have been modified and shall be interpreted, so as to comply with applicable state or federal laws and regulations dealing with benefits, eligibility, enrollment, termination, or other rights and duties.

Confidentiality

Except as otherwise specifically provided herein, and except as may be required in order for us to administer coverage and benefits, specific medical information concerning you, received by Providers, shall be kept confidential by us in conformity with applicable law. Such information may be disclosed to third parties for use in connection with bona fide medical research and education, or as reasonably necessary in connection with the administration of coverage and benefits, specifically including BCBSF's quality assurance and Blueprint for Health Programs. Additionally, we may disclose such information to entities affiliated with us or other persons or entities we utilize to assist in providing coverage, benefits or services under this plan. 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 a Provider may require that we release certain claims and medical information about persons covered under this plan to that Provider even if treatment has not been sought by or through that Provider. By accepting coverage, you hereby authorize us to release to Providers claims information, including related medical information, pertaining to you in order for any such Provider to evaluate your financial responsibility under this plan.

Summary Plan Description (SPD)

You have been provided with an Identification Card as evidence of your coverage under this plan. This Summary Plan Description is available at www.polk-fl.net, keyword "Insurance". To receive a paper copy of this SPD, you must submit a request, in writing, directly to the Risk Management Department of The School Board of Polk County.

Modification of Provider Network and the Participation Status

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

Cooperation Required of You and Your Covered Dependents

You must cooperate with BCBSF and The School Board of Polk County, and must execute and submit to us 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).

Non-Waiver of Defaults

Any failure by BCBSF or The School Board of Polk County at any time, or from time to time, to enforce or to require the strict adherence to any of the terms or conditions described herein, will in no event constitute a waiver of any such terms or conditions. Further, it will not affect BCBSF's or The School Board of Polk County's right at any time to enforce any terms or conditions under this SPD.

Notices

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

If to BCBSF:

To the address printed on the Identification Card.

If to you:

To the latest address provided by you or to your latest address on file with The School Board of Polk County.

You must notify The School Board of Polk County immediately of any address change.

If to The School Board of Polk County:

To the address indicated by The School Board of Polk County.

Our Obligations Upon Termination

Upon termination of your coverage for any reason, there will be no further liability or responsibility to you under the Group Health Plan, except as specifically described herein.

Promissory Estoppel

No oral statements, representations, or understanding by any person can change, alter,

delete, add, or otherwise modify the express written terms of this SPD.

features or promotional offers at any time without your consent.

Florida Agency for Health Care Administration Performance Data

The performance outcome and financial data published by the Agency for Health Care Administration (AHCA), pursuant to Florida Statute 408.05, or any successor statute, located at the web site address www.floridahealthfinder.gov, may be accessed through the link provided on the Blue Cross and Blue Shield of Florida corporate web site at www.bcbsfl.com.

Third Party Beneficiary

The terms and provisions of the Group Health Plan shall be binding solely upon, and inure solely to the benefit of, The School Board of Polk County and individuals covered under the terms of this SPD, and no other person shall have any rights, interest or claims thereunder, or under this plan, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. The School Board of Polk County 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 The School Board of Polk County Group Health Plan or this SPD.

Customer Rewards Programs

From time to time, we may offer programs to our customers that provide rewards for following the terms of the program. We will tell you about any available rewards programs in general mailings, member newsletters and/or on our website. Your participation in these programs is completely voluntary and will in no way affect the coverage available to you under this plan. We reserve the right to offer rewards in excess of \$25 per year as well as the right to discontinue or modify any reward program

Section 23: Definitions

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

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

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

Administrative Services Only Agreement or ASO Agreement means an agreement between The School Board of Polk County and BCBSF. Under the Administrative Services Only Agreement, BCBSF provides claims processing and payment services, customer service, utilization review services and access to BCBSF's NetworkBlue and BCBSF's network of Traditional Insurance Providers.

Adverse Benefit Determination means any denial, reduction or termination of coverage, benefits, or payment (in whole or in part) under the plan 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 this section, shall also constitute an Adverse Benefit Determination.

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

consent.

1. In the case of an In-Network Provider located in Florida, this amount will be established in accordance with the applicable agreement between that Provider and BCBSF.
2. In the case of an In-Network Provider located outside of Florida, this amount will generally be established in accordance with the negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to us, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the BlueCard[®] (Out-of-State) Program section for more details.
3. In the case of Out-of-Network Providers located in Florida who participate in the Traditional Program, this amount will be established in accordance with the applicable agreement between that Provider and BCBSF.
4. In the case of Out-of-Network Providers located outside of Florida who participate in the BlueCard[®] (Out-of-State) Traditional Program, this amount will generally be established in accordance with the negotiated price that the Host Blue passes on to us, except when the Host Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the BlueCard[®] (Out-of-State) Program section for more details.
5. In the case of an Out-of-Network Provider that has not entered into an agreement with BCBSF to provide access to a discount from the billed amount of that Provider for the specific Covered Services provided to you, the Allowed Amount will be the lesser of that Provider's actual billed amount for the specific Covered Services or an amount established by 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 Out-of-Network Provider and/or by other Providers, either in Florida or in other comparable market(s), that BCBSF determines are comparable to the Out-of-Network Provider that provided the specific Covered Services (which may include payment accepted by such Out-of-Network Provider and/or by other Providers as participating providers in other provider networks of third-party payers which may include, for example, other insurance companies and/or health maintenance organizations); (iii) payment amounts which are consistent, as determined by 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 an Out-of-Network Provider that has not entered into an agreement with another Blue Cross and/or Blue Shield organization to provide access to discounts from the billed amount for the specific Covered Services under the BlueCard (Out-of-State) Program, the Allowed Amount for the specific Covered Services provided to you 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.

Please specifically note that, in the case of an Out-of-Network 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 Out-of-Network Provider for such Services. You will be responsible for any

difference between such Allowed Amount and the amount billed for such Services by any such Out-of-Network Provider.

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

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.

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 the Group, in which benefits accumulate toward the satisfaction of Deductibles, out-of-pocket maximums and any applicable benefit maximums. Your Benefit Period is listed on your 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® (Out-of-State) Program means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield of Florida, Inc. Subject to any applicable BlueCard® (Out-of-State) Program rules and protocols, you may have access to the Provider discounts of other participating Blue Cross and/or Blue Shield plans. See the BlueCard® (Out-of-State) Program section for more details.

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

BlueCard® (Out-of-State) Traditional Program means a national Blue Cross and Blue Shield Association program available through Blue Cross and Blue Shield of Florida, Inc. Subject to any applicable BlueCard® (Out-of-State)

Program rules and protocols, you may have access to the BlueCard® (Out-of-State) Traditional Program discounts of other participating Blue Cross and/or Blue Shield plans.

BlueCard® (Out-of-State) PPO Program

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

BlueCard® (Out-of-State) Traditional Program

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

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative 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).

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

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

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

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

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

Coinsurance means your share of health care expenses for Covered Services. After your Deductible requirement is met, a percentage of the Allowed Amount will be paid for Covered Services, as listed in the Schedule of Benefits. The percentage you are responsible for is your Coinsurance.

Concurrent Care Decision means a decision by us to deny, reduce, or terminate coverage, benefits, or payment (in whole or in part) with respect to a course of treatment to be provided over a period of time, or a specific number of treatments, if we had previously approved or authorized 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 personal case management Program as described in the "Blueprint For Health Programs" section of this SPD.

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

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

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

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

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

Covered Dependent means an Eligible Dependent who 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 Plan Participant (See the “Eligibility Requirements for Dependent(s)” subsection of the “Eligibility for Coverage” section).

Covered Person means a Covered Plan Participant or a Covered Dependent.

Covered Plan Participant means an Eligible Employee or other individual who meets and continues to meet all applicable eligibility requirements and who is enrolled, and actually covered, under this plan other than as a Covered Dependent.

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

Custodial or Custodial Care means care that serves to assist 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 that are your responsibility. The term, Deductible, does not include any amounts you are responsible for in excess of the Allowed Amount, or any Coinsurance/Copay amounts, if applicable.

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

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

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

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

Durable Medical Equipment means equipment furnished by a supplier or a Home Health Agency that: 1) can withstand repeated use;

2) is primarily and customarily used to serve a medical purpose; 3) not for comfort or convenience; 4) generally is not useful to an individual in the absence of a Condition; and 5) is appropriate for use in the home.

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

Effective Date means, with respect to individuals covered under this plan, 12:01 a.m. on the date The School Board of Polk County specifies that the coverage will commence as further described in the "Enrollment and Effective Date of Coverage" section of this SPD.

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

Eligible Employee means an individual who meets and continues to meet all of the eligibility requirements described in the Eligibility Requirements for Covered Plan Participant subsection of the Eligibility for Coverage section in the Benefit Booklet and is eligible to enroll as a Covered Plan Participant. Any individual who is an Eligible Employee is not a Covered Plan Participant until such individual has actually enrolled with, and been accepted for coverage as a Covered Plan Participant by The School Board of Polk County.

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

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.

Endorsement means an amendment to the Group Health Plan or this SPD.

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 this plan.

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

1. such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration

or the Florida Department of Health and approval for marketing has not, in fact, been given at the time such is furnished to you; or

2. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device; or
3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations; or
4. credible scientific evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question; or
5. credible scientific evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question; or
6. credible scientific evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently published Medical Literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices; or

7. there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or

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

"Credible scientific evidence" shall mean (as determined by BCBSF or The School Board of Polk County):

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

Note: Health Care Services which are determined by BCBSF or The School Board of Polk County to be Experimental or Investigational are excluded (see the “What Is Not Covered?” section). In determining whether a Health Care Service is Experimental or Investigational, BCBSF or The School Board of Polk County 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 who is placed in your residence and care under the Foster Care Program by the Florida Department of Health & Rehabilitative Services in compliance with *Florida Statutes* or by a similar regulatory agency of another state in compliance with that state’s applicable laws.

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

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

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

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

Group means the employer, labor union, trust, association, partnership, or corporation, department, other organization or entity through which coverage and benefits under this SPD are made available to you, and through which you and your Covered Dependents become entitled to coverage and benefits for the Covered Services described herein.

Group Health Plan or Group Plan means the plan established and maintained by The School Board of Polk County for the provision of health care coverage and benefits to the individuals covered under this SPD.

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

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

Home Health Care or Home Health Care Services means Physician-directed professional, technical and related medical and personal care Services provided on an intermittent or part-time basis directly by (or

indirectly through) a Home Health Agency in your home or residence. For purposes of this definition, a Hospital, Skilled Nursing Facility, nursing home or other facility will not be considered an individual's home or residence.

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

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

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

Note: If services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitative Facilities, payment for these

services will not be denied solely because such Hospital lacks major surgical facilities and is primarily of a rehabilitative nature. Recognition of these facilities does not expand the scope of Covered Services. It only expands the setting where Covered Services can be performed for coverage purposes.

Identification (ID) Card means the card(s) issued to Covered Plan Participants under the BlueOptions 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, this 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 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.

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

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

In Vitro Fertilization (IVF) means a process in which an egg and sperm are combined in a laboratory dish to facilitate fertilization. If

fertilized, the resulting embryo is transferred to the woman's uterus.

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

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

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

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

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

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

1. in accordance with Generally Accepted Standards of Medical Practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury or disease; and

3. not primarily for your convenience, or that of your Physician or other health care Provider, and not more costly than an alternative Service or sequence of Services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness.

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

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

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

Mental and Nervous Disorder means any disorder listed in the diagnostic categories of the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9 CM), or their

equivalents in the most recently published version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder.

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

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

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

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

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

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

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

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

Outpatient Rehabilitation Facility means an entity which renders, through providers properly licensed pursuant to Florida law or the similar law or laws of another state: outpatient physical therapy; outpatient speech therapy; outpatient occupational therapy; outpatient cardiac rehabilitation therapy; and outpatient Massage for the primary purpose of restoring or improving a bodily function impaired or eliminated by a Condition. Further, such an entity must meet 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 seven hours of institutional care during a portion of a 24-hour period and returns home or leaves the treatment facility during any period in which treatment is not scheduled. A Hospital shall not be considered a "home" for purposes of this definition.

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

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

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

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

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

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

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

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".

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

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

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

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

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

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

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

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

Rehabilitation Services means Services for the purpose of restoring function lost due to illness, injury or surgical procedures including but not limited to cardiac rehabilitation, pulmonary

rehabilitation, Occupational Therapy, Speech Therapy, Physical Therapy and Massage Therapy.

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

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

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 us, as a Specialty Drug due to special

handling, storage, training, distribution requirements and/or management of therapy.

Specialty Pharmacy means a Pharmacy that has signed a Participating Pharmacy Provider Agreement with us to provide specific Prescription Drug products, as determined by us.

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.

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

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

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

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

Traditional Program means, or refers to, BCBSF's provider contracting programs called

Payment for Physician Services (PPS) and Payment for Hospital Services (PHS). For purposes of this SPD, the term Traditional Program also refers, when applicable, to the traditional Provider contracting programs of other Blue Cross and/or Blue Shield organizations as designated under the Blue Cross and Blue Shield Association's BlueCard® Program.

Traditional Program Providers means, or refers to, those health care Providers who are not NetworkBlue Providers, but who, or which, at the time you received Services from them were participating in the Traditional Program. For purposes of payment under this SPD only, the term Traditional Program Provider also refers, when applicable, to any health care Provider located outside the state of Florida who or which, at the time Health Care Services were rendered to you, participated as a BlueCard® Traditional Provider under the Blue Cross and Blue Shield Association's BlueCard® Program.

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 SPD, an Urgent Care Center is not a Hospital, Psychiatric Facility, Substance Abuse Facility, Skilled Nursing Facility or Outpatient Rehabilitation Facility.

Waiting Period means the length of time established by The School Board of Polk County which must be met by an individual before that individual becomes eligible for coverage under this plan.

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

Section 24: Know Your Rights

HIPAA Notice of Privacy Practices

This notice explains our privacy practices. It describes how the School Board of Polk County, Florida, may use and disclose your health information. It will explain:

- How your health information will be used and disclosed;
- Your rights related to your health information; and
- How to complain if you believe your rights have been violated.

In this notice, the School Board of Polk County, Florida, may be referred to as “we,” “our,” or “us.” We will protect your health information. Health information is information about you that may identify you and medical information, such as your symptoms, test results, diagnoses, treatments, and plans of care.

We are required to abide by the terms of this notice. However, we may change our notice at any time. Any new notice will be effective for all health information maintained at the time of the change. Upon your request, we will provide you with a copy of any new notice. The new notice will also be posted at our business locations.

Uses and Disclosure of Health Information

Your health information may be used and disclosed by your doctor, our support staff, and others who are involved in your care. Your health information may be used and disclosed for a number of reasons. This notice explains those reasons and gives some examples of the types of uses and disclosures. The examples are not meant as a total list, and they do not

explain all of the ways we might use and/or disclose information.

Treatment: We will use and disclose your health information to provide and coordinate your healthcare and any related services you may require. This includes the coordination and management of your care with a third party, such as a hospital or home health agency. We will also disclose health information to other doctors and their staff who may be caring for you. We may disclose your health information to a referring doctor or laboratory who may be involved in your care to assist your doctor with your diagnosis or treatment.

Payment: Your health information will be used, as needed, to obtain payment for the healthcare services you receive. This may include certain activities that your health insurance plan requires before it will approve or pay for services that we recommend, such as approving a hospital admission or approving certain medical equipment, like a wheelchair.

Healthcare Operations: We may use or disclose health information, as needed, to support our business activities as they relate to your health care. These activities may include, but are not limited to, quality assessment, employee and physician review, training students, and limited marketing. For example, we may disclose your health information to healthcare students working with patients within our offices.

We may use a sign-in sheet at the registration desk, asking you to provide us with your name and the name of the doctor. We may call you by name when your doctor is ready to see you. We may also use or disclose your health information to remind you of an upcoming appointment.

We may share your health information with third parties who provide services or functions that are essential to our they may business. These third parties are called “business associates,” and include billing agents or transcription services. We will make sure that all business associates have signed a written contract that will protect the privacy of your health information.

We may use or disclose your health information, as necessary, to provide you with information about treatment alternatives or other benefits that may be of interest to you. We may disclose your health information for some marketing activities. For example, your name and address may be used to send you a newsletter about special healthcare services that we offer. We may send you information about products or services that we believe may be beneficial to you. You may request that these materials not be sent to you by writing to our Privacy Officer at the address on the back.

Others Involved in Your Healthcare: We may disclose your information to a family member, a close friend, or any other person you identify. This may include telling a family member about your location, general condition, or death. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. If you are not present or able to object, then your doctor may use his or her professional judgment to decide whether the disclosure is in your best interest.

Emergencies: We may use or disclose your health information in an emergency situation. If this happens, your doctor will try to obtain your consent as soon as reasonably possible after the deliver of treatment. If your doctor or another doctor is required by law to treat you and the doctor was unable to get your consent, he or

she may still use or disclose your health information to treat you.

Communication Barriers: We may use and disclose your health information if we attempt to obtain your consent, but we are unable to do so because of a substantial communication barrier. In this case your doctor will use professional judgment to decide whether you would consent.

Required by Law: We may use or disclose your health information to the extent that the disclosure is required by law.

The use or disclosure will be made and limited in accordance with the law.

Coroners, Funeral Directors, and Organ Donation: We may disclose health information to a coroner or medical examiner for identification purposes or other duties as required by law. Health information may also be used and disclosed for organ, eye, or tissue donation purposes.

Research: We may disclose your health information to researchers. Federal rules govern these disclosures and require your authorization or the approval by an appropriate board that has reviewed the research and documents. We will act in accordance with federal rules related to disclosing information for research purposes.

Military and National Security: We may disclose the health information of armed forces personnel if authorized by military command authorities. We may also disclose your health information to authorized federal officers for conducting national security and intelligence activities.

Workers’ Compensation: We may disclose your health information to comply with Workers’ Compensation laws and other similar worksite programs.

Uses and Disclosures Based Upon Your Written Authorization: Other uses and

disclosures of your health information will be made only with your written authorization. You may give, amend, or revoke your authorization at any time, in writing. You may not revoke to the extent that your doctor has already taken action in reliance on it. For more information about authorizations, please talk to your doctor or contact the Privacy Officer.

Your Rights

Below is a statement of your rights with respect to your health information and a description of how you may exercise these rights.

You have the right to inspect and copy your health information. This means that you may inspect or copy part or all of your health information that is contained in a designated record set for as long as we maintain that information. A “designated record set” contains medical and billing records.

Under federal law, you may not inspect or copy the following records: (i) psychotherapy notes; (ii) information compiled for use in a civil, criminal, or administrative action or proceeding; and (iii) health information that is restricted by another law.

You may submit your request to inspect and copy particular information to our Risk Management Department at 863-519-3858. You may also request a summary of your information.

If your request is accepted, you may be charged a reasonable, cost-based fee. If your request is denied, you have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about any request that may be denied.

You have the right to request a restriction on the

release of your health information. You may ask is not to disclose part of your health information for the purposes of treatment, payment, or healthcare operations. You may also ask us not to disclose at any part of your health information to family members or friends who may be involved in your care and who may ask for the information for notification purposes.

We are not required to agree to a restriction that you may request. We will review your request, and if we agree, we will comply with the restriction unless your information is needed for emergency treatment. We cannot agree to restrict disclosures that are required by law. We encourage you to discuss requests for restrictions with your doctor.

You may request a “Health Information Restriction Request Form” from our Privacy Officer. You must complete, sign, and date the form. Your request must state to whom the restriction will apply, and it must specify the restriction requested.

You can ask us to communicate with you by an alternate means or at an alternate location if the communication could endanger you. We will agree to all reasonable requests. We may evaluate the reasonableness of your request by asking you for information about payments, alternative addresses, or other methods of contacting you. We may condition your request. Please make this request in writing to our Privacy Officer at the address on the back of this notice.

You have the right to request that your doctor amend your health information. You may request an amendment of your health information in a designated record set if you believe it is incorrect or incomplete. All requests must be in writing. In certain cases, we may deny your request for an amendment. For example, we may deny your request if we did

not create the information, if the information is something you would not be permitted to inspect or copy, or if it is complete and accurate. If we deny your request, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement. Please contact the Privacy Office or if you have any questions about amending your information.

You have the right to receive an accounting or list of certain disclosures we have made. This right applies to disclosures for purposes other than treatment, payment, and healthcare operations as described in this notice. It also excludes: (i) disclosures that you have authorized; (ii) disclosures made directly to you; (iii) disclosures to family members or friends involved in your care; (iv) disclosures for national security or intelligence purposes; and (v) disclosures to law enforcement officials. You have the right to receive information about disclosures that occurred after April 14, 2003. You must request this information in writing. Your request should state a timeframe for the disclosures. Your right to receive this information may be subject to certain exceptions, restrictions, and limitations.

You have the right to obtain a paper copy of this notice. Upon request we will send you a paper copy of this notice, even if you have agreed to accept this notice electronically.

How to Complain if You Believe Your Rights Have Been Violated

We encourage you to send any complaints about our privacy practices to our Privacy Officer. To submit a complaint or for further information about the complaint process, contact the Privacy Officer, using the information found below. We will not retaliate against you for filing a complaint.

You may also complain to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us.

If you have any questions about this notice, please contact our Privacy Officer:

Patricia W. Hunter, Director
Equity & Compliance
1915 South Floral Avenue
Bartow, FL 33830
Phone: 863-534-0513
Fax: 863-534-0770
Patricia.Hunter@polk-fl.net

COBRA Rights Notice

Insurance coverage terminates on the last day of the month in which the employee separates from service with the School Board of Polk County. An information packet, including written notice explaining the terminated employee's rights under COBRA will be sent by the Polk County School Board COBRA administrator, Ceridian. This information will be sent to the address on file in SAP, so it is very important to update your contact information anytime you have an address change.

The Consolidated Omnibus Budget Reconciliation Act of 1993 (COBRA) allows you to continue the coverage you had as an active employee if you elect to continue the coverage by paying the full amount of the premium plus an administrative charge of 2 percent.

Each qualified beneficiary must be offered the option to continue coverage following a qualifying event. Qualifying beneficiaries include any eligible dependent that is covered on the insurance coverage at the time of the employee's separation of service that is eligible and that continues to be eligible for coverage. Any qualifying beneficiary that experiences a qualifying event separate from the employee separating from service, i.e. a spouse in the

case of a divorce, must also be offered the option to continue coverage.

See **Section 13: Continuing Coverage Under COBRA** for additional details.

Summary of the COBRA Premium Reduction Provisions under the American Recovery and Reinvestment Act (ARRA)

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law gives “Assistance Eligible Individuals” the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months.

To be considered an “Assistance Eligible Individual” and get reduced premiums you:

- MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage;
- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;
 - MUST NOT be eligible for Medicare; AND;
 - MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse’s employer.**

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008 through February 16, 2009 and were offered, but did not elect, continuation coverage OR who elected continuation coverage and

subsequently discontinued it may have the right to an additional 60-day election period.

◆ IMPORTANT ◆

- If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you **MUST** notify the plan in writing. If you do not, you may be subject to a tax penalty.
- Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.
- The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.

For general and specific information regarding your plan’s COBRA coverage, please visit our Web site www.ceridianbenefits.com, or contact the COBRA Services Center by mail - 3201 34th Street South, St. Petersburg, Florida 33711. For quick access to information, go to www.ceridianbenefits.com. You may also call 800-877-7994. Please note that the COBRA Services Center is experiencing heavy call volume due to this new legislation. To avoid phone delays we strongly encourage you to use the Web site if at all possible.

To notify Ceridian of your ineligibility to continue paying reduced premiums, mail the Notification of Ineligibility of Premium Reduction form to: Ceridian COBRA Continuation Services, Attn: COBRA Benefits Administration, 3201 34th Street South, St. Petersburg, Florida 33711. The form is provided to you in this package, and is also available on www.ceridian-benefits.com. If you are denied treatment as an "Assistance Eligible Individual" you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to: www.dol.gov/COBRA or call 1-866-444-EBSA (3272).

* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual Notice

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. Call Customer Service at 1-855-600-6701 for more information.

Newborn and Mothers Health Protection Act

The Newborn and Mothers Health Protection Act has set rules for group health plans and insurance issuers regarding restrictions to

coverage for hospital stays in connection with childbirth.

The length of stay may not be limited to less than:

- 48 hours following a vaginal delivery OR;
- 96 hours following a cesarean section

Determination of when the hospital stay begins is based on the following:

- For an in the hospital delivery:
- The stay begins at the time of the delivery. For multiple births, the stay begins at the time of the last delivery.
- For a delivery outside the hospital (i.e. birthing center):
- The stay begins at the time of admission to the hospital.

Requiring authorization for the stay is prohibited. If the attending provider and mother are both in agreement, then an early discharge is permitted.

Group Health Plans may not:

- Deny eligibility or continued eligibility to enroll or renew coverage to avoid these requirements.
- Try to encourage the mother to take less by providing payments or rebates.
- Penalize a provider or provide incentives to a provider in an attempt to induce them to furnish care that is not consistent with these rules.
- These rules do not mandate hospital stay benefits on a plan that does not provide that coverage.

The group plan is not prohibited from imposing deductibles, coinsurance, or other cost-sharing related to the benefits.

Family and Medical Leave Act and Leave of Absence

While you are out on a Leave of Absence, it is your responsibility to contact the Risk Management & Employee Benefits Department at 863-519-3858 regarding the continuation of your insurance benefits provided by the Board, and any other voluntary insurance benefits in which you are enrolled. If the necessary arrangements are not made to continue your benefits, interruption or cancellation of the benefits may result.

Family and Medical Leave Act

According to the Family and Medical Leave Act of 1993 eligible employees must be granted up to 12 work weeks of unpaid leave by their employer for any of the following reasons occurring during a 12 month period:

- Birth of employee's child
- Adoption or placement of a foster child
- Caring for ill or injured immediate family member (spouse, child, parent)
- Serious illness or Injury of employee (employee unable to work)

Effective January 16, 2009 the FMLA regulations have been updated to include implementation of new military family leave entitlements enacted under the National Defense Authorization Act for FY 2008. This change permits any of the following family members to take up to 26 work weeks of leave to care for a member of any of the Armed Forces; Active, Reserve or National Guard, undergoing medical treatment or recuperation (including therapy), for serious injury or illness:

- Spouse Parent
- Child Next of Kin

Leave of Absence

Unless otherwise specified by law, leave is granted at the discretion of the School Board. Policies regarding leave are designed to protect school operation from unnecessary interruption due to absences. When employees apply for leave, they must complete the appropriate form and include the reason for requesting the leave in writing. The School Board may cancel the leave if it is used for a different purpose or cause. Leave is generally granted in advance, not retroactively. However, emergencies that cannot be anticipated are considered "granted" in advance if they are promptly reported. Except for military leave, leave cannot be granted beyond July 1 of the next fiscal year. However, a new application may be filed at the expiration of leave, with new leave granted at the discretion of the School Board. The person on leave is responsible for requesting a renewal; it is not automatic. If a renewal is not requested, employment will be terminated.

Types of Leave

- Professional
- Charter School
- Military
- Jury Duty
- Family Medical Leave
- Medical Leave
- Illness-in-the-Line-of-Duty
- Temporary Duty Assignment

Unpaid Leave and Employee Benefits

If you go on official unpaid leave, you are entitled to any and all of your benefits. However, for as long as you are on leave, to the extent permitted by law, the Board does not contribute to your health or life insurance coverage. You

will be responsible for payroll deductions that you would have paid if you were still on active status, plus the amount the Board would have contributed. If you fail to pay your premium, the Insurance Department may cancel the coverage. Employees on leave are entitled to the same annual enrollment that active employees have.

Medicaid and the Children's Health Insurance Program (CHIP)

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is

called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

You may be eligible for assistance paying your employer health plan premiums.

Contact the Florida Medicaid / SCHIP office at www.fdhc.state.fl.us/Medicaid/index.shtml or by phone: 1-866-762-2237

To see if any more States have added a premium assistance program since January 22, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Notice About the Early Retiree Reinsurance Program

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act.

Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

You are responsible for providing a copy of this notice to your family members who are participants in this plan.

Social Security Number Collection Policy

This statement serves as notification of the purpose and usage of social security numbers in compliance with Chapter 119 of the Florida Statutes. The Polk County School Board Risk Management & Employee Benefits Department acknowledges that a social security number is a unique identifier and can be used to obtain sensitive information; however, social security numbers must be collected under certain circumstances for the department to properly and accurately perform its duties as part of an educational institution.

The Risk Management & Employee Benefits Department of the Polk County School Board, Florida collects beneficiary social security numbers for specific purposes, including life insurance claims processing. A copy of this notice should be given to all parties you have listed as beneficiaries for your life insurance through the Employee Group-Term Life Insurance policy with the Polk County School Board, Florida.

The full written policy is available on the Risk Management & Employee Benefits page of the Polk County School Board Website at:

<http://www.polk-fl.net/staff/employeeinfo/riskmanagement/default.htm>

Medicare Prescription Drug Coverage (Part D) Creditable Coverage Notice

Important Notice from The School Board of Polk County about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The School Board of Polk County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan.

If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The School Board of Polk County has determined that the prescription drug coverage offered by The School Board of

Polk County's medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

Your current School Board of Polk County coverage pays for other health expenses, in addition to prescription drugs, and If you decide to join a Medicare drug plan, please keep in mind that you cannot also be enrolled in the School Board of Polk County Medical Plan.

The School Board of Polk County plan provides comprehensive prescription drug coverage through retail and mail providers. There is a \$25 per year per individual deductible for Brand Name drugs in addition to the follow copayments:

Generic

Retail 30 Days: \$8.00

Retail 90 Days: \$8.00

Mail 90 Days: \$8.00

Preferred Brand

Retail 30 Days: \$30.00+10%* (max \$60.00)
Retail 90 Days: \$90.00 +10%* (Max \$180.00)
Mail 90 Days: \$75.00

Non-Preferred Brand

Retail 30 Days: \$50.00 +10%* (max \$100.00)
Retail 90 Days: \$150.00 + 10%* (max \$300.00)
Mail 90 Days: \$125.00

*10% of the cost of the prescription minus the deductible.

IMPORTANT NOTE: If you purchase a brand-name medication when a generic medication is available or when your doctor requests a brand-name medication when a generic medication is available, you will pay the generic co-payment, plus the difference in cost between the brand and the generic.

When Will You Pay a Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your coverage with the School Board of Polk County and don't enroll in a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the Risk Management & Employee Benefits Department for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Polk County School Board changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at: www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 800-325-0778).

Important

Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: August 1, 2011

Name of Entity/Sender: The School Board of Polk County

Contact: Kathy Faulkner, Retiree Clerk

Address: 1915 Floral Avenue, Bartow, FL 33830

Phone Number: 863-519-3858

If you join a non-School Board of Polk County Medicare drug plan and drop your current School Board of Polk County health plan, be advised that you and your dependents will no longer be eligible for the School Board of Polk County Retiree Health Plan.

Section 25: Schedule of Benefits

Important things to keep in mind as you review this Schedule of Benefits:

- This Schedule of Benefits is part of your Summary Plan Description (SPD), where more detailed information about your benefits can be found.
- NetworkBlue is the panel of Providers designated as In-Network for your plan. You should always verify a Provider’s participation status prior to receiving Health Care Services. To verify a Provider’s specialty or participation status, you may contact the local BCBSF office or access the most recent BlueOptions Provider directory on our website at www.bcbsfl.com. If you receive Covered Services outside the state of Florida from BlueCard® participating Providers, payment will be made based on In-Network benefits.
- References to Deductible are abbreviated as "DED".
- Your benefits accumulate toward the satisfaction of Deductibles, Out-of-Pocket Maximums, and any applicable benefit maximums based on your Benefit Period unless indicated otherwise within this Schedule of Benefits.

Your Benefit Period..... **01/01 – 12/31**

Deductible, Coinsurance and Out-of-Pocket Maximums

Benefit Description	In-Network	Out-of-Network
Deductible (DED)		
Per Person per Benefit Period		\$750
Per Family per Benefit Period		\$1,500
Coinsurance (The percentage of the Allowed Amount you pay for Covered Services)	20%	40%
Out-of-Pocket Maximums		
Per Person per Benefit Period	\$5,000	Unlimited
Per Family per Benefit Period	\$9,000	Unlimited

Amounts incurred for In-Network Services will only be applied to the amounts listed in the In-Network column and amounts incurred for Out-of-Network Services will only be applied to the amounts listed in the Out-of-Network column, unless otherwise indicated within this Schedule of Benefits. This includes the Deductible and Out-of-Pocket Maximum amounts.

What **applies** to out-of-pocket maximums?

- DED
- Coinsurance
- Copayments

What **does not apply** to out-of-pocket maximums?

- Non-covered charges
- Any benefit penalty reductions
- Charges in excess of the Allowed Amount
- Any Prescription Drug Cost Share amounts (except for Medical Pharmacy Services)

Important information affecting the amount you will pay:

As you review the Cost Share amounts in the following charts, please remember:

- Review this Schedule of Benefits carefully; it contains important information concerning your share of the expenses for Covered Services you receive. Amounts listed in this schedule are the Cost Share amounts **you pay**.
- Your Cost Share amounts **will vary** depending upon the Provider you choose, the type of Services you receive, and the setting in which the Services are rendered.
- Payment for Covered Services is based on our **Allowed Amount** and may be less than the amount the Provider bills for such Service. You are responsible for any charges in excess of the Allowed Amount for Out-of-Network Providers.
- If a Copayment is listed in the charts that follow, the Copayment applies per visit.

Office Services

A Family Physician is a Physician whose primary specialty is, according to BCBSF's records, one of the following: Family Practice, General Practice, Internal Medicine, and Pediatrics.

Benefit Description	In-Network	Out-of-Network
Office visits and Services not otherwise outlined in this table rendered by Family Physicians	\$40	DED + 40%
Other health care professionals licensed to perform such Services	\$40	DED + 40%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by Family Physicians	DED + 20%	DED + 40%
Other health care professionals licensed to perform such Services	DED + 20%	DED + 40%
Allergy Injections rendered by Family Physicians	\$10	DED + 40%
Other health care professionals licensed to perform such Services	\$10	DED + 40%
E-Visits rendered by Family Physicians	\$10	DED + 40%
Other health care professionals licensed to perform such Services	\$10	DED + 40%
Durable Medical Equipment, Prosthetics, and Orthotics	DED + 20%	DED + 40%
Convenient Care Centers	\$40	DED + 40%

Medical Pharmacy

Benefit Description	In-Network	Out-of-Network
Physician Administerd Specialty and Non-Specialty Drugs administered in the office by: All Physicians and other health care professionals licensed to perform such Services	Included with cost share based on the location of service	DED + 40%
<p>Important – Physician Administered medications may require prior authorization. Immunizations, allergy injections as well as self-adminstered drugs covered through your pharmacy program are not considered Medical Pharmacy. Please refer to your SPD for a description of Medical Pharmacy.</p>		

Preventive Health Services

Benefit Description	In-Network	Out-of-Network
Adult Wellness Services		
Rendered by Family Physicians	\$0	DED + 40%
Other health care professionals licensed to perform such Services	\$0	DED + 40%
All other locations	\$0	DED + 40%
Adult Well Woman Services		
Rendered by Family Physicians	\$0	DED + 40%
Other health care professionals licensed to perform such Services	\$0	DED + 40%
All other locations	\$0	DED + 40%
Child Health Supervision Services rendered by		
Family Physicians	\$0	DED + 40%
Other health care professionals licensed to perform such Services	\$0	DED + 40%
All other locations	\$0	DED + 40%
Mammograms	\$0	\$0
Routine Colonoscopy	\$0	DED + 40%

Outpatient Diagnostic Services

Benefit Description	In-Network	Out-of-Network
Independent Clinical Lab	DED	DED + 40%
Independent Diagnostic Testing Facility		
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	DED + 20%	DED + 40%
All other diagnostic Services (e.g., X-rays)	DED + 20%	DED + 40%

Benefit Description	In-Network	Out-of-Network
Independent Clinical Lab	DED	DED + 40%
Outpatient Hospital Facility	See Hospital Services Outpatient	

Emergency and Urgent Care Services

Benefit Description	In-Network	Out-of-Network
Ambulance Services	DED + 20% of Billed Charges This cost share continues to apply after the plan Out-of-Pocket Maximum has been met	
Emergency Room Visits	See Hospital Services Emergency Room Visits	
Urgent Care Center	\$40	DED + 40%

Outpatient Surgical Services

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center (ASC)		
Facility (per visit)	DED + 20%	DED + 40%
Radiologists, Anesthesiologists, and Pathologists	DED + 20%	In-Network DED + 20%
Other health care professional Services rendered by all other Providers	DED + 20%	DED + 40%
Diagnostic Colonoscopies	\$0 at ASC Only	DED + 40%
Outpatient Hospital Facility	See Hospital Services Outpatient	

Hospital Services

Benefit Description	In-Network		Out-of-Network
	Option 1* and Out-of-State BlueCard® Participating	Option 2*	
Inpatient			
Facility Services (per admission)	DED + 20%	DED + 25%	DED + 40%
Physician and other health care professional Services	DED + 20%		In-Network DED + 20%
Outpatient			
Facility (per visit)	DED + 20%	DED + 25%	DED + 40%
Physician and other health care professional Services	DED + 20%		In-Network DED + 20%
Therapy Services	DED + 20%	DED + 25%	DED + 40%
Diagnostic Colonoscopies	20%	25%	DED + 40%
Emergency Room Visits			
Facility (Copayment waived if admitted)	DED + 20%		DED + 20%
Physician and other health care professional Services	DED + 20%		In-Network DED + 20%

Important:

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

*Please refer to the current Provider Directory to determine the applicable option for each In-Network Hospital.

Behavioral Health Services

Benefit Description	In-Network	Out-of-Network
Mental Health Services Outpatient Facility Services rendered at: Emergency Room ----- Hospital	 DED + 20% ----- DED + 20%	 INN DED + 20% ----- DED + 40%
Physician and other health care professionals licensed to perform such Services Family Physician office ----- Specialist office ----- All other locations	 \$40 ----- \$40 ----- DED + 20%	 DED + 40% ----- DED + 40% ----- DED + 40%
Inpatient Facility Services ----- Physician and other health care professionals licensed to perform such Services	 DED + 20% ----- DED + 20%	 DED + 40% ----- INN DED + 20%

Benefit Description	In-Network	Out-of-Network
Substance Dependency Care and Treatment Services Outpatient Facility Services rendered at: Emergency Room ----- Hospital	 DED + 20% ----- DED + 20%	 INN DED + 20% ----- DED + 40%
Physician and other health care professionals licensed to perform such Services Family Physician office ----- Specialist office ----- All other locations	 \$40 ----- \$40 ----- DED + 20%	 DED + 40% ----- DED + 40% ----- DED + 40%
Inpatient Facility Services ----- Physician and other health care professionals licensed to perform such Services	 DED + 20% ----- DED + 20%	 DED + 20% ----- INN DED + 20%

Benefit Maximums

Ambulance Services Per day for ground, air and water travel Unlimited

Autism Spectrum Disorder Services

Per Benefit Period..... Unlimited

Per Lifetime..... Unlimited

Enteral Formula per Benefit Period..... \$2,500

Home Health Care Visits per Benefit Period..... 20

Inpatient Rehabilitation days per Benefit Period..... 21

Outpatient Therapies and Spinal Manipulations Visits per Benefit Period..... 35

Note: Refer to the Benefit Booklet for reimbursement guidelines.

Preventive Adult Wellness per Benefit Period Unlimited

Skilled Nursing Facility days per Benefit Period 60

Total Lifetime Maximum Benefit Unlimited

Additional Benefits/Features

Prescription Drug Program

Prescription Drug Coverage is not provided through BCBSF. Please refer to the Pharmacy Coverage Section of your SPD.

Section 26: Pharmacy Coverage

Pharmacy Benefit Administration

The School Board of Polk County is the Plan Sponsor and has contracted with a Third Party Administrator (TPA), MEDCO Health Solutions (MEDCO) to provide certain third party administrative services, including claims processing, customer service, and other services, and access to certain of its Provider networks. The payment of claims under the Group Health Plan depends exclusively upon the funding provided by The School Board of Polk County Health Benefits Plan.

Customer Service 800-476-6819

Website <http://www.medco.com>

Schedule of Benefits

Supply	Generic	Preferred Brand	Non-Preferred Brand
Retail 30	\$8	\$30 + 10%* (max \$60)	\$50 + 10%* (max \$100)
Retail 90	\$8	\$90 + 10%* (max \$180)	\$150 + 10%* (max \$300)
Mail 90	\$8	\$75	\$125

- *10% of the cost of the prescription minus the deductible.
- \$25.00 per person annual deductible for brand name medications only.
- If you purchase a brand-name medication when a generic medication is available or when your doctor requests a brand-name medication when a generic medication is available, you will pay the generic co-payment, plus the difference in cost between the brand and the generic.

In Network Pharmacies

- Albertsons
- BiLo
- Costco
- CVS
- Eckerd
- Kash n' Karry
- K Mart
- Kroger
- Publix
- Rite Aid
- Sam's Club
- Target
- Walgreens

- Wal-Mart
- Winn-Dixie

These are examples of in network pharmacies. Visit <http://www.medco.com> for more information.

Pharmacy Mail Service

Through the Prescription Drug Program, you can take advantage of convenient delivery of your covered maintenance medications to your home or other specified address. Be sure to ask your physician for a 90-day prescription in order to take advantage of this benefit.

Order online anytime, or call 1 800 4REFILL (1 800 473-3455) and use the automated telephone system. You can also mail in your refill orders by using the special mail-order pharmacy envelope. If you order by phone or via www.medco.com, you will need to provide your member number and the 12 -digit prescription number shown on the medication container and the refill slip.

A website designed just for you: After a one-time registration at www.medco.com, you can login anytime to order refills, check the status of an order, price and compare medication costs, review prescription history, obtain Medco By Mail order forms and much more.

You will pay your copays for prescriptions ordered through Medco's mail order service directly to Medco.

Generic Drugs

The United States Food and Drug Administration (FDA) requires generic drugs to be as safe and effective as their brand-name counterparts? That means you can save money without compromising quality. A generic must contain identical amounts of the same active ingredients—in the same dosage form and strength—as its brand-name counterpart and be shown to work the same way in the body. There are many new generics available for conditions such as high cholesterol, allergies and depression. We suggest you take the preferred prescriptions member guide with you whenever you visit your doctor to discuss whether a generic medication is appropriate for you.

Preferred Prescriptions Member Guide

For an updated and complete listing of your prescription benefit, you can visit the —Benefit Highlights|| section of the Medco website—www.medco.com—and click on the View your preferred drug list link. Not all medications listed here are covered by every prescription drug plan. Updates are made quarterly for additions and once a year in January for deletions.

Vacation Overrides

If you need to refill your prescription prior to the allowed refill date because you will be going away on vacation, please contact the Risk Management & Employee Benefits Department at: 863-519-3858.

Utilization Management

Medco's comprehensive utilization management programs ensure that members get the right drug in the right dosage at the right time. They also encourage appropriate drug use and drug selection, and utilization management programs increase member safety.

If you submit a prescription for a drug that has coverage limits; for example, prescription drugs used for cosmetic purposes may not be covered, or a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your doctor a toll-free number to call. If you use Medco By Mail, your doctor will be contacted directly.

When a coverage limit is triggered, more information is needed to determine whether your use of the medication meets the plan's coverage conditions. Medco will notify you and your doctor in writing of the decision. If coverage is approved, the letter will indicate the amount of time for which coverage is valid. If coverage is denied, an explanation will be provided, along with instructions on how to submit an appeal.

Appeals

In the event you receive an adverse benefit determination following a request for coverage of a prescription benefit claims, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician).

To initiate an appeal for coverage, provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to:

MEDCO HEALTH SOLUTIONS
ATTN: Clinical REVIEWS
8111 ROYAL RIDGE PKWY
IRVING TX, 75063-0000

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request. If you are not satisfied with the coverage decision made on appeal, or if you would like further information on the appeals process, you may request a second level appeal in writing within 90 days of receipt of notice of the decision.

Medication Management

The following medications or groups of medication may require documentation from your physician prior to coverage:

- acne topical
- ADHD
- narcolepsy
- Byetta
- Crinone 8%
- Lamisil
- Migraine
- Penlac
- Sporanox
- Symlin

Specialty Medications

Prescriptions for specialty medications must be filled through:

Accredo Health Group, Inc.
640 Century Center Parkway
Memphis, TN 38134

For any Accredo Health Group referral, please call 866-591-9075 (toll-free).

Below are examples of groups of medications that may be considered specialty medications:

- Anemia
- Cancer
- Hepatitis C
- Multiple Sclerosis
- Auto Immune Disorders
- Cystic Fibrosis

For a complete listing contact Medco at 1-800-476-681

Section 27: Pre-Tax Dollars

Under Section 125, health coverage premiums are paid with pre-tax dollars. This means that the premiums are deducted from gross income before FWT and FICA taxes are deducted.

Therefore, you are not paying taxes on these premiums. You are automatically enrolled under Section 125 for all eligible benefits unless you notify the Employer, in writing, of your intent not to participate. There are certain guidelines set out under Section 125 that employers are required to enforce. These guidelines are as follows:

1. **Cost Changes:** Coverage may be revoked if there is a significant increase in plan cost, but only if the Employee and/or dependents have other coverage.

2. **Coverage Changes:** Coverage may be revoked if the Plan is significantly curtailed or ceases during the period of coverage.

3. **Change in Family Status:** Plan may permit Employees to revoke existing elections in the event of certain family status changes and make new elections consistent with these changes. Status changes allowed are:

1. The Employee's marriage;
2. the Employee's divorce;
3. death of the Employee's spouse or a dependent;
4. birth or adoption of a child of the Employee;
5. termination or commencement

6. of employment by the Employee's spouse;
7. the Employee or Employee's spouse switching from part-time to full-time employment, or from full-time to part-time employment;
8. the Employee or the Employee's spouse taking an unpaid leave of absence;
9. significant changes in the health coverage of the Employee or of the Employee's spouse attributable to the spouse's employment;
10. any dependent no longer eligible.

4. **Separation from Service:** Individuals who are rehired as employees of the School Board of Polk County are considered newly hired employees for purposes of this section. The provisions of the Group Health Plan Description (which includes Evidence of Coverage) which are applicable to newlyhired employees and their Eligible Dependents (e.g., enrollment, Effective Dates of coverage, Pre-existing condition exclusionary period, and Waiting Period) are applicable to rehired employees and their Eligible Dependents.

5. **Cessation of Required Contributions:** A benefit will cease to be provided to an Employee if the Employee fails to make required premium payments. If this occurs, the Plan must not allow the

Employee to make a new benefit election for the remainder of the Plan year. Any Employee on a leave of absence who does not continue paying for benefits or does not elect COBRA will fall into this category.

Benefits cannot be reinstated when the Employee returns to work until the beginning of the next Plan year; Plan Year starts January 1.