Florida Blue

Job Aid: 2019 Temporary Insurance Plans Benefits

Pre-Existing Conditions

Temporary insurance plans cover medical care for conditions that are treated after the plan's effective date. The member is responsible for the cost of treatment for conditions they had before their coverage went into effect (also called a pre-existing condition). Even if they had prior coverage where pre-existing conditions were covered, they won't be covered with these temporary insurance plans. Refer to the *Is a Temporary Insurance Plan Right for You?* flier for more information.

Temporary Insurance vs. ACA Plans

- Temporary insurance plans are not required to meet minimum essential coverage under the ACA and are not intended to be a long term coverage solution.
- Temporary insurance plans will help in emergencies and unexpected illnesses over a short period of time.
- Keep in mind that when temporary insurance coverage ends, it does not qualify for a Special Enrollment Period.

Benefits at a Glance

BlueOptions/BlueSelect	580T/280T 590T/290T	581T/281T 591T/291T	582T/282T 592T/292T	583T/283T 593T/293T	584T/284T 594T/294T
Network	Choose BlueOptions or BlueSelect				
Deductible	$1K	$2.5K	$5K	$7.5K	$10K
OOPM	$5K	$7.5K	$10K	$15K	$20K
Coinsurance	Choose 20% or 50%				
Out-of-Network Coinsurance	50% coinsurance				
OON Coinsurance OOPM	$7.5K	$11.25K	$15K	$20K	$25K
Lifetime Maximum	$2M				
Doctor Office Visit	Value Choice Provider (VCP) : No Charge Non-VCP: – 1st visit @ $50 then DED + COINS per contract per member				
Urgent Care	$75				
Emergency Room	DED+ COINS				
Inpatient	DED+ COINS				
All other services	DED+ COINS				
Pharmacy: BlueRx Discount Program	Saving on Generic, Preferred Brand and Non-Preferred Brand prescription drugs Mail order or Retail at 40K pharmacies				

Optional Riders

Maternity	Coverage for routine pregnancy, delivery, and post partum follow-up. 50% coinsurance coverage after $2,500 rider deductible is met.

A detailed plan design and information on the Blue Rx Discounts program can be found on accessBlue.

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Maternity Rider

Temporary insurance plans are not intended for consumers planning to have children. Consumers will find more value and generally pay less if covered under an ACA plan. If a consumer is outside of the ACA open enrollment period and needs coverage a maternity rider is available for purchase if the following key eligibility requirements are met:

1. Rider must be purchased with a TIP policy at least 30 days prior to a pregnancy occurring.
2. Concurrent maternity riders must be purchased with a TIP plan during pregnancy in order to maintain coverage or enroll in an ACA plan.

	Member Pays	Florida Blue Pays
Up to $2,500 deductible	$2,500	Nothing
After $2,500 deductible	50% coinsurance	50% coinsurance

High level benefits of the rider include:

1. Physician or Midwife Services provided to you for routine pregnancy, delivery and post-partum follow-up.
2. Hospital or Birth Center Services for labor and delivery of the baby. This includes a physical assessment of the mother and any necessary clinical tests in keeping with prevailing medical standards, newborn assessment and room and board for the mother and routine nursery care. You may also choose to deliver your baby at home.
3. Routine nursery care for the newborn child during the covered portion of the mother's maternity stay is included under this benefit. However, when an infant requires non-routine treatment during or after the mother's stay, the newborn is considered a patient in his or her own right and will be covered separately only if the newborn is properly enrolled. The newborn's hospital admission in this case is subject to separate Cost Share amounts applicable to your Contract.

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Supplemental Benefits

Remember to discuss supplemental coverage plans when selling temporary insurance plans. Supplemental plans can help protect members from out-of-pocket costs.

Accident

Two plan choices that cover select accidents in addition to accidental death or dismemberment

Critical Illness

$10K-$50K benefit options, upon first diagnosis of a covered illness (i.e. cancer, heart attack, stroke)

Hospital Confinement

Three plan choices that pay daily confinement amounts in addition to annual hospital admission and special ICU rates

Highlights

- Coverage is available to the applicant and their dependents
- Cash benefits are paid directly to the member to use as they choose
- Policy is guaranteed renewable
- Rates don't increase due to age (locked into age at effective date)
- Not coordinated with health plans
- 30-day free look period

Note: Agents must be appointed with USAble Life to sell these products.
Start the process today by emailing Licensing@USAbleLife.com

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Benefit Exclusions

THIS IS A SUMMARY, THE TERMS OF THE CONTRACT WILL PREVAIL. FOR A COMPLETE LIST SEE THE WHAT'S NOT COVERED SECTION OF THE CONTRACT

General Exclusions

Benefits will not be paid for services or supplies that are not administered or ordered by a doctor and medically necessary to the diagnosis or treatment of an illness or injury, as defined in the policy.

No benefits are payable for expenses:

For a pre-existing condition - any Condition that manifests itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care or treatment was recommended or received during the 24-month period immediately preceding your Effective Date of coverage under this Contract; or a pregnancy existing on the Effective Date of coverage under this Contract.

Abortions that are elective.

Adult Wellness, preventive care or routine screening Services.

Ambulance Services including but not limited to:

1. Services for situations that are not Medically Necessary
2. Services for a patient who is legally pronounced dead
3. Aid rendered by an Ambulance crew without transport. Non-emergency transport to or from a patient's home or a residential, domiciliary or custodial facility.
4. Transfers by medical vans or commercial transportation
5. Ambulance transport for patient convenience or patient and/or family preference.
6. Air and water Ambulance Services in the absence of an Emergency Medical Condition, unless such Services are authorized by us in advance.

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

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

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

Complementary or Alternative Medicine

Contraceptive medications, devices, appliances, or other Health Care Services, when provided for contraception, except as otherwise covered in the WHAT IS COVERED? section.

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

Cosmetic Services, including any Service to improve the appearance or self-perception of an individual

Custodial Care as defined in the DEFINITIONS section of this Contract.

Dental Services except as indicated in the WHAT IS COVERED?

Drugs

1. Drugs prescribed for uses other than the United States Food and Drug Administration (FDA) approved label indications. This exclusion does not apply to any Drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the Drug is recognized for treatment of your particular cancer in a Standard Reference Compendium or recommended for treatment of your particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.

1. Drugs dispensed to, or purchased by you from a pharmacy. This exclusion does not apply to drugs dispensed to you when:
   a. you are an inpatient in a Hospital, Ambulatory Surgical Center or Skilled Nursing Facility, or Psychiatric Facility;
   b. you are in the outpatient department of a Hospital;
   c. dispensed to your Physician for administration to you in the Physician's office and prior coverage authorization has been obtained (if required); or
   d. you are receiving Home Health Care according to a plan of treatment and the Home Health Care Agency bills us for such drugs, including Self-Administered Prescription Drugs that are rendered in connection with a nursing visit.
2. Any non-Prescription medicines, remedies, vaccines, biological products (except insulin), pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, over-the-counter drugs, products, or health foods.
3. Any drug which is indicated or used for sexual dysfunction, such as Cialis, Levitra, Viagra and Caverject.

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4. Any Self-Administered Prescription Drug except when indicated as covered in the WHAT IS COVERED? section of this Contract.
5. Any drug which requires prior coverage authorization when prior coverage authorization is not obtained.
6. Blood or blood products used to treat hemophilia, except when provided to you for:
   e. emergency stabilization;
   f. during a covered inpatient stay, or
   g. when proximately related to a surgical procedure.

The exceptions to the exclusion for drugs purchased or dispensed by a pharmacy described in exclusion two above, do not apply to hemophilia drugs excluded under this subparagraph.

7. New Prescription Drug(s), as defined in the DEFINITIONS section.
8. Convenience Kits as defined in the DEFINITIONS section
9. Drugs that are FDA approved, but lack proven benefits and/ or efficacy as defined in the product prescribing information or noted in our coverage policy as an output from our Pharmacy and Therapeutics Committee, Medical Policy Committee or any other nationally recognized source.

Durable Medical Equipment which is primarily for convenience and/or comfort; modifications to motor vehicles and/or homes

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

Eye Care except as indicated in the WHAT IS COVERED? section

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

Foot care (routine), including any Service or supply in connection with foot care in the absence of disease General Exclusions include, but are not limited to:

1. Any Health Care Service received prior to your Effective Date or after the date your coverage terminates.
2. Any Health Care Service not within the Covered Services Categories described in the WHAT IS COVERED? section or any Endorsement that is part of this Contract, unless such Services are specifically required to be covered by applicable law.
3. Any Health Care Service you render to yourself or those rendered by a Physician or other health care Provider related to you by blood or marriage.
4. Any Health Care Service that is not Medically Necessary as defined in this Contract and determined by us. The ordering of a Service by a health care Provider does not, in itself, make such Service Medically Necessary or a Covered Service.
5. Any Health Care Service rendered at no charge.
6. Any Health Care Service to diagnose or treat any Condition which initially occurred while you were (or which, directly or indirectly, resulted from, or is in connection with, you being) under the influence of alcoholic beverages, any chemical substance set forth in Section 877.111 of the Florida Statutes, or any substance controlled under Chapter 893 of the Florida Statutes (or, with respect to such statutory provisions, any successor statutory provisions). Notwithstanding, this exclusion shall not apply to the use of any prescription medication by you if such medication is taken on the specific advice of a Physician in a manner consistent with such advice.
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 Service to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with:
   a. war or an act of war, whether declared or not;
   b. your participation in, or commission of, any act punishable by law as a felony whether or not you are charged or convicted, or which constitutes riot, or rebellion except for an injury resulting from an act of domestic violence or a medical Condition;
   c. your engaging in an illegal occupation except for an injury resulting from an act of domestic violence or a medical Condition;
   d. Services received at military or government facilities to treat a Condition arising out of your service in the armed forces, reserves and/or National Guard;
   e. Services received to treat a Condition arising out of your service in the armed forces, reserves and/or National Guard;
   f. you being under the influence of alcohol or any narcotic, unless taken on the specific advice of a Physician in a manner consistent with such advice;

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g. an intentionally self-inflicted Condition, suicide or attempted suicide, whether you are sane or insane; or

h. Services that are not patient-specific, as determined solely by us, such as office infection control charges.

9. Health Care Services rendered because they were ordered by a court, unless such Services are otherwise Covered Services under this Contract.

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

11. Any Health Care Service subject to an Exclusive Provider Provision rendered or supplied by or through any Provider other than the Provider designated solely by us, as the Exclusive Provider of such Services, except when such Services are required for treatment of an Emergency Medical Condition. Please refer to your Schedule of Benefits to determine which Services are subject to an Exclusive Provider Provision.

12. Expenses for completion of any form and /or medical information or for copies of your records or charts including any costs associated with forwarding or mailing copies of your records or charts.

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 (external or implantable) and Services related to the fitting or provision of hearing aids, including tinnitus maskers, batteries and repair costs.

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

Hospice Services rendered at any location.

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

Immunizations except those covered under the Preventive Child Health Supervision Services category of the WHAT IS COVERED? section.

Infertility Treatment including Services beyond what is necessary to determine the cause or reason for infertility and Services rendered to assist in achieving pregnancy are excluded

Inpatient Rehabilitation Services including all inpatient Rehabilitation Services for Pain Management and respiratory ventilator management Services.

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

Maternity/Obstetrical Care, including inpatient and outpatient maternity/obstetrical care Services of a Midwife or Certified Nurse Midwife and/or Physician including prenatal care, delivery and all Services related to maternity/obstetrical care and Services or early termination of pregnancy.

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

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

Orthomolecular Therapy including nutrients, vitamins, and food supplements.

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

Oversight of a medical laboratory by a Physician or other health care Provider.

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

Private Duty Nursing Care rendered at any location.

Prosthetic Devices except as indicated in the WHAT IS COVERED? section, including expenses for cosmetic enhancements to artificial limbs.

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

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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.

Services to Treat Complications of Non-Covered Services Skilled Nursing Facilities expenses for an inpatient admission to a Skilled Nursing Facility for Custodial Care, convalescent care, or any other Service primarily for your convenience or that of your family members or the Provider.

Smoking Cessation Programs 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.

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.

Telemedicine Services, as defined in this Contract.

Telephone Consultations

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

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

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

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

Weight Control Services including any Service to lose, gain or maintain weight regardless of the reason for the Service or whether the Service is part of a treatment plan for a Condition.

Wigs and/or cranial prosthesis.

Qualified Exclusion for AIDS and ARC

If, in the opinion of a Physician, you either first exhibited objective manifestations of Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) that are not attributable to another cause or tested HIV positive, or were diagnosed as having AIDS or ARC, at any time prior to 12 months from your original Effective Date of coverage, there is no coverage under this Contract for any expense related, directly or indirectly, to AIDS or ARC. This exclusion is in addition to any other rights we have, including but not limited to, enforcement of the Pre-Existing Condition limitation provision, and rescission or cancellation of this Contract for fraud or Material Misrepresentation.

This exclusion shall not apply if:

1. We fail to assert this provision within the first two years of your coverage under this Contract; and
2. We fail to notify you, in writing, of the applicability of this provision within 90 days of our determination that you are subject to this provision.

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