

BlueCare

HMO Benefit Booklet for Covered Plan Participants of Lake County Board of County Commissioners Group Health Plan

A Self-funded and Grandfathered Group
Health Benefit Plan Serviced by Health
Options, Inc.

Effective: October 1, 2014

**For Customer Service Assistance:
(800) 352-2583**

The Lake County Board of County Commissioners believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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Attachment A: Service Area

Section 1: How to Use Your Benefit Booklet

This is your Benefit Booklet. It describes your coverage and benefits for Health Care Services, as well as the limitations and exclusions that apply, under the Group Health Benefit Plan (“Group Health Plan” or “Group Plan”) established and maintained by Lake County Board of County Commissioners. Your Group Health Plan is self-funded. This means that benefits for Covered Services under the Group Plan will be paid either directly from Lake County Board of County Commissioners’ general assets or a combination of its general assets and contributions made by Covered Plan Participants. The benefits provided under the Group Health Plan are not guaranteed or insured by an insurance company or by Health Options, Inc. (“HOI”).

HOI has entered into an Administrative Services Agreement (“ASA”) with Lake County Board of County Commissioners, the sponsor of your Group Health Plan, to provide certain third party administration services, including claims processing, customer service, and other services, and access to its Health Maintenance Organization (“HMO”) provider network. HOI does not guarantee your benefits under the Group Health Plan, nor does it assume any financial risk or obligation with respect to claims received for processing under your Group Health Plan.

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

- your benefits;
- Coverage Access Rules;
- what is covered;
- what is excluded or limited;
- coverage and payment rules;
- how to access your benefits;

- how and when to file a claim;
- how to resolve a Complaint or Grievance;
- how much, and under what circumstances, payment will be made;
- what you will have to pay as your share of the expenses you incur for covered Health Care Services; and
- other important information, including when benefits may change, how and when your coverage under this Benefit Booklet stops; how to continue coverage if you are no longer eligible; how benefits will be coordinated with other policies or plans; as well as the subrogation rights of the Group Health Plan and its right of reimbursement.

You will need to refer to your Schedule of Copayments or Schedule of Benefits in this Booklet to determine how much you have to pay for particular Health Care Services.

When reading your Booklet, please remember that:

- You should read this Benefit Booklet in its entirety.
- The headings of sections contained in this Booklet 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 that refer solely to you as the Covered Employee, Covered Plan Participant or solely to your Covered Dependent(s) will be noted as such.

- 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.

What is an HMO?

A Health Maintenance Organization (HMO) is an alternative health care financing and/or delivery organization that either provides directly, or through arrangements made with other persons or entities, comprehensive health care coverage and benefits or Services, or both, in exchange for a prepaid per capita or prepaid aggregate fixed sum.

In order for most Health Care Services to be covered under an HMO plan, covered individuals usually must coordinate their care through a Primary Care Physician, and obtain authorizations in accordance with the Coverage Access Rules established by the HMO. With a few exceptions, if the Coverage Access Rules are not followed, the individual is fully responsible for the entire cost of the Health Care Service expenses incurred.

While some HMOs are similar, not all HMOs operate or are organized in the same way. An HMO may be organized and operate as a staff model, a group model, a direct contract model, an Individual Practice Association (“IPA”) model, a network model, or a combination of these forms. HOI, for example, is structured as a direct contract / IPA model HMO. Refer to the Types of HMOs subsection of the General Provisions section for further information.

Your HMO health plan is self-funded. This means that while HOI makes its HMO provider network available to you, it does not assume or bear any financial risk with respect to the comprehensive health care coverage and benefits available to you under the Group Health

Plan. The financing of your health care benefits under the Group Health Plan is the responsibility of Lake County Board of County Commissioners in accordance with the terms of the ASA.

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 to obtain coverage under the Group Health Plan?**
Read the “Coverage Access Rules” section.
- **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.
- **How do I add or remove a Covered Dependent?**
Read the “Enrollment and Effective Date of Coverage”.
- **How do I know what doctor or provider is in the HOI network in my Service Area?**
Read the “Coverage Access Rules” section and refer to your provider directory.
- **What can you do if you do not like your Primary Care Physician (PCP)?**
Read the Choosing a Primary Care Physician (PCP) subsection of the “Coverage Access Rules” section.
- **What can you do if you have a concern about a coverage or payment decision?**
Read the “Complaint and Grievance” section.
- **What happens if you are covered under this Benefit Booklet 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 do the terms used throughout this Booklet mean?**

Read the “Definitions” section.

- **Where do you find information on Contracting Providers’ financial incentives?**

Read the “Coverage Access Rules” section.

Section 2: Your Rights and Responsibilities

You have the following rights and responsibilities under Lake County Board of County Commissioners' Group Health Plan.

Rights

1. To be provided with information about the coverage and benefits available under this Benefit Booklet, the Coverage Access Rules you must follow in order to get coverage for Health Care Services, the names of the providers contracting with HOI from whom you can receive Services, and your responsibilities under the Group Health Plan.
2. To receive medical care and treatment from Contracting Providers who have met HOI's credentialing standards.
3. To expect health care providers who contract with HOI to: a) discuss appropriate or Medically Necessary treatment options for your Condition, regardless of cost or benefit coverage; and b) permit you to participate in the major decisions about your health care, consistent with legal, ethical, and relevant patient-provider relationship requirements.
4. To expect courteous service from HOI, and considerate care from Contracting Providers with respect and concern for your dignity and privacy.
5. To voice your Complaints concerning, or appeal, unfavorable coverage or benefit decisions by following the established appeal or Grievance procedures found in this Booklet or other procedures established for such purposes.
6. To inform Contracting Providers that you refuse treatment, and to expect to have such providers honor your decision if you choose to accept the responsibility and the consequences of such a decision.

7. To have access to your records and to have confidentiality of your medical records maintained in accordance with applicable law.
8. To call or write HOI or Lake County Board of County Commissioners Employee Services with helpful comments, questions, and observations, whether concerning something you like about the coverage or benefits available under the Group Health Plan, or something you feel is a problem area. You may also make recommendations regarding the rights and responsibilities described herein.

Responsibilities

1. To seek all non-emergency care through a Primary Care Physician (PCP) or a Contracting Specialist and to cooperate with all persons providing your care and treatment.

Note: Wellness Services must be rendered by your assigned Primary Care Physician.
2. To be respectful of the rights, property, comfort, environment and privacy of other individuals and not be disruptive.
3. To take responsibility for understanding your health problems and participate in developing mutually agreed upon treatment goals, as best as possible, then following the plans and instructions for care that you have agreed upon with your provider.
4. To provide accurate and complete information concerning your health problems and medical history and to answer all questions truthfully and completely.
5. To be financially responsible for any applicable Copayments, Deductible and/or Coinsurance amounts and non-covered Services, and to provide current information

concerning your enrollment status to any Contracting Providers from whom you are seeking care.

6. To follow established procedures for filing a Grievance concerning Adverse Benefit Determinations that you feel are in error.
7. To request records in accordance with HOI's rules and procedures and applicable law.
8. To follow the Coverage Access Rules described in this Booklet or established by HOI.

Disclosure of Continuing Care Facility Resident/Retirement Facility Resident Rights

If, at the time of enrollment as a Member of Health Options, Inc., you are a resident of a continuing care facility certified under Chapter 651, Florida Statutes, or a retirement facility consisting of a nursing home or assisted living facility and residential apartments, your Primary Care Physician must refer you to that facility's skilled nursing unit or assisted living facility if:

1. requested by you and agreed to by the facility;
2. your Primary Care Physician finds that such care is Medically Necessary;
3. the facility agrees to be reimbursed at the HOI contract rate with similar providers for the same Covered Services and supplies; and
4. the facility meets all guidelines established by HOI related to quality of care, utilization, referral authorization, risk assumption, use of the HOI provider network, and other criteria applicable to providers under contract with HOI for the same Services.

If your request to be referred to the skilled nursing unit or assisted living facility that is part of your place of residence is not honored, you have the right to initiate a Grievance under the process described in this Benefit Booklet.

Section 3: Coverage Access Rules

It is important that you become familiar with the rules for accessing health care coverage under your Group Health Plan. The following subsections explain HOI's role and the role of your Primary Care Physician (PCP), how to access specialty care, and what to do if Emergency Services and Care are needed. It is also important for you to review all Service Area-specific Coverage Access Rules for particular types of Services and Contracting Providers within the Service Area. These Service Area-specific Coverage Access Rules, if any, are set forth in the provider directory and may vary based on negotiated provider contracts and other network factors specific to the Service Area.

Choosing a Primary Care Physician (PCP)

The first and most important decision you must make in order to obtain coverage and benefits under your Group Health Plan is the selection of your Primary Care Physician (PCP). This decision is important since it is through, this Physician that all other Health Care Services, particularly those of Specialists are coordinated. You are free to choose any Primary Care Physician (PCP) listed in HOI's most recent published list of Primary Care Physician's (PCPs) whose practices are open to additional individuals covered by HOI or individuals covered under self-funded plans administered by HOI. This choice should be made when you enroll. As the Covered Plan Participant, you are responsible for choosing a Primary Care Physician (PCP) for all your minor Covered Dependents including a newborn child or an adopted newborn child. If you fail to choose a Primary Care Physician (PCP) when enrolling, HOI will automatically assign you one and notify you of that assignment. The following includes

important information concerning your Primary Care Physician (PCP) relationship:

Primary Care Physicians (PCPs) are trained to provide a broad range of medical care and can be a valuable resource to coordinate your overall health care needs. Developing and continuing a relationship with a Primary Care Physician allows the Physician to become knowledgeable about your health history. A Primary Care Physician can help you determine the need to visit a Specialist and also help you find one based on their knowledge of you and your specific health care needs. A Primary Care Physician may specialize in internal medicine, family practice, general practice, or pediatrics. Also, a gynecologist or obstetrician/gynecologist may elect to contract with HOI as a Primary Care Physician. Additionally, care rendered by your Primary Care Physician usually results in lower out of pocket expenses for you. Refer to the Primary Care Physicians section(s) of the provider directory for Physicians who are Primary Care Physicians. The Primary Care Physician you select maintains a Physician-patient relationship with you, and will be, except as specified by the Coverage Access Rules set forth in the provider directory, if any, responsible for helping to coordinate medical Services for you.

It is important that you and your Primary Care Physician (PCP) have a good relationship. To be certain this relationship is conducive to effective health care, both you and your Primary Care Physician (PCP) may request a change in the Primary Care Physician (PCP) assignment:

1. You may request a transfer to another Primary Care Physician (PCP) listed in HOI's most recent published list of Primary Care Physicians (PCPs) whose practices are open to additional individuals covered by

HOI or individuals covered under self-funded plans administered by HOI. The transfer of care to the newly selected Primary Care Physician (PCP) shall be effective the first day of the following calendar month provided HOI receives the request before the 15th of the month.

2. Instances may occur where your Primary Care Physician (PCP), for good cause, finds it impossible to establish an appropriate and viable Physician-patient relationship with you. In such circumstances, the Primary Care Physician (PCP) may request that HOI assist you in the selection of another Primary Care Physician (PCP).

HOI may assist you in selecting, or assign you, another Primary Care Physician (PCP) if the Primary Care Physician (PCP) you selected terminates his or her contract with HOI, or is unable to perform his or her duties, or is on a leave of absence.

Specialist Care

If you require an office visit to a Specialist, you and/or your Primary Care Physician (PCP) may choose any Contracting Specialist.

Your Primary Care Physician (PCP) may consult with HOI regarding coverage or benefits and with the Specialist in order to coordinate your care. This procedure provides you with continuity of treatment by the Physician who is most familiar with your medical history and who understands your total health profile.

You do not need to obtain referrals from your Primary Care Physician to see a Contracting Specialist; however, some Services require an authorization for coverage. The HOI Contracting Provider is responsible for obtaining authorization from HOI.

Services that require authorization include, but are not limited to:

1. hospitalization, both inpatient and observation stays;

2. certain radiology Services, including advanced diagnostic imaging Services, such as CT scans, MRIs, MRAs and nuclear imaging;
3. Home Health Care;
4. certain Durable Medical Equipment;
5. pain management;
6. surgery;
7. Services provided by Non-Contracting Providers;
8. Physical Therapy, Occupational Therapy and Speech Therapy;
9. Skilled Nursing Facilities;
10. certain injections and infusion therapy;
11. certain provider-administered drugs, as denoted with a special symbol in the Medication Guide;
12. Hospice Services; and
13. certain diagnostic Services.

If Specialist Services from a Non-Contracting Provider are required, payment for such Services will only be made if HOI authorizes coverage. When appropriate, HOI may request that you and the Non-Contracting Provider agree upon a written treatment plan in advance of your receipt of Services from that provider. Your Primary Care Physician (PCP) or the Contracting Specialist who is treating you is responsible for obtaining this authorization.

Continuity of Coverage and Care upon Termination of a Provider Contract

If you are actively receiving treatment for a Condition when HOI's agreement with a Contracting Provider (including a Primary Care Physician (PCP)) is terminated without cause, you may continue to be covered under this Benefit Booklet for treatment of that Condition with the same Provider after the date of the

Contracting Provider's termination. Coverage for that Condition with the same Provider will continue only until:

1. the completion of treatment for the Condition;
2. you select another Contracting Provider; or
3. the next Open Enrollment Period.

Coverage under this provision for Covered Services you receive from such a Provider shall, in no event, continue for longer than six months after termination of HOI's agreement with the provider.

Maternity benefits under the Group Health Plan shall continue, regardless of the trimester in which care was initiated, until completion of postpartum care for a covered pregnant individual who has initiated a course of prenatal care prior to the termination of the Contracting Provider's contract.

Coverage or payment is not required for any Services under this subsection for an individual whose coverage under this Benefit Booklet is not in effect at the time that Services are rendered. Further, this subsection does not apply if the Contracting Provider is terminated by HOI "for cause".

Emergency Services and Care

IN THE EVENT OF AN EMERGENCY, GO TO THE NEAREST HOSPITAL OR CLOSEST EMERGENCY ROOM OR CALL 911.

Emergency Services and Care in or out of the Service Area shall be Covered Services without prior notification to HOI, subject to the Copayment amount set forth in the Schedule of Copayments. It is your responsibility, however, to notify HOI as soon as possible, concerning the receipt of Emergency Services and Care and/or any admission which results from an Emergency Medical Condition. If a determination is made that an Emergency

Medical Condition does not exist, payment for Services rendered subsequent to that determination will be your responsibility.

Follow-up care must be rendered by a Primary Care Physician or a Contracting Specialist. If the follow-up care is provided by other than a Primary Care Physician or Contracting Specialist, coverage may be denied.

Payment for Emergency Services and Care rendered by Non-Contracting Providers will be the lesser of the provider's charges, the usual and customary provider charges for similar Services in the community where the Services were provided, or the charge mutually agreed to by HOI and the provider within 60 days of the submittal of the claim for such Emergency Services and Care. It is your responsibility to furnish to HOI written proof of loss in accordance with the "Claims Review" section.

Service Area

All non-emergency services must be received within your Service Area. Refer to Attachment A for the counties in your Service Area. Refer to your provider directory for the providers in your Service Area.

Verifying Provider Participation

You are responsible for verifying the participation status of a Physician, Hospital, or other provider prior to receiving Health Care Services. To determine if a particular health care provider is in the HOI provider network and in your Service Area, you should review the most recent provider directory and call HOI to validate that the provider is still in HOI's provider network. To verify a specific health care provider's participation status, contact the local HOI office or access the HOI Provider directory at HOI's website at www.FloridaBlue.com.

Case Management

Case management focuses on covered individuals who suffer from a catastrophic illness or injury. In the event you have a catastrophic or chronic Condition, HOI may, in its sole discretion, assign a 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 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 the 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.

The fact that certain Health Care Services have been provided to you, or others, through the case management program, or that payment has been made under the case management program in the past, in no way obligates HOI, Lake County Board of County Commissioners, or the Group Health Plan to continue to provide or pay for the same or similar Services in the future. Nothing contained in this section shall be deemed a waiver of Lake County Board of County Commissioners' right to enforce this Booklet in strict accordance with its terms. The terms of this Booklet will continue to apply, except as specifically modified in writing in accordance with the case management program rules then in effect.

Access to Osteopathic Hospitals

You may obtain inpatient and outpatient Services similar to inpatient and outpatient Services by allopathic hospitals from a Hospital accredited by the American Osteopathic

Association when such Services are available in the Service Area and when such Hospital has not entered into a written agreement with HOI with regard to such Services. The Hospital providing such Services may not charge rates that exceed the Hospital's usual and customary rates less the average discount that HOI has with allopathic Hospitals within the Service Area. It is your responsibility to contact HOI to obtain the documents necessary to comply with this provision.

Access to Other Contracting Providers

Other Primary Care Physicians: You may access Primary Care Physicians other than your assigned Primary Care Physician, for Services other than preventive health Services described in the "What is Covered?" section. The Copayment applicable to Specialist visits listed on your Schedule of Copayments or Schedule of Benefits, will apply to these Services.

Contracting Specialists: You may access any Contracting Specialist for office visits, except for preventive health Services described in the "What is Covered?" section, without authorization from your Primary Care Physician. However, your Primary Care Physician can help you determine the need to visit a Specialist and also help you find one based on their knowledge of you and your specific health care needs. Certain Services may require authorization; please refer to the Specialist Care subsection in this section for additional information.

Surgical Physician Assistant: You have access to surgical assistant Services rendered by a Physician Assistant only when acting as a surgical assistant and licensed to perform surgical first assisting Services. Certain types of medical procedures and other Covered Services may be rendered by Physician Assistants, nurse practitioners or other individuals who are not Physicians.

Certified Registered Nurse Anesthetist: You have access to anesthesia Services within the scope of a duly licensed Certified Registered Nurse Anesthetist's license if you request such Services, provided such Services are available, as determined by HOI, and are Covered Services.

Obstetric and Gynecological providers: Members shall have access to Contracting Providers who specialize in obstetrics or gynecology for obstetric or gynecological care without the need for referral from their Primary Care Physician.

Services Not Available from Contracting Providers

Except as provided in the "What is Covered?" section, if a particular Covered Service is not available from any Contracting Provider, as determined by HOI, HOI may authorize coverage for such Service to be rendered by a Non-Contracting Provider. **HOI must authorize Services provided by a Non-Contracting Provider under this provision in order for such Services to be Covered Services under this Benefit Booklet. Failure to obtain authorization may result in the denial of coverage for Services you receive from such a provider.**

Health Options Uses Provider Financial Incentives

HOI attempts to hold down the cost of health care. As an HMO, it does this in several ways. One way is by offering financial incentives to Physicians and other health care providers, through one or more kinds of compensation arrangements (e.g., capitation, and participation in "risk pools" and fee "withhold" arrangements), to deliver cost-effective medically appropriate Health Care Services. Financial incentives in compensation arrangements with Physicians and other health care providers are one method by which HOI (and other HMOs and plans) attempts to reduce and control the costs of

health care. Other approaches include efforts to assist you with staying healthy through education and the offering of certain preventive health benefits such as mammograms.

The use of financial incentives by HOI is intended to encourage Physicians and other health care providers to minimize the provision of unnecessary Services, reduce waste in the application of medical resources, and to eliminate inefficiencies that may lead to the artificial inflation of health care costs. These incentives are also intended to improve doctor-patient relationship satisfaction.

You should be aware that your Physician's or health care provider's decisions regarding whether or not to provide medical care and treatment may affect the amount of money he or she earns. For example, your Physician or health care provider may be paid a set amount per month to cover the cost of providing Covered Services to you whether or not he or she actually renders care during that month. This form of provider payment is called capitation. If this predetermined amount of money paid to your Physician is less than what it actually costs your Physician to provide care to you, your Physician may lose money. Of course, it is expected that your Physician will recommend treatment alternatives that are medically appropriate for you even if your Physician loses money in providing that care. However, if you have concerns in this regard, you are strongly encouraged to discuss with your Physicians and other health care providers how their acceptance of financial risk may affect your medical care or treatment.

Away From Home Care® Guest Membership

Away From Home Care® (AFHC) Guest Membership is an out-of-area program sponsored by the Blue Cross Blue Shield Association (BCBSA) that is available to you under the Group Health Plan through HOI if the requirements of that program then in effect are met. Guest Membership is defined as a

courtesy membership for covered individuals who are temporarily residing outside of their Home HMO service area. For purposes of the Away From Home Care program, **HOI remains your Home HMO**. For purposes of the Group Health Plan, you will be a guest member of the Host HMO and will be entitled to coverage and benefits under the terms of the Host HMO's benefit booklet.

Under this program, covered individuals can receive courtesy enrollment in a participating Host HMO and have access to a comprehensive range of benefits, including routine and preventive Services with the Host HMO. As a Guest Member, you will receive the benefits of the Host HMO plan while in that HMO Plan's service area. You will remain a Covered Plan Participant of the Home HMO and will be entitled to payment for eligible Services not payable under your Away From Home Care Guest Membership under the terms of this Benefit Booklet. Should your coverage with your Home HMO terminate, you will no longer be eligible for Away From Home Care coverage, and if you are then in this program, your Away From Home Care coverage will also be terminated.

The Host HMO will pay the provider the lowest available rate on a fee-for-service basis for Covered Services and then bill the Home HMO for reimbursement. As a Guest Member, you will be required to pay any applicable Copayments and deductibles to the provider in the Host Plan's service area at the time of Service.

Guest Application

In order to enroll as a Guest Member, you must complete an AFHC Guest Application with the Home HMO, and then work with the Host HMO to locate a Primary Care Physician (PCP) in the Host Plan's service area. The Guest AFHC Application form is used to verify the Guest Member's eligibility and to provide the appropriate information for billing and reimbursement.

Guest Membership Types

The types of Guest Memberships are based on eligibility and the length of time that the covered individual will be out of the Home HMO Service Area. The 3 types of Guest Memberships are as follows:

Long-Term Traveler

The Long-Term Traveler Guest Membership is available to qualified Covered persons, including covered spouses or other dependents that are away from home for at least 90 consecutive days (3 months) but not more than 180 days (6 months).

This Long-Term Traveler Guest Membership is typically used for long-term work assignments or for a retiree with a dual residence. Home HMOs may limit the number of Long-Term Traveler Guest Memberships to 2 per year.

Families Apart

The Families Apart Guest Membership is available to qualified covered spouses or other dependents that do not reside in the Home HMO service area for 90 or more consecutive days. As a Covered Employee you are not eligible for this type of Guest Membership.

To qualify for a Families Apart Guest Membership, the covered spouse or other dependent must not be residing with the Covered Employee and must be residing in the service area of another participating HMO.

There is no administrative time limit on the length of a Families Apart Guest Membership.

Student

The Student Guest Membership is available to qualified Covered Dependents of the Covered Plan Participant who are out of the Home HMO area for 90 or more consecutive days attending school.

To qualify for a Student Guest Membership, the Covered Dependent must not be residing with

the Covered Plan Participant and must be residing in the service area of another participating HMO.

The Student Guest Membership is typically used for students during the period while they are away at school. The student membership should terminate when the student returns to the Home HMO Service Area for the summer. There is no administrative time limit on the length of a Student Guest Membership.

Student Guest Members that seek care in a third HMO service area (out of the Home HMO area and out of the Host HMO area) should be referred back to HOI, the Home HMO. You can be under only one Guest Membership at a time.

Guest Membership Policies

Guest Membership Effective Date Notification Period

Host HMOs require adequate time to process and set-up Guest Memberships prior to the effective date. A 15-day notification period is required for Host HMOs to complete the processing and set-up of the Guest Membership.

Guest Membership Renewals

A Guest Membership renewal occurs when an existing Guest Member re-applies for a separate, consecutive Guest Membership period that begins after the current membership expires. The 15-day notification period also applies to Guest Membership renewals. It is the responsibility of Guest Members to monitor the termination dates of current Guest Memberships to allow sufficient time for renewal application processing.

A Guest Membership Renewal must meet all of the requirements for an initial Guest Membership, including the 90-day out-of-area requirement. Renewals must be for a minimum of 90 or more consecutive days in length. A renewal requires that the Home HMO Guest

Membership Coordinator re-verify eligibility, submit a new Guest Application form, obtain a new signature sticker and pay a new set-up and renewal fee.

Renewals typically apply to Families Apart and Student Guest Memberships that commonly renew on an annual basis. A Long Term Traveler Guest Membership can also renew but the Member would need to re-qualify by being out-of-area for a minimum of 90 consecutive days from the date of the requested renewal, as well as meeting all other Home HMO eligibility requirements. The Member is not required to return to the Home HMO service area to qualify for a renewal.

Section 4: What is Covered?

Introduction

This section describes the Health Care Services that are Covered Services under this Benefit Booklet. In determining whether a Health Care Service is a Covered Service, the criteria listed below will be applied.

Expenses for the Health Care Services described in this section are subject to the following and will be covered under this Booklet only if the Services are:

1. within the Service categories in this “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 Benefit Booklet and for which an itemized statement or description of the procedure or Service which was rendered is received by HOI, including any applicable procedure code, diagnosis code and other information required by HOI in order to process a claim for the Service;
3. Medically Necessary, as defined in this Booklet and determined by HOI or Lake County Board of County Commissioners in accordance with HOI’s Medical Necessity coverage criteria then in effect, except as specified in this section;
4. rendered while coverage is in force;
5. not specifically or generally limited or excluded; and
6. received in accordance with the Coverage Access Rules (e.g., receipt of services from your Primary Care Physician (PCP) or Contracting Specialist, or other Contracting Providers except in an emergency or when approved by HOI). See the “Coverage Access Rules” section.

All benefits for Covered Services are subject to any applicable Deductible, Coinsurance and/or Copayment amounts and benefit maximums listed on your Schedule of Copayments or Schedule of Benefits.

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.

Benefit Guidelines

In addition to the above, payment for a Service is subject to all of the other provisions of this Benefit Booklet and any Endorsements hereto.

Payment for a Service includes payment for 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.

In determining whether Health Care Services are Covered Services, no written or verbal representation by any employee or agent of HOI or Lake County Board of County Commissioners, or by any other person, shall waive or otherwise modify the terms of this Booklet and, therefore, neither you, nor any health care provider or other person should rely on any such written or verbal representation.

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.

Ambulance Services

1. All Ambulance or other transportation Services must be authorized by HOI in advance and ordered by your Primary Care Physician (PCP) or a Contracting Specialist.
2. Transportation by Ambulance to the nearest medical facility capable of providing required Emergency Services and Care to determine if an Emergency Medical Condition exists does not require authorization in advance.

Ambulatory Surgical Centers

Health Care Services rendered at an Ambulatory Surgical Center 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.

Anesthesia Administration Services

Administration of anesthesia by a Physician or Certified Registered Nurse Anesthetist ("CRNA") may be covered.

Exclusion:

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

Autism Spectrum Disorder

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

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

Payment Guidelines for Autism Spectrum Disorder

The covered therapies provided in the treatment of Autism Spectrum Disorder outlined in paragraph three above will be applied to the Outpatient Therapies Benefit Period maximum set forth in the Schedule of Benefits. Autism Spectrum Disorder Services must be authorized in accordance with criteria established us **before**

such Services are rendered. Services performed without authorization will be denied. Authorization for coverage is not required when Covered Services are provided for the treatment of an Emergency Medical Condition.

Exclusion

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

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

Behavioral Health Services

Mental Health Services

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

Covered Services may include:

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

Exclusion

1. Services rendered for a Condition that is not a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;

2. Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or intellectual disability;
3. Services beyond the period necessary for evaluation and diagnosis of learning disabilities or intellectual disability;
4. Services for educational purposes;
5. Services for marriage counseling unless related to a Mental and Nervous Disorder as defined in this Booklet, regardless of the underlying cause, or effect, of the disorder;
6. Services for pre-marital counseling;
7. Services for court-ordered care or testing, or required as a condition of parole or probation;
8. Services to test aptitude, ability, intelligence or interest;
9. Services required to maintain employment;
10. Services for cognitive remediation; and
11. inpatient stays that are primarily intended as a change of environment.

Substance Dependency Treatment Services

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

Care and treatment for Substance Dependency includes the following:

1. Inpatient and outpatient Health Care Services rendered by a Physician, Psychologist or Mental Health Professional in a program accredited by The Joint

Commission or approved by the state of Florida for Detoxification or Substance Dependency.

2. Physician, Psychologist and Mental Health Professional outpatient visits for the care and treatment of Substance Dependency.

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

Exclusion:

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

Bereavement Counseling

Bereavement counseling is covered up to the benefit maximum set forth in the Schedule of Copayments.

Breast Reconstructive Surgery

Surgery to reestablish symmetry between two breasts and implanted prostheses, incident to Mastectomy following treatment for breast cancer may be covered. In order to be covered, such surgery must be in a manner chosen by your Primary Care Physician (PCP) or Contracting Specialist, consistent with prevailing medical standards, and in consultation with you. See also the Mastectomy Services category in this section.

Child Cleft Lip and Cleft Palate Treatment Services

Treatment and Services for Child Cleft Lip and Cleft Palate, including medical, dental, Speech Therapy, audiology, and nutrition Services for

the 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 Primary Care Physician (PCP), or a Contracting Specialist, must specifically: 1) prescribe such Services, and 2) certify, in writing, that the Services are Medically Necessary and consequent to treatment of the cleft lip or cleft palate.

Limitation:

Coverage of Speech Therapy for the treatment of cleft lip or cleft palate is limited to the number of Medically Necessary Services that are received by a Covered Dependent child within the consecutive 62-day period from the first date that the Covered Dependent child begins such Services while covered under this Booklet.

Child Health Supervision Services

Periodic Physician-delivered or Physician-supervised Services when provided to a Covered Dependent from the moment of birth up to the 17th birthday, are covered as follows:

1. Periodic examinations, which include a history, a physical examination, and a developmental assessment and anticipatory guidance necessary to monitor the normal growth and development of a child;
2. Oral and/or injectable immunizations; and
3. Laboratory tests normally performed for a well child.

Note: Preventive Services must be rendered by your assigned Primary Care Physician.

These Covered Services shall be provided in accordance with prevailing medical standards consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics, the U.S. Preventive Services Task Force, or the U.S. Advisory Committee on Immunization Practices established under the Public Health Services Act.

Dental

Dental care is limited to the following:

1. Care and treatment rendered within 62 days of an Accidental Dental Injury provided such Services are for the treatment of damage to sound natural teeth.
2. Anesthesia Services for dental care may be covered, 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 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.
3. Services for the extraction of impacted teeth only, at any location, including inpatient hospital services, surgery to remove the impacted teeth, associated x-rays and anesthesia.

Diabetes Treatment Services

Diabetes outpatient self-management training and educational Services and nutrition counseling (including all Medically Necessary equipment and supplies) to treat diabetes may

be covered, if your Primary Care Physician (PCP), or a Contracting Specialist who specializes in the treatment of diabetes, certifies that such Services are Medically Necessary.

In order to be covered, diabetes outpatient self-management training and educational Services must be provided under the direct supervision of a certified Diabetes Educator or a board-certified Physician specializing in endocrinology. Additionally, in order to be covered, nutrition counseling must be provided by a licensed Dietitian. Covered Services for the treatment of severe diabetic foot disease may also include the trimming of toenails, corns, calluses, and therapeutic shoes (including inserts and/or modifications).

Diagnostic Services

Diagnostic Services when ordered by a Primary Care Physician (PCP), or a Contracting Specialist, 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.

Dialysis Services

Dialysis Services including equipment, training, and medical supplies may be covered, when

provided at any location by a Contracting Provider licensed to perform dialysis, including a Dialysis Center, are covered.

Durable Medical Equipment

Durable Medical Equipment including diabetic equipment and supplies may be covered when prescribed by a Primary Care Physician (PCP), or a Contracting Specialist, and which has been authorized by HOI or Lake County Board of County Commissioners as a Covered Service. Diabetic equipment and supplies will not be subject to any Durable Medical Equipment Calendar Year maximum that may apply to your benefit plan. HOI and Lake County Board of County Commissioners reserve the right to rent or purchase the most cost-effective Durable Medical Equipment that meets your needs. Coverage for Durable Medical Equipment will be based on the lowest of the following: (1) the purchase price; (2) the lease/purchase price; or (3) the rental rate. Coverage for such rental equipment will not exceed the total purchase price. Services to repair medical equipment, which have been authorized by HOI or Lake County Board of County Commissioners, may be covered only if you own the equipment or are purchasing the equipment, or when necessitated due to growth of a Covered Dependent child or due to change in your Condition.

The wide variety of Durable Medical Equipment and continuing development of patient care equipment makes it impractical to provide a complete listing of covered Durable Medical Equipment, however, some Durable Medical Equipment has been specifically excluded.

Exclusion:

Equipment that is for convenience, comfort, and/or environmental control or equipment that has not been authorized by HOI is not covered. This exclusion includes, but is not limited to, modifications to motor vehicles and/or homes such as 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/cleaners/filters, humidifiers, water softeners and/or purifiers, pillows, mattresses or waterbeds, escalators, elevators, stair glides, emergency alert equipment, handrails and grab bars, heat appliances, dehumidifiers.

The replacement of Durable Medical Equipment solely because it is old or used is not covered. Also excluded is coverage for repair or replacement except when authorized by HOI or Lake County Board of County Commissioners.

Emergency Services and Care

IN THE EVENT OF AN EMERGENCY, GO TO THE NEAREST HOSPITAL OR CLOSEST EMERGENCY ROOM OR CALL 911.

Emergency Services and Care in or out of the Service Area shall be Covered Services without prior notification to HOI, subject to the Copayment amount set forth in the Schedule of Copayments. It is your responsibility, however, to notify HOI as soon as possible, concerning the receipt of Emergency Services and Care and/or any admission which results from an Emergency Medical Condition. If a determination is made that an Emergency Medical Condition does not exist, payment for Services rendered subsequent to that determination will be your responsibility.

Follow-up care must be rendered by a Primary Care Physician or a Contracting Specialist. If the follow-up care is provided by other than a Primary Care Physician or Contracting Specialist, coverage may be denied.

Payment for Emergency Services and Care rendered by Non-Contracting Providers will be the lesser of the provider's charges, the usual and customary provider charges for similar Services in the community where the Services were provided, or the charge mutually agreed to by HOI and the provider within 60 days of the submittal of the claim for such Emergency Services and Care. It is your responsibility to

furnish to HOI written proof of loss in accordance with the "Claims Processing" section.

Enteral Formulas

Prescription and non-prescription enteral formulas for home use which are prescribed by a Primary Care Physician (PCP) or Contracting Specialist as Medically 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 up to your 25th birthday includes food products modified to be low protein in an amount not to exceed \$2,500 annually.

Eye Care

Eye care including the following Services:

1. Physician Services, soft lenses or scleral 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 exercise or visual training; eye glasses and contact lenses and their fitting. 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) is also excluded.

Flu Shots

Flu shots for: 1) all Members age 50 and older; 2) women in the third trimester of pregnancy, if needed; or 3) any individual six months or older with high risk factors for contracting influenza

such as chronic illness (e.g., cardiovascular disease, pulmonary disease including asthma, diabetes mellitus, alcoholism, cirrhosis, cerebrospinal leaks and compromised immune systems).

Home Health Care

The Home Health Care Services listed below are covered when all of 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.
2. The Home Health Care Services rendered have been prescribed by a Primary Care Physician (PCP), or a Contracting Specialist, 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 to HOI.
3. The formal written treatment plan is approved in writing by HOI.
4. The Home Health Care Services are provided directly by (or indirectly through) a Home Health Agency within the Service Area. and
5. You are meeting or achieving the desired treatment goals set forth in the treatment plan as documented in the clinical progress notes.

Coverage for Home Health Care Services under this Benefit Booklet is 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., one visit per day of up to, but not exceeding, 2 hours) nursing care by a Registered Nurse, Licensed Practical Nurse and/or home health aide;

2. medical social Services;
3. nutritional guidance;
4. respiratory or inhalation therapy (e.g., oxygen); and
5. Physical Therapy by a Physical Therapist, Occupational Therapy by an Occupational Therapist, and Speech Therapy by a Speech Therapist.

Note: In order to be covered, home health aide Services must be consistent with the plan of treatment and rendered under the supervision of a Registered Nurse.

Exclusion:

1. homemaker or domestic maid Services;
2. sitter or companion Services;
3. Services rendered by an employee or operator of an adult congregate living facility; an adult foster home; an adult day care center, or a nursing home facility;
4. Speech Therapy provided for a diagnosis of developmental delay;
5. Custodial Care;
6. food, housing, and home delivered meals; and
7. Services rendered in a Hospital, nursing home, or intermediate care facility.

Hospice Services

Health Care Services provided in connection with a Hospice treatment program approved by HOI or Lake County Board of County Commissioners, may be Covered Services, provided the Hospice treatment program is approved by a Primary Care Physician (PCP), or

a Contracting Specialist. Your Physician may be required to certify your life expectancy in writing.

Exclusion:

Any Service provided in a Hospice that is not approved as part of the Hospice treatment program is excluded.

Hospital Services

Hospital Services provided at Contracting Hospitals when authorized by HOI. Such Services may 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 (except for take-home drugs) administered by the Hospital;
7. intravenous solutions;
8. administration of, including the cost of, whole blood or blood products;
9. dressings, including ordinary casts;
10. anesthetics and their administration;
11. transfusion supplies and equipment;
12. diagnostic Services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
13. chemotherapy treatment for proven malignant disease;
14. Physical Therapy, Speech Therapy, Occupational Therapy, and Cardiac Therapy (in connection with a covered Condition);
15. other Medically Necessary Services; and

16. transplants as described in the Transplant Services category in this section.

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. Inpatient Occupational Therapy, inpatient Speech Therapy, inpatient Physical Therapy, and inpatient 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.

Infertility Services

Infertility Services may be covered for a Member who meets the criteria established by HOI, including office visits, diagnosis, and diagnostic procedures to determine the cause of infertility.

Exclusion:

Infertility treatment Services and associated expenses and any outpatient prescription medications for In Vitro Fertilization (IVF); Gamete Intrafallopian Transfer (GIFT) procedures; Zygote Intrafallopian Transfer (ZIFT) procedures; embryo transport; surrogate parenting; donor semen and related costs

including collection and preparation; infertility treatment medications except when used for diagnostic purposes only, are excluded. Laboratory work and treatment of infertility limited to testing, Artificial Insemination, and surgical procedures to correct Conditions causing infertility are also excluded.

Inpatient Rehabilitation

Inpatient Rehabilitation Services may be covered subject to the maximum number of days indicated in the Schedule of Benefits when all of the following criteria are met:

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

Exclusion:

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

Mammograms

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

Mastectomy Services

Breast cancer treatment including treatment for physical complications for all stages of a Mastectomy (including lymphedemas), and outpatient post-surgical follow-up care in accordance with prevailing medical standards in a manner determined in consultation with you and the attending Physician are Covered Services. Outpatient post-surgical follow-up care for Mastectomy Services shall be covered when provided by a Contracting 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 Care

Health Care Services provided to a Member for pregnancy, delivery, miscarriage, and pregnancy complications, are covered, including the following:

1. routine office visits for prenatal and postnatal care;
2. delivery Services; and
3. postpartum care for the mother including the following: a postpartum assessment provided at the Hospital, the attending Physician's office, at a Birth Center, or in the home by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Midwife or

Certified Nurse Midwife. The postpartum assessment Services include:

- a) the physical assessment of the mother; and
- b) performance of clinical tests in keeping with prevailing medical standards.

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

Exclusion:

Prenatal care and delivery outside the Service Area, unless the need for such Services was not, and reasonably could not have been, anticipated before leaving the Service Area.

Note: For newborn child Health Care Services, please refer to the Newborn Child Care category in this section.

Newborn Child Care

Health Care Services provided to a newborn child of a Member are covered from the moment of birth, provided that the newborn child is properly enrolled, including the following:

1. Services for injury or sickness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, and premature birth;
2. postnatal care for the newborn including: a postnatal assessment provided at the Hospital, the attending Physician's office, at

a Birth Center, or in the home by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Midwife or Certified Nurse Midwife. The postnatal assessment Services include:

- a) the physical assessment of the newborn; and
 - b) performance of clinical tests and immunizations in keeping with prevailing medical standards.
3. Ambulance Services when necessary to transport the newborn child to and from the nearest appropriate facility which is appropriately staffed and equipped to treat the newborn child's Condition, as determined by HOI or Lake County Board of County Commissioners and certified by the Primary Care Physician (PCP) or a Contracting Specialist as Medically Necessary to protect the health and safety of the newborn child.

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

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

Orthotic Devices

Orthotic Devices designed and fitted by an Orthotist including braces and trusses for the

leg, arm, neck and back, and special surgical corsets are covered when authorized in advance by HOI and arranged by a Primary Care Physician (PCP) or a Contracting Specialist or HOI.

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 Condition, or when necessitated due to growth of a child.

Coverage for Orthotic Devices is based on the most cost-effective Orthotic Device that meets your medical needs as determined by HOI or Lake County Board of County Commissioners.

Exclusion:

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.

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;
4. individuals who have primary hyperparathyroidism; and
5. individuals who have a family history of osteoporosis.

Outpatient Rehabilitation Services

Outpatient rehabilitation Services are limited per Member per Condition to the number of Medically Necessary rehabilitation Services that you receive within the consecutive 62-day period which immediately follows the first date that you begin such Services. Outpatient rehabilitation Services are limited to the therapy categories listed below:

1. **Speech Therapy:**

Services of a Speech Therapist or licensed audiologist to aid in the restoration of speech loss or an impairment of speech resulting from illness, injury, stroke, or surgical procedure.

2. **Physical/Occupational Therapy:**

Services of a Physical Therapist or Occupational Therapist for the purpose of aiding in the restoration of normal physical function lost due to illness, injury, stroke or a surgical procedure.

3. **Cardiac Therapy:**

Services provided for cardiac rehabilitation for the purpose of aiding in the restoration of normal heart function lost due to illness, injury, stroke, or a surgical procedure.

Benefit Guidelines for Outpatient Rehabilitation Services

In order to be covered:

1. a Rehabilitation Plan submitted or authorized by your Primary Care Physician (PCP) or a Contracting Specialist must be reviewed, for coverage and payment purposes only, by HOI;
2. HOI must agree that your Condition is likely to improve significantly within 62 days from the first date such Services are to be rendered;

3. such Services must be provided to treat functional defects which remain after an illness or injury; and
4. such Services must be Medically Necessary for the treatment of a Condition.

Rehabilitation Plan means a written plan, describing the type, length, duration, and intensity of rehabilitation Services to be provided to you with rehabilitation potential. The Rehabilitation Plan is required and must be renewed periodically as requested by HOI. Such a plan must have realistic goals that are attainable by you within a reasonable length of time and must be likely to result in significant improvement within 62 days from the first date such Services are to be rendered.

Limitation:

Coverage is limited to a maximum of 62 consecutive days of treatment per Condition from the first date such treatment Services are rendered.

Exclusion:

Rehabilitation Services, including physical, speech, occupational and other rehabilitation therapies that meet one or more of the following are excluded:

1. Services or supplies provided to you as an inpatient in any Hospital, Skilled Nursing Facility, institution, or other facility, where the admission is primarily to provide rehabilitative Services;
2. Services that maintain rather than improve a level of physical function, or where it has been determined that the Services will not result in significant improvement in your Condition within a 62-day period;
3. Services for treatment of abuse of or addiction to alcohol and drugs; or
4. long-term rehabilitation Services (i.e., Services in excess of 62 days from the first date you begin such Services).

Oxygen

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

Physician Services

Health Care Services provided by a Physician may be covered.

Preventive Health Services

Periodic Physician-delivered or Physician-supervised preventive health Services for health maintenance and the prevention and detection of disease are covered. Except as noted below, payment for preventive health Services will only be made when rendered by your assigned Primary Care Physician (PCP). Preventive health Services include:

1. periodic health assessments;
2. instruction in personal health care measures;
3. routine immunizations and inoculations;
4. eye and ear screening examinations in the office of your assigned Primary Care Physician (PCP) to determine the need for vision and hearing correction;
5. family planning counseling and information on birth control, sex education, including prevention of venereal disease, Intrauterine devices (IUD) and fitting of diaphragms;
6. health education programs organized, sponsored, or offered by HOI or Lake County Board of County Commissioners, including nutrition education and counseling; instruction in personal health care and the appropriate use of Services; information regarding the coverage and benefits offered by Lake County Board of County Commissioners and the generally accepted medical standards for the use and frequency of each; and
7. one annual routine preventive gynecological examination per Calendar Year, provided by your Primary Care Physician (PCP) or a Contracting Specialist who is an obstetrician or gynecologist, including Medically Necessary covered follow-up care. The annual examination may include family planning counseling and information on birth control, sex education, including prevention of venereal disease, and fitting of diaphragms, a manual breast exam, a pelvic exam, and a pap smear.

Prosthetic Devices

The following Prosthetic Devices are covered when designed and fitted by a Prosthetist who is a Contracting Provider when authorized in advance by HOI or Lake County Board of County Commissioners and arranged by a Primary Care Physician (PCP) or a Contracting Specialist or HOI:

1. artificial hands, arms, feet, legs and eyes, including permanent implanted lenses following cataract surgery;
2. appliances needed to effectively use artificial limbs or corrective braces;
3. penile prostheses and surgery to insert a penile prosthesis when necessary in the treatment of organic impotence resulting from treatment of:
 - a) prostate cancer;
 - b) diabetes mellitus;
 - c) peripheral neuropathy;
 - d) medical endocrine causes of impotence;
 - e) arteriosclerosis/postoperative bilateral sympathectomy;
 - f) spinal cord injury;
 - g) pelvic-perineal injury;
 - h) post-prostatectomy;
 - i) post-priapism;

- j) epispadias; and
- k) exstrophy.

Covered Prosthetic Devices 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, except:

1. cardiac pacemakers;
2. prosthetic devices incident to Mastectomy; and
3. ventricular assist devices (see the Transplant Services category in this section).

Coverage for Prosthetic Devices is based on the most cost-effective Prosthetic Device that meets your medical needs as determined by HOI or Lake County Board of County Commissioners.

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.

Second Medical Opinion

If you elect to obtain a second medical opinion, you must notify your Primary Care Physician (PCP) or Contracting Specialist of your intent to do so prior to obtaining the second medical opinion. You may request and obtain a second medical opinion when you dispute the opinion of HOI, Lake County Board of County Commissioners, your Primary Care Physician (PCP) or a Contracting Specialist, regarding the reasonableness or necessity of a surgical procedure or you are subject to a serious injury or illness. You may request and obtain a second medical opinion if you feel that you are not responding to the current treatment plan in a satisfactory manner after a reasonable lapse of time for the Condition being treated. HOI or Lake County Board of County Commissioners may also require you to obtain such a second

medical opinion. In either case, you may select any licensed Physician who practices medicine within the Service Area to render the second medical opinion. **All tests in connection with rendering the second medical opinion, including tests deemed necessary by a Non-Contracting Provider, must be Medically Necessary and must be performed within the HOI network of Contracting Providers.**

Services rendered by a Contracting Provider related to a second medical opinion will be subject to the same Copayment requirement as set forth in the Schedule of Copayments or Schedule of Benefits. Services rendered by a Non-Contracting Provider for a second medical opinion are subject to a Copayment amount equal to 40% of the Allowance. Covered Plan Participants are responsible for the payment of any charges billed by a Non-Contracting Provider in excess of the Allowance.

Benefits, granted under this provision, may be denied in the event you seek in excess of three second medical opinions per Calendar Year if the second medical opinion costs are deemed by HOI to be evidence that you have unreasonably over-utilized the second medical opinion privileges. The decision of HOI, derived after review of the documentation from the second medical opinion that you obtained, will be controlling as to coverage obligations for the second medical opinion.

Skilled Nursing Facilities

The following Skilled Nursing Facility Services may be covered when: a) authorized in writing by a Primary Care Physician (PCP) or Contracting Specialist, and for which coverage is approved by HOI; and b) 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 a Primary Care Physician (PCP) or Contracting Specialist, may be required for determining 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 Covered Services at a Skilled Nursing Facility beyond the number of days per Member per Calendar Year set forth in the Schedule of Copayments or Schedule of Benefits are also excluded.

Spinal Manipulations

Non-surgical spine and back disorder treatments consisting of manipulations of the spine to correct a slight dislocation of a bone or joint that is demonstrated by x-ray are covered.

Surgical Assistant Services

Services rendered by a Physician, Registered Nurse First Assistant or Physician Assistant licensed to perform surgical first assisting Services, when acting as a surgical assistant (provided no intern, resident, or other staff physician is available), and 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. Medical review may be required to determine if the Service is Medically Necessary as defined herein; 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. (See the Second Medical Opinion category in this section).

Exclusion:

Reversal of voluntary, surgically induced sterility, including the reversal of tubal ligations and vasectomies.

Transplant Services

Transplants, as described below, may be covered when authorized by HOI or Lake County Board of County Commissioners and when performed at a facility acceptable to HOI or Lake County Board of County Commissioners, subject to the conditions and limitations listed below.

Transplant Services include Health Care Services related to the donation or acquisition of an organ or tissue for you once the donor has been identified and has agreed to donate the organ, pre-transplant, transplant and post-discharge Services and treatment of complications after transplantation in connection with the following transplants:

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 a donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;
2. corneal transplant;
3. heart transplant; (including a ventricular assist device, if indicated, when used as a bridge to heart transplant);
4. heart-lung combination transplant;
5. kidney transplant;
6. liver transplant;
7. lung-whole single or whole bilateral transplant;
8. pancreas transplant performed simultaneously with a kidney transplant; or
9. pancreas transplant alone or after a kidney transplant.

Note: Pre-transplant Services include ventricular assist devices for up to 30 days when used as a bridge during heart or heart-lung transplants.

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

Benefit Guidelines

For a transplant to be covered, written prior coverage authorization from HOI or Lake County Board of County Commissioners is required in advance of the procedure. You or your Physician must notify HOI prior to your initial evaluation for the transplant. HOI or Lake County Board of County Commissioners must be given the opportunity to evaluate the clinical results of your evaluation. Coverage authorization will be based on the terms of this Booklet as well as written criteria and procedures established by HOI, if any. If prior coverage authorization is not obtained, the transplant will not be covered.

Once a coverage authorization decision is made, you or your Physician will be notified of the coverage decision.

For covered transplants and all related complications, Hospital expenses and Physician expenses will be paid under the Hospital Services and Physician Services categories of this section in accordance with the same terms and conditions for care and treatment of any other covered Condition.

Exclusion:

No benefit is payable for, or in connection with, the following:

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

2. HOI and your Primary Care Physician (PCP) or Contracting Specialist are not contacted for authorization prior to referral for evaluation of the transplant;
3. HOI or Lake County Board of County Commissioners does not pre-authorize coverage for the transplant;
4. transplant procedures involving the transplantation or implantation of any non-human organ or tissue;
5. transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered under this Benefit Booklet;
6. transplant procedures involving the implant of an artificial organ (e.g., artificial heart), including the artificial organ;
7. any organ, tissue, marrow, or stem cells that are sold rather than donated;
8. 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 or any successor publication of the federal government;
9. any Service in connection with identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant;
10. 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 except as covered under the Lodging, Meals, and Transportation Covered Services in the Transplant Services Subsection; or

11. any artificial heart devices (if used as a bridge to transplant), except ventricular assist devices.

Lodging, Meals and Transportation

HOI will pay for reasonable and necessary lodging, meals and transportation expenses related to a covered transplant for an adult transplant recipient who is a Member and one companion or a child transplant recipient who is a Member and two adult companions.

Under this Endorsement, payment for lodging, meals and transportation will only be made if the site of the covered transplant is 50 miles or more away from the transplant recipient's home.

Benefit Maximum

This benefit is limited to a \$10,000 lifetime maximum.

Reimbursement

Expenses for lodging, meals and transportation related to a covered transplant will be reimbursed at 100% of charges up to the lifetime maximum set forth herein. In order to be reimbursed for expenses incurred for lodging, meals, and transportation related to a covered transplant, all receipts must be furnished to HOI within 90 days from the date the expenses were incurred in accordance with the Claims Processing Section of the Member Handbook.

Wigs

Wigs and/or cranial prosthesis are covered after chemotherapy.

Section 5: What is Not Covered?

Introduction

The following Health Care Services, supplies, drugs or charges are expressly excluded. The following exclusions are in addition to any exclusions specified in the “What is Covered?” section:

Abortion, by choice; not Medically Necessary.

Ambulance Services other than those specifically provided for in the “What is Covered?” section.

Arch supports shoe inserts designed to effect conformational changes in the foot or foot alignment, orthopedic shoes, 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.

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

Complementary and alternative healing methods 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, music or art therapy; 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, Swedish massage,

traditional Chinese massage, Trager therapy, trigger-point myotherapy, and biofield therapeutics; Reiki, SHEN therapy, and therapeutic touch; bioelectromagnetic applications in medicine; and herbal therapies.

Complications of non-Covered Services including the diagnosis or treatment of any Condition that arises as a complication of a non-Covered Service (e.g., Services to treat a complication of cosmetic surgery are not covered).

Contraceptive medications including contraceptive injectables, implants, devices; or appliances, except when dispensed for specific treatment of a Condition; or as indicated in the “What is Covered?” section of this Benefit Booklet.

Copayments whether or not the Copayment has been waived by the provider.

Cosmetic Services includes any Service to improve the appearance or self-perception of an individual (except as covered under the Breast Reconstructive Surgery category of the “What is Covered?” section), including without limitation: cosmetic surgery and procedures or supplies to correct hair loss or skin wrinkling (e.g., Minoxidil, Rogaine, Retin-A), and hair implants/transplants.

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

Custodial Care and any Service of a custodial nature, including 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 purpose of allowing a family member or caregiver of a Member to return to work.

Dental care care or treatment of the teeth or their supporting structures or gums, or dental procedures, including, but not limited to: extraction of teeth except as indicated in the “Dental” subsection of the *What Is Covered?* section, 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 any non-surgical Phase II treatment (as defined by the American Dental Association) for TMJ dysfunction including, but not limited to, orthodontic treatment. This exclusion does not apply to Accidental Dental Care, Child Cleft Lip and Cleft Palate Treatment Services described in the “What is Covered?” section.

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 that has been proven safe, effective and accepted for the treatment of the specific medical Condition for which the drug has been prescribed, as evidenced by the results of good quality controlled clinical studies published in at least two or more peer-reviewed full length articles in respected national professional medical journals. This exclusion also does not apply to any drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the drug is recognized for treatment of the your particular cancer in a Standard Reference Compendium, or is recommended for treatment of your particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.
2. All drugs dispensed to, or purchased by you from a pharmacy. This exclusion does not apply to drugs dispensed to you when:
 - a) you are an inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility or a Hospice facility;
 - b) you are in the outpatient department of a Hospital;
 - c) dispensed by a pharmacy under contract with HOI to provide injectable medications to you at home for self-administration, or to provide injectable 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.
3. Any non-prescription medicine, remedy, vaccine, biological product (except insulin), pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, or over-the-counter drugs, supplies, products, or health foods.
4. Any Drug which is indicated or used for sexual dysfunction (e.g., Cialis, Levitra, Viagra, Caverject). The exception described in exclusion number one above does not apply to sexual dysfunction Drugs excluded under this paragraph.

Exercise Devices or Training necessary to participate in sports, e.g. custom-made knee braces.

Experimental or Investigational Services except as otherwise covered under the Bone Marrow Transplant provision of the Transplant Services subsection of the “What is Covered?” section.

Family planning services other than those Services specifically described in the “What is Covered?” section.

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, and chronic foot strain, corns, or calluses, or trimming of toenails.

General Exclusions include, but are not limited to, the following:

1. Any Health Care Service not specifically listed in the “What is Covered?” section or in any Endorsement attached hereto, unless coverage for such Services is specifically required by applicable law;
2. If you do not follow the Coverage Access Rules set forth in this Benefit Booklet and required by HOI, any expenses for Health Care Services provided to, or received by you are excluded. For further information, please refer to the “Coverage Access Rules” section;
3. Any Health Care Service, which, in the opinion of HOI or Lake County Board of County Commissioners, was, or is, not Medically Necessary. The ordering of a Service by a health care provider, including and without limitation, a health care provider who is a Contracting Provider, other than as authorized by HOI or Lake County Board of County Commissioners, does not in itself make such Service Medically Necessary or a Covered Service;
4. Health Care Services rendered because they were ordered by a court, unless such Services are Covered Services;
5. Any Health Care Service received prior to the effective date of your coverage, or received on or after the date your coverage terminates under the Group Health Plan;
6. Any Health Care Service you render to yourself, or which are provided by a Physician or other health care provider related to you by blood or marriage;
7. 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;
8. Any Health Care Service rendered at no charge;
9. Elective care, routine care, or any care other than Medically Necessary emergency care, you require while outside of the Service Area;
10. Any Service to diagnose or treat any Condition resulting from or in connection with your job or employment; or
11. Any Health Care Services to diagnose or treat a Condition that, 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; or
 - d. Services received to treat a Condition arising out of your service in the armed forces, reserves and/or National Guard.

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 and devices (external or implantable, including cochlear implants) and Services related to the fitting or provision of hearing aids, including tinnitus maskers, maintenance agreements, repair or batteries.

Infertility Services including without limitation, treatment of infertility, which includes testing, infertility medications, Artificial Insemination (AI), and surgical procedures specifically related to

infertility (inpatient or outpatient), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), and In-vitro Fertilization and any services associated with these procedures, or any services associated with the donation or purchase of sperm. Laboratory work and treatment of infertility including testing, Artificial Insemination, and surgical procedures to correct Conditions causing infertility are also excluded.

Immunizations and physical examinations when required for travel, or when needed for school, employment, insurance, or governmental licensing, except immunizations necessary in the course of other medical treatments of an illness or injury or within the scope of, and coinciding with, periodic health assessments and/or state law requirements.

Maternity Services rendered to a Member 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-partum, and post-partum maternity/obstetrical care, and Health Care Services rendered to the Member acting as a Gestational Surrogate.

Military service-connected medical care received at military or government facilities.

Oral surgery for any reason, including oral surgery, the primary purpose of which is to improve the appearance or self-perception of an individual, except as provided under the "What is Covered?" section.

Orthomolecular therapy including nutrients, vitamins, and food supplements.

Orthotic 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.

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 and purifiers/cleaners/filters, furnaces, water purification systems, water softeners, humidifiers, dehumidifiers, vacuum cleaners or any other similar equipment and devices for environmental control or to enhance an environmental setting;
10. hot tubs, Jacuzzis, whirlpools, 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 Booklet.

Private duty nursing care in an inpatient basis.

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?". Rehabilitative Therapies provided for the purpose of maintaining rather than improving your Condition are also excluded.

Remedial reading recreational or activity therapy, all forms of special education and supplies or equipment used in conjunction with such activity.

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

Services of a covered provider that are not patient specific. Such non-patient-specific services include, but are 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, testing equipment, or laboratory technicians.

Sexual reassignment, or modification Services including but not limited to any Health Care Service related to such treatment, including 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 and transdermal patches).

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, including programs primarily for pain management, or vocational rehabilitation programs to improve grades, test scores or educational performance. This exclusion does not apply to Diabetes Outpatient Self Management.

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

Transportation services that are non-emergency transportation between institutional care facilities, or to and from your temporary or permanent residence.

Volunteer Services or Services which would normally be provided free of charge or Services of a person who ordinarily resides in the home of the terminally ill Member, or is a member of your family, or of your spouse's family, and any charges associated with Copayment 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 a Covered Plan Participant's ability to assimilate food.

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

Wigs and/or cranial prosthesis except as indicated in the "Wigs" subsection of the *What Is Covered?* section.

Section 6: Medical Necessity

Except for any preventive care benefits (and certain home health aide Services) specifically described in the “What is Covered?” section, in order for Health Care Services to be covered under this Booklet, such Services must be Medically Necessary, as defined by this Benefit Booklet, and meet all of the requirements for a Covered Service.

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

All decisions that require or pertain to independent professional medical/clinical judgment or training, or the need for medical Services, are solely your responsibility and that of your treating Physicians and health care providers. You and your Physicians are responsible for deciding what Health Care Services should be rendered or received and when that care should be provided. Lake County Board of County Commissioners retains full and final discretionary authority for determining whether expenses incurred for

Health Care Services are covered under your Group Health Plan. In making coverage decisions, neither HOI nor Lake County Board of County Commissioners 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 in this Benefit Booklet) or a Covered Service. Please refer to the “Definitions” section for the definitions of “Medically Necessary” or “Medical Necessity”.

Section 7: 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 Copayments or Schedule of Benefits to determine your share of the cost with regard to Covered Services.

Copayments

You are obligated to pay the Copayment amounts set forth in the Schedule of Copayments or Schedule of Benefits for Covered Services you receive. You are also responsible for the payment of all Copayments for Covered Services with respect to every individual enrolled as your Covered Dependent. All such payment obligations are due and payable as they are incurred, and must be paid directly to the health care provider.

Note: You are not required to pay a Copayment for a covered newborn's initial Hospital stay following birth if the newborn child is discharged along with the mother.

Non-Covered Services

You are responsible for the payment of all expenses for Health Care Services that are not covered, and for the payment of charges in excess of any maximum benefit limitations set forth in the Schedule of Copayments or Schedule of Benefits.

You are responsible for payment of expenses for claims denied because HOI did not receive information requested from you regarding whether or not you have other coverage and the details of such coverage.

Contributions

The Covered Plan Participant is responsible for any contribution amount required by Lake County Board of County Commissioners.

Calendar Year Out-of-Pocket Maximum

After the applicable out-of-pocket maximum amounts listed on your Schedule of Copayments or Schedule of Benefits are met, Covered Services received by you, or your covered family members, will not be subject to a Copayment and/or Coinsurance, if applicable, for the remainder of the Calendar Year. Coinsurance amounts, if applicable, will be automatically applied to your out-of-pocket maximum, however, it is your responsibility to submit a receipt to HOI for each Copayment you pay after the individual or family Copayment limit has been reached. When HOI receives the appropriate documentation, you will be reimbursed for each Copayment you have paid.

Note: The Copayments and any applicable Calendar Year Deductible and/or Coinsurance amounts will accumulate towards the Calendar Year out-of-pocket maximums. Any non-covered charges will not accumulate towards the out-of-pocket Calendar Year maximums.

How Calendar Year Out-of-Pocket Maximums will be Credited

Only amounts actually paid for Covered Services will be credited towards any applicable Calendar Year out-of-pocket maximums. The amounts paid which are credited towards your Calendar Year out-of-pocket maximums will be based on the Allowance for the Covered Services provided.

Section 8: BlueCard® (Out-of-State) Program

Out-of-Area Services

We have a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates (“Licensees”) referred to generally as “Inter-Plan Programs”. Whenever you obtain Health Care Services outside of our Service Area, the claims for these Services may be processed through one of these Inter-Plan Programs.

Typically, when accessing care outside our Service Area and the service area of Blue Cross and Blue Shield of Florida, Inc. (“BCBSF”), you will obtain care from health care Providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from non-participating health care Providers. Our payment practices in both instances are described below.

Your plan covers only limited Health Care Services received outside of our service area. As used in this section, “Out-of-Area Covered Health Care Services” include Emergency Services for treatment of an Emergency Medical Condition obtained outside the geographic area we serve. Any other Services will not be covered when processed through any Inter-Plan Programs arrangements. These “other Services” must be provided or authorized by your Primary Care Physician (“PCP”).

BlueCard Program

Under the BlueCard Program, when you obtain Out-of-Area Covered Health Care Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However the Host Blue is responsible for contracting with and generally

handling all interactions with its participating health care Providers.

The BlueCard Program enables you to obtain Out-of-Area Covered Health Care Services, as defined above, from a health care Provider participating with a Host Blue, where available. The participating health care Provider will automatically file a claim for the Out-of-Area Covered Health Care Services provided to you, so there are no claim forms for you to fill out. You will be responsible for your Cost Share amount, as stated in your Schedule of Benefits.

Emergency Services: If you experience a medical emergency while traveling outside the Service Area, go to the nearest emergency or urgent care facility.

Whenever you access Covered Services outside our Service Area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar Copayment, is calculated based on the lower of:

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

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above.

However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

Out-of-Network Providers Outside Our Service Area

Your Liability Calculation

When Covered Services are received from Out-of-Network Providers, our payment will be based on the Allowed Amount, as defined in the DEFINITIONS section.

Section 9: Eligibility for Coverage

Each employee or other individual who meets and continues to meet the eligibility requirements described in this Booklet will be entitled to apply for coverage under this Booklet. 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 Lake County Board of County Commissioners.

Acceptable documentation may be required as proof that an individual meets and continues to meet the eligibility requirements such as a court order naming the Covered Plan Participant as the legal guardian or appropriate “adoption” documentation described in the “Enrollment and Effective Date of Coverage” section.

Eligibility Requirements for Covered Plan Participants

In order to be eligible to enroll as a Covered Plan Participant, 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 Lake County Board of County Commissioners;
2. The employee's job must fall within the job classifications designated by Lake County Board of County Commissioners;
3. The employee must maintain his/her primary residence in the Service Area or be regularly employed in the Service Area;
4. The employee must have completed any applicable Waiting Period established by Lake County Board of County Commissioners; and
5. The employee must meet any additional eligibility requirements established by Lake County Board of County Commissioners.

The Covered Plan Participant eligibility classification may be expanded to include:

1. retired employees;
2. additional job classifications;
3. employees of affiliated or subsidiary companies of Lake County Board of County Commissioners; and
4. other individuals as determined by Lake County Board of County Commissioners (e.g., members of associations or labor unions).

Any expansion of the Covered Plan Participant eligibility class must be approved in writing by Lake County Board of County Commissioners prior to such expansion.

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 Benefit Book:

1. The Covered Plan Participant's spouse under a legally valid existing marriage.
2. The Covered Plan Participant's natural, newborn, adopted, Foster, or step child(ren) (or a child for whom the Covered Plan Participant has been court-appointed as legal guardian or legal custodian) who is maintaining his or her primary residence in the Service Area and has not reached the end of the Calendar Year in which he or she reaches age 26 (or in the case of a Foster Child, is no longer eligible under the Foster Child Program), regardless of the dependent child's student or marital status, financial dependency on the covered parent, whether the dependent child resides with the covered parent if the dependent child is not eligible for coverage through his or her own employer.

3. The newborn child of a Covered Dependent child who has not reached the end of the Calendar Year in which he or she becomes 26. The newborn child is eligible for coverage if enrolled at birth. Coverage will automatically terminate at 18 months of age.

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

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

Extension of Eligibility for Dependent Children

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

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

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

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 Plan Participant 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.

Exception for Students on Medical Leave of Absence from School

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

Other Provisions Regarding Eligibility

1. No individual whose coverage has been terminated for cause (see the Termination of Individual Coverage for Cause subsection) shall be eligible to re-enroll with HOI.
2. No Eligible Employee or Eligible Dependent who meets the eligibility requirements described in this section will be refused enrollment or re-enrollment in HOI because of race, color, creed, marital status, sex, or age.
3. The Covered Plan Participant must notify HOI and Lake County Board of County Commissioners as soon as possible when a

Covered Dependent is no longer eligible for coverage. If a Covered Dependent fails to continue to meet each of the eligibility requirements, and proper notification is not received by HOI and Lake County Board of County Commissioners in a timely manner from the Covered Plan Participant, the coverage of such Covered Dependent will be retroactively terminated to the date any such eligibility requirement was not met. Upon request, the Covered Plan Participant shall provide proof of a Covered Dependent's continuing eligibility for coverage, which is acceptable to Lake County Board of County Commissioners.

4. If Lake County Board of County Commissioners offers an alternative health benefit plan for Medicare eligibles or retirees, and you elect to be covered under such plan, then you are not eligible for coverage under this Benefit Booklet.

Section 10: Enrollment and Effective Date of Coverage

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

Any Eligible Employee or Eligible Dependent who is not properly enrolled will not be covered under this Benefit Booklet. Neither HOI nor Lake County Board of County Commissioners shall have any obligation whatsoever to any individual who is not properly enrolled.

Enrollment Forms/Electing Coverage

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

1. complete and submit the Enrollment Forms, through Lake County Board of County Commissioners;
2. provide, at the request of HOI or Lake County Board of County Commissioners, any additional information needed to determine eligibility;
3. pay any required contribution; and
4. complete and submit, through Lake County Board of County Commissioners, the Enrollment Forms to add Eligible Dependents or delete Covered Dependents.

When making application for coverage, you as the Eligible Employee must elect one of the types of coverage available under Lake County Board of County Commissioners' program.

Such types may include:

1. Employee Only Coverage: Provides coverage for the Eligible Employee only.
2. Employee/Family Coverage: Provides coverage for the Eligible Employee, spouse and the employee's Eligible Dependents.

There may be additional contribution amounts for each Covered Dependent based on the

coverage selected by Lake County Board of County Commissioners.

Enrollment Periods

The enrollment periods for applying for coverage are as follows:

Initial Enrollment Period is the 30-day period of time during which an Eligible Employee or Eligible Dependent is first eligible to enroll. It starts on the Eligible Employee's or Eligible Dependent's initial date of eligibility and ends no less than 30 days later.

Annual Open Enrollment Period is the period of time during which each Eligible Employee is given an opportunity to select coverage from among the alternatives included in Lake County Board of County Commissioners' health benefit program. The period is established by HOI or Lake County Board of County Commissioners, occurs annually and will take place prior to the Anniversary Date.

Special Enrollment Period is the 30-day period 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" subsection.

Employee Enrollment

1. An Eligible Employee must submit completed Enrollment Forms to enroll during the Initial Enrollment Period in order to become covered as of Lake County Board of County Commissioners' Effective Date.
2. An individual who becomes an Eligible Employee after Lake County Board of County Commissioners' Effective Date (for example, newly-hired employees) must submit completed Enrollments Forms to enroll before or within his or her Initial Enrollment Period.

Dependent Enrollment

1. Eligible Dependents may be enrolled at the same time the Eligible Employee enrolls. The Eligible Employee must submit completed Enrollment Forms to enroll during the Initial Enrollment Period in order to become covered as of Lake County Board of County Commissioners' Effective Date.
2. For an individual who becomes an Eligible Dependent after Lake County Board of County Commissioners' Effective Date, the Covered Plan Participant must submit completed Enrollments Forms to enroll Eligible Dependents before or within their Initial Enrollment Period.

Described below are special rules for certain Eligible Dependents.

1. Newborn Child:

To enroll a newborn child who is an Eligible Dependent, the Covered Plan Participant must submit Enrollment Forms during the 30-day period immediately following the date of birth. The Effective Date of coverage for a newborn child will be the date of birth. HOI must be notified, in writing, within 30 days after the birth.

If HOI is not notified within 30 days of the date of birth, the child will be added as of the date of birth so long as the Covered Plan Participant provides notice to Lake County Board of County Commissioners, and an Enrollment Form is received by HOI within 60 days of the birth. If HOI is not notified within 60 days of the date of birth, you must make application during an Annual Open Enrollment Period in order for the adopted newborn child to be covered.

Note: For a Covered Dependent child who has reached the end of the Calendar Year in which he or she becomes 26 if the Covered Dependent child obtains a dependent of their own (e.g., through birth or adoption),

such newborn child will not be eligible for this coverage and cannot enroll. Further, such Covered Dependent child will also lose his or her eligibility for this coverage.

2. Adopted Newborn Child:

To enroll an adopted newborn child, the Covered Plan Participant must submit Enrollment Forms during the 30-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 agreement is enforceable.

The Covered Plan Participant may be required to provide any information and/or documents, which are deemed necessary in order to administer this provision.

If HOI is not notified within 30 days of the date of birth, the child will be added as of the date of birth so long as the Covered Plan Participant provides notice to Lake County Board of County Commissioners, and an Enrollment Form is received by HOI within 60 days of the birth. If HOI is not notified within 60 days of the date of birth, you must make application during an Annual Open Enrollment Period in order for the adopted newborn child to be covered.

If the adopted newborn child is not ultimately placed in your residence, there shall be no coverage for the adopted newborn child. It is your responsibility to notify Lake County Board of County Commissioners within ten calendar days of the date that placement was to occur if the adopted newborn child is not placed in your residence.

3. Adopted/Foster Children:

To enroll an adopted child or Foster Child, the Covered Plan Participant must submit Enrollment Forms during the 30-day period

immediately following the date of placement. The Effective Date for an adopted or Foster child (other than an adopted newborn child) will be the date such adopted or Foster child is placed in the residence of the Covered Plan Participant in compliance with Florida law. The Covered Plan Participant may be required to provide any information and/or documents deemed necessary in order to properly administer this provision.

If HOI is not notified within 30 days of the date of placement, the child will be added as of the date of placement so long as you provide notice to Lake County Board of County Commissioners, and HOI receives the Enrollment Forms within 60 days of the placement. If HOI is not notified within 60 days of the date of placement, the Covered Plan Participant must make application during an Annual Open Enrollment Period in order for the adopted or Foster child to be covered.

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 HOI through Lake County Board of County Commissioners. It is your responsibility to notify HOI through Lake County Board of County Commissioners if the adoption does not take place. Upon receipt of this notification, HOI will terminate the coverage of the child as of the Effective Date of the adopted child.

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

child's coverage will be terminated on the date provided by the Group on the first billing date following receipt of the written notice.

4. Marital Status:

A Covered Plan Participant may apply for coverage of an Eligible Dependent due to a legally valid existing marriage. To apply for coverage, the Covered Plan Participant must submit completed Enrollment Forms. The Covered Plan Participant must make application for enrollment within 30 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.

5. Court Order:

If a court has ordered coverage to be provided for a minor child under the Covered Plan Participant's plan, a Covered Plan Participant may apply for coverage for an Eligible Dependent outside of the Initial Enrollment Period and Annual Open Enrollment Period. To apply for coverage, you must submit completed Enrollment Forms. The Covered Plan Participant must make application for enrollment within 30 days of the court order. The Effective Date of coverage for an Eligible Covered Dependent who is enrolled as a result of a court order is the date required by the court order.

Annual Open Enrollment

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 submitting complete and accurate Enrollment Forms during the Annual Open Enrollment Period.

The Effective Date of Coverage for an Eligible Employee and any Eligible Dependent(s) will be the first billing date following the Annual Open Enrollment Period.

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" subsection.

Special Enrollment

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 and forward it to Lake County Board of County Commissioners 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 is submitted to Lake County Board of County Commissioners 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;

- 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 (not recognized in the state of Florida) or employer contributions toward such coverage was terminated; and
- c) you submit the applicable Enrollment Form to Lake County Board of County Commissioners within 30 days of the date your coverage was terminated.

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

or

2. If when offered coverage under this plan at the time of initial eligibility, 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 to Lake County Board of County Commissioners within 30 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 to Lake County Board of County Commissioners 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

1. Rehired Employees:

Individuals who are rehired as employees of Lake County Board of County Commissioners are considered newly hired employees for purposes of this section. The provisions of the Group Health Plan which are applicable to newly hired employees and their Eligible Dependents (e.g., enrollment, Effective Dates of coverage and Waiting Period) are applicable to rehired employees and their Eligible Dependents.

2. Adding or Deleting Dependents:

You are responsible for adding and deleting dependents by notifying Lake County Board of County Commissioners in accordance with all requirements and on a timely basis. Lake County Board of County Commissioners is responsible to notify HOI of the addition of, or the deletion of, employees or dependents. HOI is not responsible for providing coverage for any individual who should not have been added or who should have been deleted.

Section 11: Termination of Coverage

Termination of a Covered Plan Participant's Coverage

A Covered Plan Participant's coverage will automatically terminate under this Benefit Booklet at 12:01 a.m. on the date that:

1. the Covered Plan Participant becomes covered under an alternative health benefit plan which is offered through or in connection with Lake County Board of County Commissioners;
2. the ASA between HOI and Lake County Board of County Commissioners terminates;
3. the Covered Plan Participant otherwise fails to continue to meet each of the eligibility requirements; or
4. the Covered Plan Participant's coverage is terminated for cause (see the "Termination of Individual Coverage for Cause" subsection).

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. 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;
4. last day of the Calendar Year 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).

Termination of Individual Coverage for Cause

1. Lake County Board of County Commissioners may terminate your coverage for cause if:
 - a) you are, or exhibit, disruptive, unruly, abusive, unlawful, fraudulent or uncooperative behavior to the extent that your continued coverage impairs Lake County Board of County Commissioners' ability to provide coverage and/or benefits under the Group Health Plan, or impairs HOI's ability to arrange for the delivery of Health Care Services to you or to other covered individuals. Prior to disenrolling you for any of the above reasons, HOI, if requested by Lake County Board of County Commissioners, may:
 - i. make a reasonable effort to resolve the problem presented by the individual, including the use or attempted use of the Complaint and Grievance Process (refer to the "Complaint and Grievance Process" section of this Booklet);
 - ii. determine, to the extent possible, that your behavior is not related to the use of medical Services or mental illness; and
 - iii. document the problems encountered, efforts made to resolve the problems, and any of your medical Conditions involved.
 - b) you make a knowing misrepresentation, omission, or give false information on Enrollment Forms, or other forms completed, by or on your behalf;
 - c) you make a fraudulent statement, or make a material misrepresentation, or

omission in enrolling for coverage, or in requesting the receipt of Covered Services;

- d) you misuse your Membership Card;
 - e) you no longer reside or work in the Service Area; or
 - f) you are a Covered Dependent and you reach the limiting age as specified in the "Eligibility for Coverage" and "Enrollment and Effective Date of Coverage" sections.
2. Any termination made under the provisions stated above is subject to review in accordance with the Complaint and Grievance Process described in this Booklet.

Notice of Member Termination

It is Lake County Board of County Commissioners' 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 Group Health Plan established by Lake County Board of County Commissioners. 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 call the customer service phone number indicated on this Booklet or on your Membership 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).

Rescission of Coverage

HOI reserves the right to Rescind the coverage under this Group Plan for any individual covered under this Group Plan as permitted by law.

HOI may only Rescind the coverage of a Member under this Group Plan if:

1. the Member, or another person on the Member's behalf commits fraud, intentional misrepresentation of material fact or omission in applying for coverage or benefits; or
2. The Member or another person on the Member's behalf knowingly misrepresents, omits or gives false information to HOI for the purpose of obtaining coverage under this Group Plan.

HOI will provide at least 45 days advance written notice of its intent to Rescind Membership.

Rescission of coverage is considered an Adverse Benefit Determination and is subject to the Adverse Benefit Determination review procedure described in the "Complaint and Grievance Process" section of this Benefit Booklet.

Section 12: Continuing Coverage Under COBRA

A federal continuation of coverage law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, also known as Section 4980B of the Internal Revenue Code of 1986, may apply to Lake County Board of County Commissioners. If COBRA applies to the Group Health Plan established by Lake County Board of County Commissioners, 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 Lake County Board of County Commissioners to determine if you or your Covered Dependent is entitled to COBRA continuation of coverage. Lake County Board of County Commissioners is solely responsible for meeting all of the obligations under COBRA, including the obligation to notify all Members of their rights under COBRA. If you fail to meet your obligations under COBRA and this Benefit Booklet, Lake County Board of County Commissioners will not be liable for any claims incurred by you or your Covered Dependent(s) after your 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 Lake County Board of County Commissioners and you are eligible for such coverage:

1. You may elect to continue your 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 your Covered Dependents 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 is 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. You must supply notice of the disability determination to Lake County Board of County Commissioners 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 (not recognized in the state of Florida) 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 Covered Dependent child may elect the 36-month extension if the Covered Dependent child ceases to be an Eligible Dependent under the terms of Lake County Board of County Commissioners' 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.

If you are eligible to continue group health insurance coverage pursuant to COBRA, the following conditions must be met:

1. Lake County Board of County Commissioners must notify you of your continuation of coverage rights under COBRA within 14 days of the event that creates the continuation option. If coverage would be lost due to Medicare entitlement, divorce, legal separation (not recognized in the state of Florida) or the failure of a Covered Dependent child to meet eligibility requirements, you or your Covered Dependent must notify Lake County Board of County Commissioners, in writing, within 60 days of any of these events. Lake County Board of County Commissioners' 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 Lake County Board of County Commissioners.
3. COBRA coverage will terminate if you become covered under any other group health plan. However, COBRA coverage may continue if the new group health 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 SSA that you are no longer disabled. You must inform Lake County Board of County Commissioners of the SSA 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, as described in the Group Health Plan.
7. COBRA coverage will terminate on the date Lake County Board of County Commissioners ceases to provide 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 Lake County Board of County Commissioners.

Section 13: The Effect of Medicare Coverage/Medicare Secondary Payer Provisions

When you become covered under Medicare and continue to be eligible and covered under this Benefit Booklet, coverage under this Benefit Booklet 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 Benefit Booklet will be secondary to any Medicare benefits. To the extent the Benefits under this Benefit Booklet are primary, claims for Covered Services should be filed with HOI first.

Under Medicare, Lake County Board of County Commissioners MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to you. Also, Lake County Board of County Commissioners MAY NOT induce you to decline or terminate your group health coverage and elect Medicare as primary payer.

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

Individuals with End Stage Renal Disease

If you are entitled to Medicare coverage because of ESRD, coverage under this Benefit Booklet 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 Benefit Booklet 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 Booklet, on a primary basis for 30 months.

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 Benefit Booklet provided that:

Lake County Board of County Commissioners employed at least 100 or more full-time or part-time employees. 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.

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 Benefit Booklet.
2. HOI will not be liable to Lake County Board of County Commissioners or to any individual covered under this Benefit Booklet due to any nonpayment of primary benefits resulting from any failure of performance of Lake County Board of County Commissioners' obligations as described in this section or in the Group Health Plan.

Section 14: 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 Benefit Booklet.

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 HOI and Lake County Board of County Commissioners 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 HOI and Lake County Board of County Commissioners 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 Personal Injury Protection ("PIP") insurance policy and/or

medical payment coverage with which the law permits us to coordinate 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 Group Health Plan is the primary payer. When primary, payment will be made for Covered Services without regard to coverage under other plans. When the Group Health Plan is not primary, payment for Covered Services may be reduced so that total benefits under all your plans will not exceed 100% of the total reasonable expenses actually incurred for Covered Services. For purposes of this section, if you receive Covered Services from a Contracting Provider, "total reasonable expenses", will mean the total amount required to be paid to the Contracting Provider pursuant to the applicable provider contract. **In the event that the primary payer's payment exceeds the maximum amount established by us, 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;
 - b) if both parents have the same birthday, excluding year of birth, and the other plan has covered one of the parents longer than HOI, 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 currently married, the plan of the parent with custody is primary;
 - b) if the parent with custody is currently married, the plan of the parent with custody is primary; the step-parent's plan is secondary; and the plan of the parent without custody pays last;
 - c) regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the plan of that parent is primary.
4. When 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 that 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 Covered Dependent;
 - b) second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's Covered 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.

Non-Duplication of Government Programs and Workers' Compensation

The benefits under this Booklet 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, TRICARE) or Workers' 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 15: Subrogation

Subrogation

In the event payment is made to you (or on your behalf) under this Benefit Booklet 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, Lake County Board of County Commissioners 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. HOI on behalf of Lake County Board of County Commissioners and/or the Group Health Plan, and Lake County Board of County Commissioners, shall have the right to subrogate out of any recovery or settlement you are able to obtain even if you are not made whole for his/her losses. HOI may recover, on behalf of Lake County Board of County Commissioners and/or the Group Health Plan, the amount of any payments made on your behalf minus HOI or Lake County Board of County Commissioners' pro rata share for any costs and attorney fees incurred by you in pursuing and recovering damages. HOI may subrogate, on behalf of Lake County Board of County Commissioners and/or the Group Health Plan, against all money recovered regardless of the source of the money including, but not limited to, uninsured motorists coverage. Although Lake County Board of County Commissioners may, but is not required to, take into consideration any special factors relating to your specific case in resolving the subrogation claim, Lake County Board of County Commissioners 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 believe 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 HOI, and shall do whatever is necessary to enable HOI to exercise Lake County Board of County Commissioners' subrogation rights and shall do nothing to prejudice such rights. Additionally, you or your legal representative shall promptly notify HOI in writing of any settlement negotiations prior to entering into any settlement agreement, shall disclose to HOI any amount recovered from any person or entity that may be liable, and shall not make any distributions of settlement or judgement proceeds without Lake County Board of County Commissioners' prior written consent. No waiver, release of liability, or other documents executed by you without such notice to HOI shall be binding upon Lake County Board of County Commissioners.

Section 16: Right of Reimbursement

If any payment under the Group Health 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, Lake County Board of County Commissioners 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.

Lake County Board of County Commissioners' and/or the Group Health Plan's right of reimbursement will be in addition to any subrogation right or claim available to Lake County Board of County Commissioners, 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 HOI on behalf of Lake County Board of County Commissioners, and/or the Group Health Plan, to exercise Lake County Board of County Commissioners' and/or the Group Health Plan's right of reimbursement hereunder. You or your lawyer must notify HOI, by certified or registered mail, if you intend to claim damages from someone for injuries or illness. You must do nothing to prejudice Lake County Board of County Commissioners' 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 HOI and HOI's written consent, acting on behalf of Lake County Board of County Commissioners, will be binding upon Lake County Board of County Commissioners.

Section 17: Claims Processing

Introduction

This section is intended to:

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

Under no circumstances will HOI be held responsible for, nor will HOI accept liability relating to, the failure of your Group Health Plan's sponsor or plan administrator to:

- 1) comply with disclosure requirements;
- 2) provide you with a Summary Plan Description (SPD); or
- 3) comply with any other legal requirements.

You should contact your plan sponsor or administrator if you have questions relating to your Group Health Plan's SPD. HOI is not your Group Health Plan's sponsor or plan administrator. In most cases, a plan's sponsor or plan administrator is the employer who establishes and maintains the plan.

Types of Claims

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

Post-Service Claims

How to File a Post-Service Claim

This section defines and describes the three types of claims that may be submitted to HOI. Experience shows that the most common type of claim HOI will receive from you or your treating providers will likely be Post-Service Claims.

Contracting Providers have agreed to file Post-Service Claims for Services rendered to you. If you receive a bill from a Contracting Provider, it should be forwarded to HOI. If you require Emergency Services and Care from a Non-Contracting Provider while inside or outside the Service Area or, if we refer you to a Non-Contracting Provider, Covered Services provided to you will be paid. If you receive a bill from a Non-Contracting Provider for such Services, it should be forwarded to HOI. HOI relies on the information you provide when processing a claim.

HOI 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 HOI does not receive it at the address indicated on the Membership Card within one year of the date the Service was rendered, unless you are legally incapacitated.

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

1. the date the Service was provided;
2. a description of the Service including any applicable procedure code(s);
3. the amount actually charged by the provider;

4. the diagnosis including any applicable diagnosis code(s);
5. the provider's name and address;
6. the name of the individual who received the Service; and
7. the Covered Plan Participant's name and contract number as they appear on the membership card.

Note: If Lake County Board of County Commissioners provides prescription drug coverage, please refer to the pharmacy program endorsement for information on the processing of prescription drug claims. Further, special claims processing rules may apply for Health Care Services you receive outside the state of Florida under the BlueCard® (Out-of-State) Program (See the "BlueCard® (Out-of-State) Program" section or the "Away From Home Care®" subsection).

The Processing of Post-Service Claims:

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

1. Payment for Post-Service Claims:

When payment is due under the terms of this Booklet, HOI will use its best efforts to pay (in whole or in part) for electronically submitted Post-Service Claims within 20 days of receipt. Likewise, HOI will use its 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 HOI is unable to determine whether the claim or a portion of the claim is payable because HOI needs additional information, HOI may contest or deny the claim within the timeframes set forth below.

2. Contested Post-Service Claims:

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

3. Denial of Post-Service Claims:

In the event HOI denies a Post-Service Claim submitted electronically, HOI will use its best efforts to provide notice, within 20 days of receipt that the claim or a portion of the claim is denied. In the event HOI denies a paper Post-Service Claim, HOI will use its best efforts to provide notice, within 30 days of receipt of the claim, that the claim or a portion of the claim is denied. The notice may identify the denied portion(s) of the claim and the reason(s) for denial. It is your

responsibility to ensure that HOI receives all information that HOI determines is necessary to adjudicate a Post-Service Claim. **If HOI does not receive the necessary information, the claim or a portion of the claim may be denied.**

A Post-Service Claim denial is an Adverse Benefit Determination and is subject to the Adverse Benefit Determination standards in this section, and the appeal procedures described in the “Complaint and Grievance Process” section.

4. Additional Processing Information for Post Service Claims:

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

Pre-Service Claims

How to file a Pre-Service Claim

This Booklet may condition coverage, benefits, or payment (in whole or in part) for a specific Covered Service, on the receipt by HOI of a Pre-Service Claim as that term is defined herein. In order to determine whether HOI must receive a Pre-Service Claim for a particular Covered Service, please refer to the “Coverage Access Rules” section, the “What is Covered?” section and other applicable sections of this Booklet.

You may also call the customer service number on the Membership Card for assistance.

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

Benefit Determinations on Pre-Service Claims Involving Urgent Care:

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

Benefit Determinations on Pre-Service Claims that do not Involve Urgent Care:

HOI will use its best efforts to provide notice of a decision of 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 HOI one time for up to an additional 15 days. If such an extension is necessary, HOI will use its best efforts to

provide notice of the extension and reasons for it. HOI will use its 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 HOI.

If additional information is necessary to make a determination, HOI will use its best efforts to:

- 1) provide notice of the need for additional information, prior to the expiration of the initial 15-day period;
- 2) identify the specific information that you or the provider may need to provide;
- and 3) inform you of the date that HOI reasonably expects to notify you of the decision.

If HOI requests additional information, HOI must receive it within 45 days of the request for the information. HOI will use its best efforts to provide notice of the decision on the 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 in this section, and the appeal procedures described in the "Complaint and Grievance Process" 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:

- HOI has approved, in writing, coverage or benefits for an ongoing course of Services to be provided over a period of time or a number of Services to be rendered;
- the reduction or termination occurs before the end of such previously approved time or number of Service(s); and
- the reduction or termination of coverage or benefits by HOI was not due to an

Endorsement to this Booklet or termination of your coverage as provided by this Booklet

HOI will use its 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 Complaint and Grievance Process described in this Booklet. In no event shall HOI be required to provide more than a reasonable period of time within which you may develop your appeal before HOI actually terminates or reduces 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, HOI will use its best efforts to notify you of the approval or denial of such requested extension within 24 hours after receipt of the request, provided it is received at least 24 hours prior to the expiration of the previously approved number or length of coverage for such Services. HOI will use its best efforts to notify you within 24 hours if:

- 1) HOI needs additional information; or
- 2) you or your representative failed to follow proper procedures in the request for an extension.

If HOI requests additional information, you will have 48 hours to provide the requested information. HOI may notify you orally or in writing, unless you or your representative specifically request that it be in writing. A denial of a request for an extension of Services is considered an Adverse Benefit Determination and is subject to the Complaint and Grievance Process described in this Booklet.

Standards for Adverse Benefit Determinations

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

HOI will use its best efforts to provide notice of any Adverse Benefit Determination in writing.

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

If the claim is a Claim Involving Urgent Care, HOI may notify the Member orally within the proper timeframes, provided HOI follows up with a written or electronic notification meeting the

requirements of this subsection no later than three days after the oral notification.

Additional Claims Processing Provisions

1. Release of Information/Cooperation:

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

2. Physical Examination:

In order to make coverage and benefit decisions, HOI may, at HOI's 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 HOI shall have no liability for such claim.

3. Legal Actions:

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

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

HOI relies on the information provided on the itemized statement when processing a claim. All such information, therefore, must be accurate, truthful and complete. Any

fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result, in addition to any other legal remedy we may have, in denial of the claim or cancellation or rescission of your coverage.

5. Communication of Claims Decisions:

All claims decisions, including denial and claims review decisions, will be communicated to you in writing. This written correspondence may indicate:

- a) The specific reason or reasons for the Adverse Benefit Determination;
- b) Reference to the specific Booklet provisions upon which the Adverse Benefit Determination is based as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;
- 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.

Section 18: Complaint and Grievance Process

HOI has established a process for reviewing Member Complaints and Grievances. The purpose of this process is to facilitate review of, among other things, the Member's dissatisfaction with HOI, HOI's administrative practices, coverage, benefit or payment decisions, or with the administrative practices and/or the quality of care provided by any independent Participating Provider. The Complaint and Grievance Process also permits the Member, or the Member's Physician, or a person acting on behalf of the Member, to expedite HOI's review of certain types of Grievances. The process described in this section must be followed if the Member has a Complaint or Grievance.

Informal Review - Complaints

HOI encourages the Member to first attempt informal resolution of any dissatisfaction by calling HOI. To advise HOI of a Complaint, the Member should first contact an HOI Customer Service Representative at the local HOI office, either by telephone or in person. The telephone number is listed on the Membership Card, and the address of the local office is listed in the Telephone Numbers and Addresses subsection. The Customer Service Representative, working with appropriate personnel, will review the Complaint within a reasonable time after its submission and attempt to resolve it to the Member's satisfaction. The Member must provide all of the facts relevant to the Complaint to the Customer Service Representative. The Member's failure to provide any requested or relevant information may delay HOI's review of the Complaint. Consequently, the Member is obliged to cooperate with HOI in its review of the matter.

If the Member remains dissatisfied with HOI's resolution of the Complaint, he or she may

submit a Grievance in accordance with the Formal Review subsection.

Formal Review - Grievances

A Member, a provider who has been directly involved in the Member's treatment or diagnosis acting on the Member's behalf, a state agency, or another person designated in writing by the Member, may submit a Grievance.

In order to begin the review process, the Member may complete a pre-printed form, write a letter or meet with HOI in person to explain the facts and circumstances relating to the Grievance. The Member should provide as much detail as possible and attach copies of any relevant documentation. The Member is not required to use HOI's preprinted form, however, HOI strongly urges the use of this form, as it was designed to help facilitate logging, identification, processing, and tracking of the Grievance through the review process.

If the Member needs assistance in preparing the Grievance, he or she may contact HOI for such assistance. Hearing impaired Members may contact HOI via TDD.

HOI's Review of Grievances involving Adverse Benefit Determination

A Grievance involving an Adverse Benefit Determination will be reviewed using the review process described below. The Grievance must be submitted to HOI in writing for an internal grievance within 365 days of the original Adverse Benefit Determination, except in the case of Concurrent Care Decisions which may, depending upon the circumstances, require the Member to file within a shorter period of time from notice of the denial. The following guidelines are applicable to reviews of Adverse Benefit Determinations:

1. Members must cooperate fully with HOI in its effort to promptly review and resolve a Complaint or Grievance. In the event the Member does not fully cooperate with HOI, he or she will be deemed to have waived his or her right to have the Complaint or Grievance processed within the time frames set forth in this section.
2. HOI will offer to meet with Members who believe that such a meeting will help HOI resolve the Complaint or Grievance to the Member's satisfaction, the Member may also initiate a request for such meeting by notifying HOI. The Member may elect to meet with HOI's representatives in person, by telephone conference call, or by video-conferencing (if facilities are available). HOI will not reimburse the Member for travel or lodging in connection with any such meeting. Appropriate arrangements will be made to allow telephone conferencing or video conferencing to be held at HOI's administrative offices within the Service Area. HOI will make these telephone or video arrangements with no additional charge to the Member.
3. The Member, or a provider or a person acting on his or her behalf, must specifically request an expedited review. Only the following Services that have yet to be rendered are subject to this Expedited Review process: (1) Pre-Service Claims; or (2) requests for extension of Concurrent Care Services made within 24 hours before the authorization for such Services expires. An expedited external review will not be accepted for an Adverse Benefit Determination on a Post-Service Claim.
4. Member's may request to review pertinent documents free of charge, such as any internal rule, guideline, protocol, or similar criterion relied upon to make the determination, and submit issues or comments in writing.
5. If the Adverse Benefit Determination is based on the lack of Medical Necessity of a particular Service or the Experimental or Investigational exclusion, the Member 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 the Contract to the Member's medical circumstances.
6. During the review process, the Services in question will be reviewed without regard to the decision reached in the initial determination.
7. HOI may consult with appropriate Physicians in the same or similar specialty as typically manages the Condition, procedure, or treatment under review, as necessary.
8. Any independent medical consultant who reviews the Adverse Benefit Determination on HOI's behalf will be identified upon request.
9. If the claim is a Claim Involving Urgent Care, the Member may request an expedited review orally or in writing in which case all necessary information on review may be transmitted between the Member and HOI by telephone, facsimile or other available expeditious method.
10. If the Member's request for expedited review arises out of a concurrent review determination by HOI that a continued hospitalization is not Medically Necessary, then coverage for the hospitalization will continue until the Member has been notified of the determination.
11. If Member's wish to give someone else permission to file a Grievance for an Adverse Benefit Determination on their behalf, HOI must receive a completed

Appointment of Representative form signed by the Member indicating the name of the person who will represent the Member with respect to the Grievance. An Appointment of Representative form is not required if the Physician is requesting review of an Adverse Benefit Determination relating to a Claim Involving Urgent Care. Appointment of Representative forms are available at www.FloridaBlue.com or by calling the customer service phone number on the Membership Card.

12. The Internal Review Panel will review the Grievance and may make a decision based on medical records, additional information, and input from healthcare professionals in the same or similar specialty as typically manages the Condition, procedure or treatment under review.
13. HOI will advise the Member of all Grievance decisions in writing, as outlined in the Timing of Our Grievance Review on Adverse Benefit Determinations sub-section.
14. HOI will provide written confirmation of its decision concerning a Claim Involving Urgent Care within two working days or three calendar days, whichever is less, after providing notification of that decision.
15. If the Member is not satisfied with HOI's decision, he or she may submit the Grievance to the Subscriber Assistance Program.

Timing of HOI's Grievance Review on Adverse Benefit Determinations

HOI will use its best efforts to review Grievances of Adverse Benefit Determinations and communicate the decision in accordance with the following time frames:

1. Pre-Service Claims: within 30 days of HOI's receipt of the Grievance;
2. Post-Service Claims: within 60 days of HOI's receipt of the Grievance; or

3. Claims Involving Urgent Care: (and requests to extend concurrent care Services made within 24 hours prior to the termination of the Services): within 72 hours of HOI's receipt of the request.

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.

Subscriber Assistance Program

The Member always has the right, at any time, to have a Complaint or a Grievance reviewed by the Florida Department of Financial Services, Office of Insurance Regulation or the Agency for Health Care Administration or the Subscriber Assistance Program. The Member may submit the Grievance to the Subscriber Assistance Program within 365 days of HOI's decision. Telephone numbers and addresses are listed in the Telephone Numbers and Address subsection. The Member must complete the entire Complaint and Grievance Process and receive a final disposition from HOI before pursuing review by the Subscriber Assistance Program.

The Member may contact an HOI Grievance Coordinator at the number listed on the Membership Card or the numbers listed below. If a Grievance is unresolved, the Member may, at any time, contact an agency at the telephone numbers and addresses listed below.

Department of Financial Services

Division of Consumer Services
200 East Gaines Street
Tallahassee, Florida 32399-0322
1-800-342-2762

HOI Office Location

Phone: (877) 352-2583
TTY- Florida Relay 711

Health Options, Inc.

Attention: Grievance Department
8400 NW 33rd Street, Suite 100
Miami, Florida 33122-193

Section 19: Relationships Between the Parties

HOI /Lake County Board of County Commissioners and Health Care Providers

Neither HOI nor Lake County Board of County Commissioners nor any of its officers, directors or employees provides Health Care Services to you. Rather, HOI and Lake County Board of County Commissioners are engaged in making coverage and benefit decisions under this Booklet. By accepting the health care coverage and benefits under this Benefit Booklet, 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 HOI and Lake County Board of County Commissioners. **In this regard, HOI and Lake County Board of County Commissioners hereby expressly disclaim any agency relationship, actual or implied, with any health care provider.** HOI and Lake County Board of County Commissioners 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 HOI nor Lake County Board of County Commissioners will assume liability for any loss or damage arising as a result of acts or omissions of any health care provider.

Members and Providers

The relationship between you and your providers shall be that of a health care provider-

patient relationship, in accordance with any applicable professional and ethical standards.

HOI and Lake County Board of County Commissioners

Neither Lake County Board of County Commissioners nor any Member is HOI's agent or representative, and neither shall be liable for any acts or omissions by HOI's agents, servants, employees or HOI. Neither HOI nor Lake County Board of County Commissioners will be liable, whether in tort or contract or otherwise, for any acts or omissions of any other person or organization with which HOI has made or hereafter make arrangements for the provision of Covered Services. HOI is not your agent, servant, or representative nor is HOI an agent, servant, or representative of Lake County Board of County Commissioners and HOI will not be liable for any of your acts or omissions, or those of Lake County Board of County Commissioners, its agents, servants, employees, or any person or organization with which Lake County Board of County Commissioners has entered into any agreement or arrangement. By acceptance of coverage and benefits hereunder, you agree to the foregoing.

Medical Decisions – Responsibility of Member's Physician, Not HOI /Lake County Board of County Commissioners

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

Section 20: General Provisions

Access to Information

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

If you file any action or Complaint regarding Services you received (including, without limitation, the filing of a lawsuit, administrative action, or Grievance) against HOI or a Contracting Provider, HOI will have the right to receive from any health care provider rendering Services to you information and records reasonably necessary to investigate the allegations in such action or Complaint. This right includes, without limitation, your authorization for HOI, or our legal representatives, to discuss your Condition with, and receive all relevant reports and records from, Contracting Providers and Non-Contracting Providers who provided Services to you, or consulted with you, as a result of injuries alleged in any action or Complaint, even if such Services or consultations are provided subsequent to termination of coverage. The authorization described in this section survives the termination of our coverage.

Benefit Booklet

You have been provided with this Benefit Booklet and a Membership Card as evidence of your coverage under this Benefit Booklet.

Compliance with Applicable Laws and Regulations

The terms of coverage and benefits to be provided under this Benefit Booklet shall be deemed to have been modified and shall be interpreted, so as to comply with applicable laws and regulations dealing with benefits, eligibility, enrollment, termination, or other rights and duties of a Covered Plan Participant, Lake County Board of County Commissioners, or HOI.

Confidentiality

Except as otherwise specifically provided herein, and except as may be required in order for HOI to administer coverage and benefits, specific medical information concerning you, received from providers, shall be kept confidential by HOI in conformity with applicable law. Such information may be disclosed to third parties, and by accepting coverage you hereby authorize HOI to disclose such information, 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 HOI's quality assurance and utilization review activities. Additionally, HOI may disclose such information to entities affiliated with HOI or other persons or entities HOI utilizes to assist HOI. Further, any documents or information that are properly subpoenaed in a judicial proceeding, or by order of a regulatory agency, shall not be subject to this provision.

HOI's arrangements with Contracting Providers may require that HOI release certain claims and medical information about persons covered under this Booklet even if treatment has not been sought by or through that provider. By accepting coverage, you hereby authorize HOI to release to Contracting Providers claims information, including related medical information, pertaining to you in order for the Contracting Provider to evaluate financial responsibility under their contracts with HOI.

Cooperation Required of You and Your Covered Dependents

You must cooperate with HOI and Lake County Board of County Commissioners, and must execute and submit to HOI 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 by HOI. (See the "Termination of Individual Coverage for Cause" subsection in the "Termination of Coverage" section.)

Employer as Plan Administrator

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

Limitations

Your coverage under this Benefit Booklet is subject to the limitations set forth on your

Schedule of Copayments or Schedule of Benefits and the limitations within this section.

Circumstances Beyond the Control of HOI or Lake County Board of County Commissioners:

To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within HOI's or Lake County Board of County Commissioners' control, results in HOI's or Lake County Board of County Commissioners' facilities, personnel or financial resources being unable to arrange for provision of the Covered Services, neither HOI nor Lake County Board of County Commissioners shall have any liability or obligation for any delay in the provision of, or any failure by any provider to provide, such Covered Services, except that HOI and Lake County Board of County Commissioners may make a good faith effort to arrange such Services, taking into account the impact of the event. For the purposes of this paragraph, an event is not "within control" if HOI or Lake County Board of County Commissioners cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

Membership Cards

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

Modification of Provider Network

The provider network available through HOI and the participation status of individual providers available through HOI are subject to change at any time by HOI without prior approval of, or notice to, you or Lake County Board of County Commissioners. Additionally, HOI may, at any time, terminate or modify the terms of any provider contract and may enter into additional

provider contracts without prior notice to, or approval of you or that of Lake County Board of County Commissioners. It is your responsibility to determine whether a health care provider is a Contracting Provider at the time the Health Care Service is rendered.

Non-Waiver of Defaults

Any failure by HOI or Lake County Board of County Commissioners 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 HOI's or Lake County Board of County Commissioners' right at any time to enforce any terms or conditions under this Benefit Booklet.

Notices

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

If to HOI:

To the address printed on the Membership Card.

If to you:

To the latest address provided by you or to your latest address on the Enrollment Forms actually delivered to HOI.

You must notify HOI immediately of any address change.

If to Lake County Board of County Commissioners:

To the address indicated by Lake County Board of County Commissioners.

HOI's 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 Booklet.

Right to Recovery

Whenever the Group Health Plan has made payments in excess of the maximum provided for under this Booklet, HOI or Lake County Board of County Commissioners 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.

Right to Receive Necessary Information

In order to administer coverage and benefits, HOI or Lake County Board of County Commissioners 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 you or any person covered under this Booklet or applicant for enrollment that HOI or Lake County Board of County Commissioners deem to be necessary.

Types of HMOs

While some HMOs are similar, not all HMOs operate or are organized in the same way. For example, an HMO can be organized and operate as a staff model, a group model, an IPA model or a network model. Here are a few important ways in which these types of HMOs differ:

1. Staff and Group Model HMOs:

In a staff model HMO, the doctors and other providers providing care are usually salaried employees of the HMO and generally provide care in a clinic setting rather than in their own personal medical offices. Group model HMOs, on the other hand, contract

with large medical group practices to provide or arrange for most Health Care Services. Typically, the doctors in the medical groups own the HMO. In both these models, the HMO's contracting doctors and other providers typically do not see patients covered by other third party payers or managed care organizations.

2. IPA and Network Model HMOs:

In an IPA model HMO, the HMO typically contracts with individual, independent doctors and/or a Physician organization, which may, in turn, contract Services with additional doctors and providers. Unlike the staff or group model HMOs, the IPA model HMO does not itself provide Health Care Services. Instead, it contracts with independent doctors and/or a physician organization to provide health care to its members. The contracting doctors in an IPA model HMO are not the agents or employees of the HMO; they typically practice in their own personal medical offices, and continue to see patients covered by other third party payers or managed care organizations.

In a network model HMO, the HMO contracts with individual, independent doctors, IPAs, and/or medical groups to make up a health care provider network. Unlike the staff or group model HMOs, the network model HMO does not itself provide Health Care Services. Instead, it contracts directly with independent, qualified providers to provide health care. The doctors in a network model HMO are not the employees or agents of the HMO and typically practice in their own personal medical offices. Like the IPA model HMO, doctors under contract with a network model HMO usually continue to see patients covered by other third party payers or managed care organizations.

Note: These descriptions are not intended to be an exhaustive discussion of all HMO organization models in use in the United States.

Health Options is a combination of an IPA and a network model HMO. **It is not a staff or group model HMO.** This means that the doctors and other providers with whom it contracts are independent contractors and not the employees or agents, actual or ostensible, of Health Options. Rather these independent doctors and providers typically continue to see their own patients in their own personal medical offices or facilities and continue to see patients covered by other third party payers or managed care organizations.

Florida Agency for Health Care Administration Performance Data

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

Assignment of Benefits to Providers

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

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

HOI specifically reserves the right to honor an assignment of benefits or payment by a you to a provider who: 1) is a Contracting Provider under your plan of coverage; 2) 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 3) 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.

Customer Rewards Programs

From time to time, HOI may offer programs to Members that provide rewards for following the terms of the program. HOI will tell you about any available rewards programs in general mailings, member newsletters and/or at www.FloridaBlue.com. Participation in these programs is completely voluntary and will in no way affect the coverage available to you under this Booklet. HOI reserves the right to offer rewards in excess of \$25 per year as well as the right to discontinue or modify any reward program features or promotional offers at any time without your consent.

Section 21: Statement on Advance Directives

The following information is provided in accordance with the Patient Self-Determination Act to advise you of your rights under Florida law to make decisions concerning your medical care, including your right to accept or refuse medical or surgical treatment, the right to formulate an advance directive, and explain HOI's policy with respect to advance directives. The information is general and is not intended as legal advice for specific needs. You are encouraged to consult with your attorney for specific advice.

Florida law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures, or to designate another person to make treatment decisions for him or her in the event that such patient should be found to be incompetent and suffering from a terminal Condition. Advance directives provide patients with a mechanism to direct the course of their medical treatment even after they are no longer able to consciously participate in making their own health care decisions.

An "advance directive" is a witnessed oral or written statement that indicates the individual's choices and preferences with respect to medical care made by the individual while he or she is still competent. An advance directive can address such issues as whether to provide any and all health care, including extraordinary life-prolonging procedures, whether to apply for Medicare, Medicaid or other health benefits, and with whom the health care provider should consult in making treatment decisions.

There are three types of documents, recognized in Florida, commonly used to express an individual's advance directives: a Living Will, a Healthcare Surrogate Designation and a Durable Power of Attorney for Healthcare.

A Living Will is a declaration of a person's desire that life-prolonging procedures be provided, withheld, or withdrawn in the event that the person is suffering from a terminal Condition and is not able to express his or her wishes. It does not become effective until the patient's physician and one other physician determine that the patient suffers from a terminal Condition and is incapable of making decisions.

Another common form of advance directive is the Healthcare Surrogate Designation. When properly executed, a Healthcare Surrogate Designation grants authority for the surrogate to make health care decisions on behalf of the patient in accordance with the patient's wishes. The surrogate's authority to make decisions is limited to the time when the patient is incapacitated and must be in accordance with what the patient would want if the patient was able to communicate his or her wishes. While there are some decisions, which by law the surrogate cannot make, such as consent to abortion or electroshock therapy, any specific limits on the surrogate's power to make decisions should be clearly expressed in the Healthcare Surrogate Designation document.

Finally, there is the Durable Power of Attorney for Healthcare. This document, when properly executed, designates a person as the individual's attorney-in-fact to arrange for and consent to medical, therapeutic, and surgical procedures for the individual. This type of advance directive can relate to any medical condition.

A suggested form of Living Will and Designation of Healthcare Surrogate is contained in Chapter 765 of the Florida Statutes. There is no requirement that a patient have an advance directive and your health care provider cannot condition treatment on whether or not you have

one. Florida law provides that, when there is no advance directive, the following persons are authorized, in order of priority, to make health care decisions on behalf of the patient:

1. a judicially appointed guardian;
2. a spouse;
3. an adult child or a majority of the adult children who are reasonably available for consultation;
4. a parent;
5. siblings who are reasonably available for consultation;
6. an adult relative who has exhibited special care or concern, maintained regular contact, and is familiar with the person's activities, health and religious or moral beliefs; or
7. a close friend who is an adult, has exhibited special care and concern for the person, and who gives the health care facility or the person's attending physician an affidavit stating that he or she is a friend of the person who is willing to become involved in making health care decisions for that person and has had regular contact with the individual so as to be familiar with the person's activities, health, religious and moral beliefs.

Deciding whether to have an advance medical directive, and if so, the type and scope of the directive, is a complex understanding. It may be helpful for you to discuss advance directives with your spouse, family, friends, religious or spiritual advisor or attorney. The goal in creating an advance directive should be for a person to clearly state his or her wishes and ensure that the health care facility, physician and whomever else will be faced with the task of carrying out those wishes, knows what you would want.

It is HOI's policy to recognize your right to make health care treatment decisions in accordance with your own personal beliefs. You have a right to decide whether or not to execute an advance directive to guide treatment decisions in the

event you become unable to do so. HOI will not interfere with your decision. It is your responsibility to provide notification to your providers that an advance directive exists. If you have a written advance directive, HOI recommends that you furnish your providers with a copy so that it can be made a part of your medical record.

Florida law does not require a health care provider or facility to commit any act which is contrary to the provider's or facility's moral or ethical beliefs concerning life-prolonging procedures. If a provider or facility in the HOI network, due to an objection on the basis of conscience, would not implement your advance directive, you may request treatment from another provider or facility.

HOI providers have, in accordance with state law, varying practices regarding the implementation of an individual's advance directive. Therefore, HOI recommends that you have discussions about advance directives with your medical caregivers, family members and other friends and advisors. Your physician should be involved in the discussion and informed clearly and specifically of any decisions reached. Those decisions need to be revisited in light of the passage of time or changes in your medical condition or environment.

Complaints concerning noncompliance with advance directives may be submitted to the following address:

Agency for Health Care Administration
Bureau of Managed Health Care
Ft. Knox #1, Suite 339
2727 Mahan Drive
Tallahassee, Florida 32308

We hope this information has been helpful to your understanding of your rights under the Patient Self-Determination Act and Florida law.

Section 22: Conversion Privilege

Eligibility Criteria for Conversion

You are entitled to apply for an HOI individual 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 Copayments and payment 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.

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 Benefit Booklet; or
4. you commit fraud or intentional misrepresentation in applying for any Covered Services;
5. you are terminated for cause as set forth in the Termination of Individual Membership for Cause subsection;
6. you have left the Service Area with the intent to relocate or to establish a new residence outside the Service Area; or
7. a. You fall under one of the following categories and meet the requirements of 7.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 Benefit Booklet; 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 Benefit Booklet; or
 - iii. benefits similar to the benefits provided under this Benefit Booklet 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 7.a.(i) or the benefits provided or available under the source referred to in paragraphs 7.a.(ii) and 3) 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 Lake County Board of County Commissioners nor HOI 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 an HOI converted policy application and the initial Premium payment to us on a timely basis. The converted policy may be issued without evidence of insurability and shall be effective the day following the day your coverage under the Group Health 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 Benefit Booklet. When applying for our converted policy, you have two options: 1) a converted policy providing coverage meeting the requirements of 641.3922 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, a converted policy will not be issued to you unless required by Florida law.

We may have other options available to you. Call the telephone number on your Membership Card for more information.

Section 23: Extension of Benefits

Extension of Benefits

In the event the Group Health Plan is terminated, coverage will end as of the termination date. There will be no coverage or benefits for any Service rendered on or after the termination date, except as described below. The extension of benefits provisions described below only apply when the Group Health Plan is terminated, and the benefits provided under an extension of benefits is subject to all other provisions, including the limitations and exclusions, described in this Benefit Booklet.

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 Benefit Booklet, as determined by us, a limited extension of benefits will be provided 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; however, 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, a person is totally disabled only if, in our 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. This would also apply to an individual who, although not engaged in an occupation (e.g., a student, non-working spouse, or children), is not able

to perform the normal day-to-day activities that they would otherwise be able to perform.

2. In the event you are pregnant as of the termination date of the Group Health Plan, a limited extension of the maternity expense benefits will be provided, provided the pregnancy commenced while you were covered under the Group Health Plan. 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.

An extension of benefits is not required to be provided, if your coverage is terminated based upon any event referred to in §641.3922(7)(a) and (e) Florida Statutes.

Section 24: Definitions

The following definitions are used in this Benefit Booklet. 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 Agreement or ASA means an agreement between Lake County Board of County Commissioners and HOI. Under the Administrative Services Agreement, HOI provides claims processing and payment services, customer service, utilization review services, and access to HOI's network of independent contracting providers.

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

- a Pre-Service Claim or a Post-Service Claim;
- a Concurrent Care Decision, as described in the "Claims Processing" section; or
- Rescission of coverage, as described in the "Termination of Coverage" section.

Allowance means the maximum amount HOI will pay to Non-Contracting Providers for Covered Services other than Emergency Services and Care. This amount is determined solely by HOI and is based upon many factors, including but not limited to: (i) payment for such Covered Services under the Medicare and/or Medicaid programs; (ii) payment often accepted for such Covered Services by that provider and/or by other providers, either in Florida or in other comparable market(s), that HOI determines are comparable to the provider that provided the specific Covered Services (which may include payment accepted by such provider and/or by other providers as participating providers in other provider networks of third-party payers which may include, for example, other insurance companies and/or health maintenance organizations); (iii) payment amounts which are consistent, as determined by HOI, with HOI's provider network strategies (e.g., does not result in payment that encourages providers participating in an HOI network to become non-participating); and/or, (iv) the cost of providing the specific Covered Services. In no event will the Allowance be greater than the amount the provider actually charge(s). The Allowance may be modified by HOI at any time without the consent or notice to the Employer or any Member.

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.

Anniversary Date means the date, one year after the Effective Date, stated on the Enrollment Forms, and subsequent annual anniversaries.

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.

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 Health Options, 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.

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 means a period of time that 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 registered 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 when applicable, means your share of health care expenses for Covered Services. After your Deductible requirement is met, if applicable, a percentage of the Allowance will be paid for Covered Services, as listed in your Schedule of Benefits. The percentage you are responsible for is your Coinsurance.

Complaint means an oral (i.e., non-written) expression of dissatisfaction, whether or not such dissatisfaction was made in person, by telephone, or on your behalf.

Concurrent Care Decision means a decision by HOI 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 HOI had previously approved or

authorized in writing, coverage, benefits, or payment for that course of treatment or number of treatments.

As defined herein, a Concurrent Care Decision shall not include any decision to deny, reduce, or terminate coverage, benefits, or payment under the Case Management subsection as described in the "Coverage Access Rules" section of this Booklet.

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

Contracting Provider means any health care institution, facility, pharmacy, Physician, or other health care provider who has entered into a contract with HOI for the provision of Health Care Services.

Contracting Specialist means a Physician, who is a Contracting Provider, who limits practice to specific services or procedures (e.g., surgery, radiology, pathology), certain age categories of patients (e.g., pediatrics, geriatrics), certain body systems (e.g., dermatology, orthopedics, cardiology, internal medicine) or types of diseases (e.g., allergy, psychiatry, infectious diseases, oncology). Specialists may have special education and training related to their respective practice and may or may not be certified by a related specialty board. (Refer to the Physicians who are listed under Specialty Physicians in the HOI Provider Directory.)

Copayment means the dollar amount that you are required to pay to a health care provider at the time certain Covered Services are rendered by that provider. While this amount may vary depending on, among other things, the contracting status of the health care provider rendering the Service and the type of Service being rendered, in no event will such amount exceed the amount specified in the Schedule of Copayments or Schedule of Benefits for the Service. Except as otherwise established by HOI or Lake County Board of County

Commissioners, if more than one Covered Service is rendered by a health care provider during a single office visit, the Copayment shall not exceed the highest Copayment specified in the Schedule of Copayments or Schedule of Benefits for any of the Services rendered during such office visit, regardless of the number of Services rendered during such office visit.

Coverage Access Rules means the rules or procedures in this Benefit Booklet, your provider directory, or established by HOI, that you must follow in order for Health Care Services you receive to be covered. Failure to follow applicable Coverage Access Rules may result in the denial of coverage or benefits under this Benefit Booklet.

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

Covered Services means those Health Care Services which meet the criteria listed in the “Coverage Access Rules” and “What is Covered?” sections and are not excluded in the “What is Not Covered?” section.

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

1. A group health plan;
2. Individual health insurance;
3. Part A and Part B Medicare;
4. Medicaid;
5. Benefits to members and certain former members of the uniformed services and their Covered 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. Children’s Health Insurance Program (CHIP);
12. public health plans established by the federal government; or
13. public health plans established by foreign governments.

Crisis Intervention means acute inpatient psychiatric care that is required for evaluation of an acute psychosis or crisis situation in which the patient presents as a danger to self or others. The acute or crisis situation may be an exacerbation of a history of mental illness or the sudden onset of a psychiatric disorder. The crisis or acute period normally extends 48 to 72 hours, but may be of greater duration depending upon the response to therapy.

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 Allowance, for Covered Services that are your responsibility. The term, Deductible, does not include any amounts you are responsible for in excess of the Allowance, 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 Member 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 (AHCA)

(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.

Effective Date means, with respect to Group, 12:01 a.m. on the date specified in the ASA. With respect to individuals covered under this Benefit Booklet, 12:01 a.m. on the date Lake County Board of County Commissioners specifies that the coverage will commence as further described in the "Enrollment and Effective Date of Coverage" section of this Benefit Booklet.

Eligible Dependent means an individual who meets and continues to meet all of the eligibility requirements described in the "Eligibility Requirements for Dependents" subsection of the "Eligibility for Coverage" section in this Benefit Booklet, 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 Participants" subsection 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 Lake County Board of County Commissioners.

Emergency Medical Condition, as indicated in the Member's chart by a Physician or, to the extent permitted by law, by other appropriately licensed professional Hospital personnel under the supervision of a Hospital Physician, means

1. A medical Condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
 - a) serious jeopardy to the health of a patient, including a pregnant woman or fetus;
 - b) serious impairment of bodily functions; or
 - c) serious dysfunction of any bodily organ or part.
2. With respect to a pregnant woman:
 - a) that there is inadequate time to effect safe transfer to another hospital prior to delivery;
 - b) that a transfer may pose a threat to the health and safety of the patient or fetus; or
 - c) that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Emergency Services and Care means medical screening, examination, and evaluation, by a Physician or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a Physician, to determine if an Emergency Medical Condition exists and, if it does, the care, treatment, or surgery by a Physician necessary to relieve or eliminate the Emergency Medical Condition, within the Service capability of a Hospital.

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

Enrollment Forms means those forms, electronic (where available) or paper, which are used to maintain accurate enrollment files under this Benefit Booklet.

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 HOI or Lake County Board of County Commissioners:

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;
2. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device;
3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations;
4. credible scientific evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;

5. credible scientific evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
6. credible scientific evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently published Medical Literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices;
7. there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or
8. such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

"Credible scientific evidence" shall mean (as determined by HOI or Lake County Board of County Commissioners):

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 that are determined by HOI or Lake County Board of County Commissioners 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, HOI or Lake County Board of County Commissioners 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 and Rehabilitative Services in compliance with Florida Statutes or by a similar applicable law in another state.

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 fallopian tube.

Gene Therapy means treating disease by replacing, manipulating, or supplementing nonfunctioning or malfunctioning genes.

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 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.

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.

Grievance means a written expression of dissatisfaction.

Group means the employer, labor union, trust, association, partnership, corporation, department, other organization or entity, through which coverage and benefits under this Benefit Booklet are made available to you, and through which you and your Eligible 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 Lake County Board of County Commissioners for the provision of health care coverage and benefits to the individuals covered under this Benefit Booklet.

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

HOI means Health Options, Inc., a Florida Corporation (and any successor corporation) operating as a health maintenance organization under applicable provisions of federal and/or state law.

Home Health Agency means a properly licensed agency or organization that provides 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 Services and personal care 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 Birth Center; a Psychiatric Facility; a Substance Abuse Facility, a convalescent, rest or nursing home; or a facility which primarily provides Custodial educational, or rehabilitative care.

Note: If Services specifically for the treatment of a physical disability are provided in a licensed Hospital which is accredited by the Joint Commission 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.

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

Internal Review Panel means a panel established by HOI to review Grievances related to Adverse Benefit Determinations made by HOI that an admission, availability of care, continued stay, or other Health Care Service has been reviewed and, based upon the information provided, does not meet HOI's requirements for Medical Necessity, appropriateness, health care setting, level of care, or efficacy. This panel

consists of Physicians who have appropriate expertise, and who were not previously involved in the initial Adverse Benefit Determination nor do these Physicians report to anyone who was involved in making the initial determination.

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

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 HOI is solely for the purpose of determining coverage or benefits under this Benefit Booklet and not for the purpose of recommending or providing medical care. In this respect, HOI 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 Benefit Booklet as determined by HOI. In applying the definition of Medical Necessity in this Benefit Booklet, HOI may apply its coverage and payment guidelines then in effect. You are free to obtain a Service even if HOI denies 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.

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

Note: The Medication Guide is subject to change at any time. Please go to www.FloridaBlue.com for the most current guide

or call the customer service phone number on the Membership Card for current information.

Member means any Covered Plan Participant or Covered Dependent.

Membership Card means the identification card(s) issued to Covered Plan Participants. The card is not transferable to another person. Possession of a card in no way verifies that a particular individual is eligible for, or covered under, this Benefit Booklet.

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 or sect who are not licensed to provide counseling services pursuant to Chapter 491.

Mental and Nervous Disorder means any disorder listed in the diagnostic categories of the International Classification of Disease, 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.

Non-Contracting Provider means any health care institution, facility, pharmacy, Physician, or other health care provider with whom HOI does not have a provider contract in effect at the time the Health Care Services are provided.

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.

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, fabrication and fitting of Orthotic Devices.

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

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

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

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

Dental Medicine (D.D.S. or D.M.D.), or Doctor of Optometry (O.D.).

Physician Assistant means a person properly licensed to perform surgical first assisting Services 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 HOI in a format acceptable to HOI.

Pre-Service Claim means any request or application for coverage or benefits for a Service that has not yet been provided to you and with respect to which the terms of this Booklet condition payment for the Service (in whole or in part) on approval of coverage or benefits for the Service before you receive the Service. 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 HOI regarding coverage, benefits, or payment for a Service that has not actually been rendered to you if the terms of this Booklet do not require approval of coverage or benefits (or condition payment) 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".

Primary Care Physician (PCP) means a Physician who provides primary care medical Services to Members under a Primary Care Physician (PCP) provider contract with HOI then in effect. A Primary Care Physician (PCP) may specialize in internal medicine, family practice, general practice, or pediatrics. Also, a gynecologist or obstetrician/ gynecologist may elect to contract with HOI as a Primary Care Physician (PCP). Refer to the Primary Care Physicians (PCPs) who are listed as Primary Care Physicians (PCPs) in the HOI Provider Directory.

Prior/Concurrent Coverage Affidavit means the form that an Eligible Employee or Eligible Dependent can submit to HOI 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, fabrication and fitting of Prosthetic Devices.

Prosthetic Device means a device that 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.

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 Booklet, 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.

Rescission or **Rescind** refers to HOI's action to retroactively cancel or discontinue coverage

under the Group Plan. Rescission does not include a cancellation or discontinuance of coverage with only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively due to non-payment of Premiums

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

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

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

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

- Has Mental Health Professionals on-site 24 hours per day and 7 days per week;
- Provides access to necessary medical services 24 hours per day and 7 days per week;
- Provides access to at least weekly sessions with a behavioral health professional fully licensed for independent practice for individual psychotherapy;
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission;

- Provides a level of skilled intervention consistent with patient risk;
- Is not a wilderness treatment program or any such related or similar program, school and/or education service.

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

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

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

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

Service Area means the geographic area in which Florida Blue HMO has been authorized by the Agency for Health Care Administrations

(AHCA) to arrange for the provision of Health Care Services to members.

A list of Florida counties in the Service Area is available at:

<http://consumerdirect.bcbsfl.com/cws/plancounties> or you may call the customer service phone number on your ID Card.

Skilled Nursing Facility means an institution or part thereof which meets HOI'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 HOI.

Specialist means a Physician who limits practice to specific Services or procedures (e.g., surgery, radiology, pathology), certain age categories of patients (e.g., pediatrics, geriatrics), certain body systems (e.g., dermatology, orthopedics, cardiology, internal medicine) or types of diseases (e.g., allergy, psychiatry, infectious diseases, oncology). Specialists may have special education and training related to their respective practice and may or may not be certified by a related specialty board. (Refer to the Physicians who are listed as Specialty Physicians in the HOI Provider Directory.)

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

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

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

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

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

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

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

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

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

Waiting Period means the period of time specified by Lake County Board of County Commissioners which must be met by an individual before that individual is eligible for coverage under the Group Health 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.

Attachment A: Service Area

Health Options, Inc. Service Area -- Refer to the Service Area below in which you work or live.

North GBU

The North Florida Service Area includes all the zip codes in the following counties only:

Alachua	Baker	Bradford	Charlotte	Clay
Citrus	Columbia	DeSoto	Dixie	Duval
Escambia	Gilchrist	Hendry	Hernando	Hillsborough
Lee	Levy	Manatee	Marion	Nassau
Okaloosa	Pasco	Pinellas	Santa Rosa	Sarasota
St. Johns	Suwanee	Walton		

The Service Area for Alabama Counties includes all the zip codes in the following counties only:

Baldwin	Covington	Escambia	Monroe
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South GBU

The South Florida Service Area includes all the zip codes in the following counties only:

Brevard	Broward	Dade	Flagler	Lake
Martin	Orange	Osceola	Okeechobee	Palm Beach
Polk	St. Lucie	Seminole	Sumter	Volusia