BlueChoice

PPO Evidence of Coverage for Covered Plan Participants of Lake County Board of County Commissioners

Effective: October 1, 2014

This Evidence of Coverage Contains Deductible Provisions

A Self-funded and Grandfathered Group Health Benefit Plan

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.

The Group Health Plan established by Lake County Board of County Commissioners and serviced by Blue Cross and Blue Shield of Florida, Inc. (BCBSF) provides an innovative combination of a preferred provider organization (PPO) program and traditional benefits programs. Under the Group Health Plan, Covered Plan Participants may receive greater benefits when obtaining Covered Services from a Preferred Patient Care (herein sometimes referred to as “PPC”) Provider; however, benefits are provided for Covered Services rendered by a non-PPC Provider.

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

To find out about a health care Provider’s participation status, you may review the PPO Provider Directory then in effect, call the provider’s office, access our web-site at www.FloridaBlue.com and/or call the customer service telephone number located in this Evidence of Coverage for Covered Plan Participants of Lake County Board of County Commissioners or on your Identification Card. You should also carefully review the Schedule of Benefits which is a part of this Evidence of Coverage for a detailed list of your financial responsibilities. This is important because your financial responsibilities, including any applicable Copayments, Deductibles, and Coinsurance responsibilities, **may vary** depending upon the Providers you choose.

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

Table of Contents

Introduction to the Evidence of Coverage for Covered Plan Participants of Lake County Board of County Commissioners

Covered Plan Participant's Financial Obligations 1-1

Health Care Provider Alternatives and Reimbursement Rules 2-1

BlueCard® Program 3-1

Individual Benefit Utilization Management/Utilization Review Programs 4-1

Medical Necessity 5-1

Covered Services 6-1

General Exclusions 7-1

Eligibility for Coverage 8-1

Enrollment and Effective Date of Coverage 9-1

Termination of an Individual Covered Plan Participant's Coverage 10-1

Continuing Coverage Under Cobra 11-1

Conversion Privilege 12-1

Extension of Benefits 13-1

The Effect of Medicare Coverage/Medicare Secondary Payer Provisions 14-1

Duplication of Coverage Under Other Health Plans/Programs 15-1

Subrogation 16-1

Right of Reimbursement 17-1

Claims Processing 18-1

Relationships Between the Parties 19-1

General Provisions 20-1

Glossary of Terms 21-1

Introduction to the Evidence of Coverage for Covered Plan Participants of Lake County Board of County Commissioners

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

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

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

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

The **Health Care Provider Alternatives section** sets forth payment rules established for Covered Services depending on the health care Provider selected by a Covered Plan Participant to provide Health Care Services.

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

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

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

The **Glossary of Terms section** will define many of the words and phrases used throughout the Evidence of Coverage. If a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. If the word or phrase has a special meaning, it will either be defined in this section or where used in the Evidence of Coverage.

Other sections contained in this Evidence of Coverage explain when benefits may change; how and when coverage stops; how to obtain coverage if coverage ends; how benefits will be coordinated with other policies or plans; the Group Health Plan's subrogation rights and right of reimbursement. These sections also explain how to file a claim when services are received from a Provider who does not participate in BCBSF's PPO or Traditional Insurance Providers.

Section 1: Covered Plan Participant's Financial Obligations

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

Deductible Requirement

Individual Deductible Requirement

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

Family Deductible Requirement Limit

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

Prior Coverage Credit For Deductible

A Covered Plan Participant may be given credit for the satisfaction or partial satisfaction of any deductible met by such Covered Plan Participant under a prior group, blanket or franchise insurance policy maintained by Lake County Board of County Commissioners, which is replaced by this Group Health Plan. This provision only applies if the prior group, blanket or franchise insurance policy was in effect immediately preceding the Effective Date of the Group Health Plan.

Coinsurance Responsibility

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

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

1. Individual Out-of-Pocket Maximum

   Once a Covered Plan Participant has reached the Individual Out-of-Pocket Maximum amount as set forth in the Schedule of Benefits, the Covered Plan Participant will have no additional Coinsurance responsibility for the remainder of the Benefit Period and payment for Covered Services will be at 100 percent of the Allowed Amount.

2. Family Out-of-Pocket Maximum

   Once the Covered Employee's family has reached the family Out-of-Pocket Maximum amount as set forth in the Schedule of Benefits, no Covered Plan Participant in the Covered Employee's family will have any additional Coinsurance responsibility for the remainder of that Benefit Period and payment for Covered Services will be at 100 percent of the Allowed Amount. The maximum amount any Covered Plan Participant can contribute toward the family

Out-of-Pocket Maximum is the amount applied toward the individual Out-of-Pocket Maximum amount.

Note: Out-of-Pocket Maximums do not include the Deductible, any Copayment (if applicable), any benefit penalty reduction, non-covered charges or any charges in excess of the Allowed Amount. If Lake County Board of County Commissioners has purchased prescription drug coverage and benefits, the applicable Cost Share does not apply to the Deductible and Coinsurance.

Prior Coverage Credit for Out-of-Pocket Coinsurance Limitation

A Covered Plan Participant may be given credit for the satisfaction or partial satisfaction of any out-of-pocket coinsurance limitation met by such Covered Plan Participant under a prior group, blanket, franchise insurance or Health Maintenance Organization (HMO) policy maintained by Lake County Board of County Commissioners if the Group Health Plan replaces such a policy. This provision only applies if the prior group, blanket, franchise insurance or Health Maintenance Organization (HMO) policy purchased by Lake County Board of County Commissioners was in effect immediately preceding the Effective Date of the Group Health Plan.

Note: The out-of-pocket Benefit Period maximums do not include the Deductible, Hospital Per Admission Deductible, Emergency Room Per Visit Deductible, any Copayment (if applicable), any benefit penalty reductions, non-covered charges or any charges in excess of the Allowance or Allowed Amount. If the Group has purchased Prescription Drug coverage and benefits, any applicable Cost Share amounts under the Prescription Drug coverage will not accumulate toward the out-of-pocket Benefit Period maximums.

Benefit Maximum Carryover

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

Additional Financial Responsibilities

In addition to the financial obligations set forth above, Covered Plan Participants are also responsible for:

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

Section 2: Health Care Provider Alternatives and Reimbursement Rules

Introduction

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

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

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

Specialty Pharmacy

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

Using the Specialty Pharmacy to provide these Specialty Drugs should lower the amount the Covered Plan Participant has to pay for these medications, while helping to preserve their benefits. Please refer to the Medication Guide for a list of Specialty Pharmacies.

Reimbursement Rules for BCBSF PPC Providers

A "BCBSF PPC^{sm} Provider" is a PPO Provider in the state of Florida, or in certain counties outside of Florida, that is also a "Preferred Patient Care^{sm}" or "PPC^{sm}" Provider (or in a BCBSF Provider network program that replaces, in whole or part, such PPC^{sm} program). To find out about a health care Provider's participation status, a Covered Plan Participant can review the PPO Provider Directory then in effect, call the Provider's office, access our web-site at www.FloridaBlue.com and/or call the customer

service telephone number in this Evidence of Coverage or on the Covered Plan Participant's Identification Card. BCBSF PPC^{sm} Providers have agreed to file claims for the services they render. They have also agreed not to bill or otherwise collect from a Covered Plan Participant any amounts in excess of BCBSF's PPO Schedule Amount, except as otherwise permitted under the terms of their Provider contracts and this Evidence of Coverage. **The payment for Covered Services rendered by a BCBSF PPC^{sm} Provider, if any, will always be made directly to the BCBSF PPC^{sm} Provider.**

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

1. the payment of any applicable Copayments, Deductible(s) and/or Coinsurance requirements;
2. the payment of expenses which are not covered, limited, or excluded;
3. the payment of any expenses in excess of any benefit maximum limitations; and
4. the payment of any applicable benefit reductions or penalties.

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

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

1. <u>Traditional Insurance Providers</u>

   Traditional Insurance Providers are those health care Providers who are not BCBSF PPC^{sm} Providers, but who have entered into a contract, then in effect, to participate in BCBSF's traditional programs (these programs are also known as Payment for Physician Services "PPS" and Payment for Hospital Services "PHS"), as applicable, in Florida or in certain counties outside of Florida, when such programs exist. These Providers have agreed to accept BCBSF's Allowance as payment in full for Covered Services. Traditional Insurance Providers have agreed to file claims for the services they render. They have also agreed not to bill or otherwise collect from a Covered Plan Participant any amounts in excess of BCBSF's Allowance, except as otherwise permitted under the terms of this Evidence of Coverage and their Provider contract. **The payment for Covered Services rendered by a Traditional Insurance Provider, if any, will always be made directly to the Provider.** The Covered Plan Participant's financial responsibility for services rendered by Traditional Insurance Providers includes, but is not limited to:

   a. the payment of any applicable Copayments, Deductible(s) and/or Coinsurance requirements;
   b. the payment of expenses which are not covered, limited, or excluded;
   c. the payment of any expenses in excess of any benefit maximum limitations; and
   d. the payment of any applicable benefit reductions or penalties.

2. <u>Reimbursement Rules for Providers Who Are Eligible to Participate as BCBSF Traditional Insurance Providers but Who Have not Entered into a Traditional Insurance Provider Contract</u>

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

Allowance as payment in full for Covered Services. Covered Plan Participants receiving Health Care Services from such Providers are responsible for filing claims in connection with those services and payment for those services. **The payment, if any, will always be made directly to the Covered Plan Participant and not the Provider.** The Covered Plan Participant's financial responsibility includes:

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

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

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

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

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

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

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

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

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

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

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

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

Assignment of Benefits to Providers

Any assignment to a Provider who does not participate in any of BCBSF's Provider contracting programs including, and without limitation, any of the following:

1. an assignment of the benefits due the Covered Plan Participant's under this Evidence of Coverage;

2. an assignment of the right to receive payments due under this Evidence of Coverage; or

3. an assignment of a claim for damage resulting from a breach, or an alleged breach, of the Group Health Plan.

BCBSF reserves the right to honor an assignment of benefits to a non-participating Provider who 1) is a licensed Hospital, Physician, or dentist and the benefits which have been assigned are for care provided pursuant to section 395.1041, *Florida Statutes*;

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

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

Section 3: BlueCard® Program

Out-of-Area Services

BCBSF has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Covered Plan Participants obtain Health Care Services outside of BCBSF's service area, the claims for these Services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between BCBSF and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside BCBSF's service area, Covered Plan Participants 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, Covered Plan Participants may obtain care from non-participating health care Providers. BCBSF's payment practices in both instances are described below.

BlueCard Program

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

Whenever Covered Plan Participants access Covered Services outside BCBSF's service area and the claim is processed through the BlueCard Program, the amount Covered Plan Participants pay for Covered Services is calculated based on the lower of:

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Covered Plan Participant's health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Covered Plan Participant's 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 BCBSF uses for the Covered Plan Participant's 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 the Covered Plan Participant calculation. If any state laws mandate other liability calculation methods, including a surcharge, BCBSF would then calculate Covered Plan Participant liability for any Covered Services according to applicable law.

Non-PPO Providers Outside BCBSF's Service Area

Covered Plan Participant Liability Calculation

When Covered Services are provided outside of BCBSF's service area by non-participating health care Providers, the payment will be based on the Allowance and Allowed Amount as defined in the Evidence of Coverage.

Section 4: Individual Benefit Utilization Management /Utilization Review Programs

Introduction

Under the Administrative Services Only (ASO) Agreement with Lake County Board of County Commissioners, BCBSF has agreed to provide certain Utilization Management and Utilization Review Programs. In this regard, BCBSF has established various Benefit Utilization Management/Utilization Review Programs ("UM/UR Programs"), including Admission Certification, Concurrent Review, Discharge Planning and Case Management. These programs help BCBSF facilitate the management and review of coverage and benefits provided under this Group Health Plan Description and, under certain limited circumstances, present opportunities, as explained below, for alternative benefits or payment alternatives for cost-effective Health Care Services.

Important Information Relating To BCBSF's UM/UR Programs

All decisions that require or pertain to independent professional medical/clinical judgement or training, or the need for medical services, are solely the responsibility of the Covered Plan Participant and the Covered Plan Participant's treating Physicians and health care Providers together with the Covered Plan Participant. Covered Plan Participants and their Physicians are responsible for deciding what medical care should be rendered or received, and when and how that care should be provided. BCBSF is solely responsible for determining whether expenses incurred, or to be incurred, for medical care are, or would be, covered under this Evidence of Coverage. In fulfilling this responsibility, neither BCBSF nor Lake County Board of County Commissioners shall be deemed to participate in or override the medical decisions of any Covered Plan Participant's health care Provider.

Admission Notification Program

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

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

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

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

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

   The Admission Notification Program also requires you to notify BCBSF of <u>ANY</u>

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

Concurrent Review Program

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

Discharge Planning

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

Case Management Program

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

BCBSF's offering to provide or providing of any alternative benefits or payments in no way obligates BCBSF to continue to provide such alternative benefit payments, or to provide alternative benefits or payments to the Covered Plan Participant or any other person insured by BCBSF or Lake County Board of County Commissioners at any time. Nothing contained in this section shall be deemed a waiver of BCBSF's right to enforce this Evidence of Coverage in strict accordance with its terms. The terms of this Evidence of Coverage will continue to apply, except as specifically modified

in writing by BCBSF, when alternative benefits or payments under this program are made available.

Appeal Process

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

Prior Coverage Authorization/Pre-Service Notification Programs

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

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

1. certain **Prescription Drugs** denoted with a special symbol in the Medication Guide as requiring prior authorization;
2. **advanced diagnostic imaging Services**, such as CT scans, MRIs, MRA and nuclear imaging;
3. **Autism Spectrum Disorder; Mental Health;** and **Substance Dependency Services;** and
4. **other Health Care Services** that are or may become subject to a prior coverage authorization program or a pre-service notification program as defined and administered by BCBSF.

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

BCBSF PPC^{sm} Providers

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

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

Providers who are not BCBSF PPC^{sm} Providers

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

   For additional details on how to obtain prior coverage authorization, and for a list of Prescription Drugs that require prior

coverage authorization, please refer to the Medication Guide.

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

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

3. In the case of **Autism Spectrum Disorder, Mental Health,** and **Substance Dependency Services**, it is the Covered Plan Participant's sole responsibility to comply with BCBSF's prior coverage authorization requirements when the Covered Plan Participant uses a Provider who is not a BCBSF PPC^{sm} Provider **before** the Services are provided. **The Covered Plan Participant's failure to obtain prior coverage authorization will result in denial of coverage for such Services**.

   For additional details on how to obtain prior coverage authorization for Autism Spectrum Disorder, Mental Health, and Substance Dependency Services, the Covered Plan Participant may call the customer service phone number on the back of the Covered Plan Participant's ID Card.

4. In the case of **other Health Care Services** under a prior coverage authorization or pre-service notification program, it is the Covered Plan Participant's sole responsibility to comply with BCBSF's prior coverage authorization or pre-service notification requirements when rendered or referred by a Provider who is not a BCBSF PPC^{sm} Provider, **before** the Services are provided. **Failure to obtain prior coverage authorization or provide pre-service notification may result in denial of the claim or application of a financial penalty assessed at the time the claim is presented for payment to BCBSF**. The penalty applied will be the lesser of $500 or 20% of the total Allowance or Allowed Amount of the claim. The decision to apply a penalty or deny the claim will be made uniformly and will be identified in the notice describing the prior coverage authorization and pre-service notification programs.

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

BCBSF will provide the Covered Plan Participant information for any Health Care Service which, when rendered by a Provider who is not a BCBSF PPC Provider, is subject to a prior coverage authorization or pre-service notification program, including how the Covered Plan Participant can obtain prior coverage authorization and/or provide the pre-service notification for such Service not already listed here. This information will be provided to the Covered Plan Participant upon enrollment, or at least 30 days prior to such Services which, when rendered by a Provider who is not a BCBSF PPC Provider, become subject to a prior coverage authorization or pre-service notification program.

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

Note: Prior coverage authorization is not required when Covered Services are provided for the treatment of a Medical Emergency.

Section 5: Medical Necessity

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

It is important to remember that any review of Medical Necessity by BCBSF or Lake County Board of County Commissioners is solely for the purposes of determining coverage or benefits under this Evidence of Coverage and not for the purpose of recommending or providing medical care. In this respect, BCBSF or Lake County Board of County Commissioners may review specific medical facts or information pertaining to a Covered Plan Participant. Any such review, however, is strictly for the purpose of determining, among other things, whether a Health Care Service provided or proposed meets the applicable coverage and payment guidelines then in effect.

All decisions that require or pertain to independent professional medical/clinical judgement or training, or the need for medical services, are solely the responsibility of the Covered Plan Participant and the Covered Plan Participant's treating Physicians and health care Providers. Covered Plan Participants and their Physicians are responsible for deciding what medical care should be rendered or received and when that care should be provided. Lake County Board of County Commissioners is solely responsible for determining whether expenses incurred, or to be incurred, for medical care are, or would be, covered under this Evidence of Coverage. In making coverage decisions, neither BCBSF nor Lake County Board of County Commissioners shall be deemed to participate in or override the medical decisions of a Covered Plan Participant or a Covered Plan Participant's health care Providers.

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

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

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

Section 6: Covered Services

Introduction

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

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

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

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

Under most circumstances, BCBSF will determine whether Health Care Services are Covered Services under this Evidence of Coverage when processing a Covered Plan Participant's claim after the Covered Plan Participant has obtained such services and a claim has been received by BCBSF for such services. In some circumstances, Lake County Board of County Commissioners or BCBSF may, but are not required to, determine whether Health Care Services are Covered Services under this Evidence of Coverage before the Covered Plan Participant is provided the service. For example, Lake County Board of County Commissioners or BCBSF may determine whether a proposed transplant is a Covered Service under this Evidence of Coverage before such transplant is provided.

In determining whether Health Care Services are Covered Services under this Evidence of Coverage, no written or verbal representation by any employee or agent of BCBSF or by any other person shall waive or otherwise modify the terms of this Evidence of Coverage except as otherwise permitted under the Group Health Plan Description, and, therefore, neither the Covered Plan Participant, nor Lake County Board of County Commissioners , nor any health care Provider or other person should rely on any such written or verbal representation.

BCBSF's Benefit Guidelines

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

1. The reimbursement for certain Health Care Services is included within the Allowed Amount for the primary procedure, and therefore no additional amount is payable for any such services and/or supplies.
2. The reimbursement is based on the Allowed Amount for the actual service rendered (i.e., not based on the Allowed Amount for a service which is more complex than the service actually rendered), and is not based on the method utilized to perform the service nor the day of the week nor the time of day the procedure is performed.

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

Covered Services Categories

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

Accident Care

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

Exclusion:

Health Care Services to treat an injury resulting from an Accident related to a Covered Plan Participant's job or employment are excluded except for services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual.

Allergy Testing and Treatments

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

Ambulance Services

Ambulance services to transport a Covered Plan Participant from:

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

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

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

Ambulatory Surgical Centers

Health Care Services rendered at an Ambulatory Surgical Center including:

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

9. diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG); and
10. chemotherapy treatment for proven malignant disease.

Anesthesia Administration Services

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

Exclusion:

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

Autism Spectrum Disorder

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

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

Payment Guidelines for Autism Spectrum Disorder

The covered therapies provided in the treatment of Autism Spectrum Disorder outlined in paragraph three above will be applied to the Outpatient Therapies Benefit Period maximum set forth in the Schedule of Benefits. Autism Spectrum Disorder Services must be authorized in accordance with BCBSF's established criteria, **before** such Services are rendered. Services performed without authorization will be denied. Authorization for coverage is not required when Covered Services are provided for the treatment of an Emergency Medical Condition.

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 Evidence of Coverage, BCBSF reserves the right to request a formal written treatment plan signed by the treating Physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

Behavioral Health Services

Mental Health Services

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

1. Physician office visits;

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

Exclusion:

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

Substance Dependency Treatment Services

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

Care and treatment for Substance Dependency includes the following:

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

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

Exclusion:

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

Bereavement Counseling

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

Breast Reconstructive Surgery

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

Child Cleft Lip and Cleft Palate Treatment

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

Child Health Supervision Services

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

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

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

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

Concurrent Physician Care

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

Consultations

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

Contraceptive Injections

Medication by injection when provided and administered by a Physician, for the purpose of contraception, is limited to only the medication and administration thereof.

Dental

Dental Care is limited to the following:

1. Care and treatment initiated within 62 days of an Accidental Dental Injury provided such services are for the treatment of damage to sound natural teeth.
2. Anesthesia services for dental care including general anesthesia and hospitalization services necessary to assure the safe delivery of necessary dental care provided to a Covered Plan Participant in a Hospital or Ambulatory Surgical Center if:
    a. the Covered Plan Participant is under 8 years of age when it is determined by a dentist and the Covered Plan Participant's Physician that dental treatment is necessary due to a dental Condition that is significantly complex, or the Covered Plan Participant has a developmental disability in which patient management in the dental office has proven to be ineffective; or

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

3. Only those Health Care Services provided for the extraction of impacted teeth at any location (i.e., inpatient hospital, surgery, associated x-rays and anesthesia).

Diabetes Outpatient Self-Management

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

Diagnostic Services

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

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

Dialysis Services

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

Durable Medical Equipment

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

Reimbursement Guidelines for Durable Medical Equipment

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

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

Exclusion:

Equipment which is primarily for the convenience and/or comfort of the Covered Plan Participant, the Covered Plan Participant's family or caretakers; modifications to motor vehicles and/or homes such as wheelchair lifts or ramps; electric scooters; water therapy devices such as Jacuzzis, hot tubs, swimming pools or whirlpools; exercise and massage equipment; hearing aids; air conditioners and purifiers, humidifiers; water softeners and/or purifiers; pillows, mattresses or waterbeds; escalators, elevators, stair glides; emergency alert equipment; handrails and grab bars; heat appliances and dehumidifiers.

Enteral Formulas

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

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

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

Eye Care

Coverage includes the following services:

1. Physician services, soft lenses or sclera shells, for the treatment of aphakic patients;
2. initial glasses or contact lenses following cataract surgery; and
3. Physician services to treat an injury or disease to a Covered Plan Participant's eyes.

Exclusion:

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

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

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

6. Physical Therapy by a Physical Therapist, Occupational Therapy by a Occupational Therapist, and Speech Therapy by a Speech Therapist.

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

Exclusion:

1. any Home Health Care service which is not directly provided by (or indirectly provided) through a Home Health Agency;
2. homemaker services;
3. domestic maid services;
4. sitter services;
5. companion services;
6. services rendered by an employee or operator of an adult congregate living facility; an adult foster home; an adult day care center, or a nursing home facility;
7. Custodial Care; and
8. food, housing, and home delivered meals.

Hospice Services

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

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

   Recertification is required every six months.

Hospital Services

Hospital services including:

1. room and board in a semi-private room when confined as an inpatient, unless the patient must be isolated from others for documented clinical reasons;
2. intensive care units, including cardiac, progressive and neonatal care;
3. use of operating and recovery rooms;
4. use of emergency rooms;
5. respiratory, pulmonary, or inhalation therapy (e.g., oxygen);
6. drugs and medicines administered (except for take home drugs) by the Hospital;
7. intravenous solutions;
8. administration of, including the cost of, whole blood or blood products;
9. dressings, including ordinary casts;
10. anesthetics and their administration;
11. transfusion supplies and equipment;
12. diagnostic services, including radiology, ultrasound, laboratory, pathology and approved machine testing (e.g., EKG);
13. Physical, Speech, Occupational, Cardiac Therapies; and
14. transplants as set forth in the Transplant subsection.

Exclusion:

Expenses for the following Hospital Health Care Services are excluded when such services could have been provided without admitting the Covered Plan Participant to the Hospital:
1) room and board provided during the Covered Plan Participant's admission; 2) Physician visits provided while the Covered Plan Participant was an inpatient; and 3) Occupational Therapy, Speech Therapy, Physical Therapy, Cardiac Therapy are not covered.

In addition, expenses for the following are also excluded:

1. gowns and slippers;

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

Infertility Services

Infertility Services may be covered for a Covered Plan Participant who meets the criteria established by BSBCFL, 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 including testing, Artificial Insemination, and surgical procedures to correct Conditions causing infertility are also excluded.

Mammograms

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

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

Mastectomy Services

Breast cancer treatment including treatment for physical complications relating to a Mastectomy (including lymphedemas), and outpatient post-surgical follow-up in accordance with prevailing medical standards as determined by the Covered Plan Participant's attending Physician and the Covered Plan Participant. Outpatient post-surgical follow-up care for Mastectomy services shall be covered when provided by a Provider in accordance with the prevailing medical standards and at the most medically appropriate setting. The setting may be the Hospital, Physician's office, outpatient center, or home of the Covered Plan Participant. The treating Physician, after consultation with the Covered Plan Participant, may choose the appropriate setting.

Maternity Services

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

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

Under Federal law, a Group Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery; or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting

with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 as applicable). In any case, under Federal law, a Group Plan can only require that a Provider obtain authorization for prescribing an inpatient hospital stay that exceeds 48 hours (or 96 hours).

Newborn Care

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

Newborn Assessment

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

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.

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

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

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

Orthotic Devices

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

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

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

Exclusion:

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

2. Expenses for orthotic appliances or devices, which straighten or re-shape the conformation of the head or bones of the skull or cranium through cranial banding or molding (e.g. dynamic orthotic cranioplasty or molding helmets) except when the orthotic appliance or device used as an alternative to an internal fixation device as a result of surgery for craniosynostosis; and
3. Expenses for devices necessary to exercise, train, or participate in sports, e.g. custom-made knee braces.

Osteoporosis Screening, Diagnosis, and Treatment

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

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

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

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

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

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

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

Reimbursement Guidelines for Massage and Physical Therapy

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

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

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

Reimbursement Guidelines for Spinal Manipulations

1. Reimbursement for covered spinal manipulation is limited to no more than 26 spinal manipulations per Benefit Period, or the maximum benefit listed in the Schedule of Benefits, whichever occurs first.
2. Reimbursement for covered Physical Therapy Services rendered on the same day as spinal manipulation is limited to one (1) Physical Therapy treatment per day, not to exceed fifteen (15) minutes in length.

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

Oxygen

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

Physician Services

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

Payment Guidelines for E-Visits:

Expenses for online E-Visits will be covered only if such Services are:

1. provided to a covered individual who is an established patient of the Physician rendering the Services at the time the Services are provided; and
2. in response to an online inquiry received through the Internet from the covered individual with respect to which the Services were provided.

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

Exclusion:

Expenses for online medical Services provided by a health care provider that is not a Physician and expenses for Health Care Services rendered by telephone are also excluded.

Prosthetic Devices

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

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

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

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

Skilled Nursing Facilities

The following Health Care Services may be Covered Services when: 1) the Covered Plan Participant is an inpatient in a Skilled Nursing Facility; and 2) the Covered Plan Participant's Physician submits a treatment plan that is acceptable to BCBSF and/or Lake County Board of County Commissioners for coverage and payment purposes:

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

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

Exclusion:

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

Surgical Assistant Services

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

Surgical Procedures

Surgical procedures performed by a Physician including the following:

1. sterilization (tubal ligations and vasectomies), regardless of Medical Necessity;
2. surgery to correct deformity which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes;
3. oral surgical procedures for excisions of tumors, cysts, abscesses, and lesions of the mouth;
4. surgical procedures involving bones or joints of the jaw (e.g., temporomandibular joint [TMJ]) and facial region if, under accepted medical standards, such surgery is necessary to treat Conditions caused by congenital or developmental deformity, disease, or injury;
5. services of a Physician for the purpose of rendering a second surgical opinion and

related diagnostic services to help determine the need for surgery.

BCBSF's Reimbursement Guidelines for Surgical Procedures

1. Reimbursement for multiple surgical procedures, performed in addition to the primary surgical procedure, on the same or different areas of the body, during the same operative session will be based on 50 percent of the Allowed Amount for any secondary surgical procedure(s) performed and the Coinsurance or Copayment (if any) indicated in the Covered Plan Participant's Schedule of Benefits. This guideline is applicable to all bilateral procedures and all surgical procedures performed on the same date of service;
2. Reimbursement for Incidental Surgical Procedures is limited to the Allowed Amount for the primary procedure, and there is no additional payment for any incidental procedure. An "Incidental Surgical Procedure" includes surgery where one, or more than one, surgical procedure is performed through the same incision or operative approach as the primary surgical procedure which, in the opinion of BCBSF and/or Lake County Board of County Commissioners, is not clearly identified and/or does not add significant time or complexity to the surgical session. For example, the removal of a normal appendix performed in conjunction with a Medically Necessary hysterectomy is an Incidental Surgical Procedure (i.e., there is no reimbursement for the removal of the normal appendix in the example); and
3. Reimbursement for surgical procedures for fracture care, dislocation treatment, debridement, wound repair, unna boot, and other related Health Care Services, is included in the Allowed Amount of the surgical procedure.

Transplant Services

Limited to the procedures listed below, if coverage has been predetermined by BCBSF and/or Lake County Board of County Commissioners and if performed at a facility acceptable to BCBSF and/or Lake County Board of County Commissioners, subject to the conditions and limitations described below:

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

1. Bone Marrow Transplant, as defined herein, which is specifically listed in Rule 59B-12.001 of the *Florida Administrative Code* (or any successor rule or regulation) or covered by Medicare as described in the most recently published *Medicare Coverage Issues Manual* issued by the Health Care Financing Administration. Coverage will be provided for the cost of donating bone marrow by a donor to a Covered Plan Participant to the same extent such cost would be covered for a Covered Plan Participant and subject to the same limitations and exclusions as would be applicable to a Covered Plan Participant. Coverage for the reasonable costs of searching for the donor will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;
2. corneal transplant;
3. heart transplant (including a ventricular assist device, if indicated, when used as a bridge to heart transplantation);
4. heart-lung combination transplant;
5. liver transplant;
6. kidney transplant;

7. pancreas;
8. pancreas transplant performed simultaneously with a kidney transplant; or
9. lung-whole single or whole bilateral transplant.

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

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

For covered transplants, and all related complications, the Group Health Plan will cover:

1. Hospital and Physician expenses provided that such services will be paid in accordance with the same terms and conditions for care and treatment of any other covered Condition.
2. Donor costs and organ acquisition for transplants, other than Bone Marrow Transplants, provided such costs are not covered in whole or in part by any other insurance carrier, organization or person other than the donor's family or estate.

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

<u>Exclusion:</u>

The following are excluded:

1. transplant procedures not included in the list above, or otherwise excluded under this Evidence of Coverage (e.g., Experimental or Investigational transplant procedures);
2. transplant procedures involving the transplantation or implantation of any non-human organ or tissue;
3. transplant procedures related to the donation or acquisition of an organ or tissue for a recipient who is not covered by the Group Health Plan;
4. transplant procedures involving the implant of an artificial organ, including the implant of the artificial organ;
5. any organ, tissue, marrow, or stem cells which is/are sold rather than donated to the Covered Plan Participant;
6. any Bone Marrow Transplant, as defined herein, which is not specifically listed in Rule 59B-12.001 (or any successor rule or regulation) of the *Florida Administrative Code* or covered by Medicare pursuant to a national coverage decision made by the Health Care Financing Administration as evidenced in the most recently published *Medicare Coverage Issues Manual;*
7. any service in connection with identification of a donor from a local, state or national listing, except in the case of a Bone Marrow Transplant. The reasonable cost of searching for a donor is covered and will be limited to a search among immediate family members and donors identified through the National Bone Marrow Donor Program;

8. any transportation costs for the Covered Plan Participant or the Covered Plan Participant's family to and from the approved facility;
9. any direct, non-medical costs for the Covered Plan Participant to and from the approved facility;
10. any temporary lodging, except as covered under the Lodging, Meals, and Transportation Covered Services in the Transplant Services Subsection; and
11. any artificial heart or mechanical device that replaces either the atrium and/or the ventricle.

Lodging, Meals and Transportation

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

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 BCBSF within 90 days from the date the expenses were incurred in accordance with the Claims Processing Section of the Certificate of Coverage.

Wigs

Wigs and/or cranial prosthesis are covered after chemotherapy.

Section 7: General Exclusions

Introduction

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

General Exclusions include, but are not limited to:

1. any Health Care Service received prior to a Covered Plan Participant's Effective Date or after the date a Covered Plan Participant's coverage terminates, unless coverage is extended in accordance with the Extension of Benefits section;
2. any Health Care Services not specifically listed in the Covered Services section or in any rider, or Endorsement attached hereto, unless such services are specifically required to be covered by applicable law;
3. any Health Care Services provided by a Physician or other health care Provider related to the Covered Plan Participant by blood or marriage;
4. any Health Care Service which is not Medically Necessary as defined in this Evidence of Coverage and determined by BCBSF or Lake County Board of County Commissioners . The ordering of a service by a health care Provider does not in itself make such service Medically Necessary or a Covered Service;
5. Experimental or Investigational Services, except as otherwise covered under the Bone Marrow Transplant provision described in the Transplant Services category of the "Covered Services" section;
6. any Health Care Service to treat an injury resulting from an Accident related to a Covered Plan Participant's job or employment are excluded except for services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual;
7. any Health Care Services rendered at no charge;
8. any Health Care Services to diagnose or treat a Condition which, directly or indirectly, resulted from or is in connection with:
   a. war or an act of war, whether declared or not;
   b. the Covered Plan Participant's participation in, or commission of, any act punishable by law as a felony, or which constitutes riot, or rebellion;
   c. the Covered Plan Participant's engaging in an illegal occupation; or
   d. services received at military or government facilities including service in the armed forces, reserves and/or National Guard.
9. court-ordered care or treatment, unless otherwise covered;
10. any Health Care Services rendered by or through a medical or dental department maintained by or on behalf of an employer, mutual association, labor union, trust, or similar person or group;
11. Health Care Services that are not patient-specific, as determined solely by BCBSF.

Additional General Exclusions

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

Abortion, by choice; not Medically Necessary.

Adult Wellness, preventive care or routine screening services, except as specified on the Schedule of Benefits.

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

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

Autopsy or postmortem examination services, unless specifically requested by Lake County Board of County Commissioners or BCBSF.

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

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

Contraceptive medications, devices, appliances, or other Health Care Services when provided for contraception, except when indicated as covered, under the adult wellness benefit, on the Schedule of Benefits (when selected by Lake County Board of County Commissioners), or otherwise covered in the Covered Services section.

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

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

Custodial Care, and any service of a custodial nature, including without limitation: Health Care Services primarily to assist the Covered Plan Participant in the activities of daily living; rest

homes; home companions or sitters; home parents; domestic maid services; and respite care.

Dental care or treatment of the teeth or their supporting structures or gums, or dental procedures, including, but not limited to: extraction of teeth except as indicated in the "Dental" subsection of the Covered Services 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 Covered Services section.

Drugs:

1. Prescribed for uses other than the Food and Drug Administration (FDA) approved label indications. This exclusion does not apply to any drug that has been proven safe, effective and accepted for the treatment of the specific medical Condition for which the drug has been prescribed, as evidenced by the results of good quality controlled clinical studies published in at least two or more peer-reviewed full length articles in respected national professional medical journals. This exclusion also does not apply to any drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the drug is recognized for treatment of the Covered Plan Participant's particular cancer in a Standard Reference Compendium, or is recommended for treatment of the Covered plan Participant's particular cancer in Medical Literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.
2. All Drugs dispensed to, or purchased by, a Covered Plan Participant from a pharmacy, except as otherwise covered when the Covered Plan Participant is inpatient in a Hospital, Ambulatory Surgical Center, Skilled Nursing Facility, Psychiatric Facility, or outpatient department of a Hospital.
3. Any non-Prescription medicine, remedy, vaccine, biological product (except insulin), pharmaceuticals or chemical compounds, vitamins, mineral supplements, fluoride products, over the counter drugs, products, or health foods.
4. Any drug which is indicated or used for sexual dysfunctional (e.g., Cialis, Levitra, Viagra, Caverject). The exception described in exclusion number one above does not apply to sexual dysfunction drugs excluded under this paragraph.
5. Drugs, which require prior coverage authorization when prior coverage authorization is not obtained.

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

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

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

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

Maternity Services rendered to a Covered Plan Participant 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 Covered Plan Participant acting as a Gestational Surrogate.

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

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

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

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

Personal Comfort, Hygiene or Convenience Items and services deemed to be not Medically Necessary and not directly related to the treatment of the Covered Plan Participant including, but not limited to: beauty and barber services; clothing including support hose; radio and television; guest meals and accommodations; telephone charges; take-home supplies; travel expenses; other than Medically Necessary Ambulance services; motel/hotel accommodations; air conditioners; humidifiers; or Physical fitness equipment; and massages except as covered in the Covered Services section of this Evidence of Coverage.

Private Duty Nursing Care rendered in an inpatient basis.

Rehabilitative Therapies provided to a Covered Plan Participant 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 Manipulation Services categories of the Covered Services section.

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

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

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

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

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

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

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

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

Wigs and/or cranial prosthesis except as indicated in the “Wigs” subsection of the Covered Services section.

Section 8: Eligibility for Coverage

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

Eligibility Requirements for Covered Employees

To be an Eligible Employee, a person must be a bona fide employee of Lake County Board of County Commissioners and must meet each of the following requirements:

1. the Eligible Employee's job must fall within a job classification set forth on the Group Application;
2. the Eligible Employee must have completed any applicable Waiting Period set forth on the Group Application; and
3. the Eligible Employee must have completed any applicable eligibility requirement (s) set forth on the Group Application.

Lake County Board of County Commissioners' Covered Employee's eligibility classification may be modified, and 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 , provided such companies and Lake County Board of County Commissioners are under common control; 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 Employee eligibility class must be approved in writing by Lake County Board of County Commissioners and BCBSF prior to such expansion.

Eligibility Requirements for Covered Dependent(s)

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

1. The Covered Employee's spouse under a legally valid existing marriage.
2. The Covered Employee's natural, newborn, Adopted, Foster, or step child(ren) (or a child for whom the Covered Employee has been court-appointed as legal guardian or legal custodian) who has not reached the end of the Calendar Year in which he or she reaches age 26 (or in the case of a Foster Child, is no longer eligible under the Foster Child Program), regardless of the dependent child's student or marital status, financial dependency on the Covered Employee, whether the dependent child resides with the Covered Employee, or whether the dependent child is eligible for or enrolled in any other health plan.
3. The newborn child of a Covered Dependent child who has not reached the end of the Calendar Year in which he or she becomes 26. 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 Employee's sole responsibility to establish that a child meets the applicable requirements for eligibility.

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

Extension of Eligibility for Dependent Children

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

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

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

Handicapped Children

In the case of a handicapped dependent child, such child is eligible to continue coverage as a

Covered Dependent, beyond the age of 26, if the child is:

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

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

Exception for Students on Medical Leave of Absence from School

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

Section 9: Enrollment and Effective Date of Coverage

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

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

Enrollment Forms/Electing Coverage

To apply for coverage, the Eligible Employee must:

1. complete and submit, through Lake County Board of County Commissioners , the Application For Group Insurance/ Membership form;
2. provide any additional information needed to determine eligibility, if requested by Lake County Board of County Commissioners;
3. complete and submit, through Lake County Board of County Commissioners , a Member Status Change Request form to add Eligible Dependents or delete Covered Dependents.

When making application for coverage, the Eligible Employee must elect one of the types of coverage available under Lake County Board of County Commissioners' program. Such types may include:

1. Employee Only Coverage. This type of coverage provides coverage for the Eligible Employee only.
2. Employee/Family Coverage. This type of coverage provides coverage for the Eligible Employee and the employee's Eligible Dependents and spouse.

Enrollment Periods

The enrollment periods for applying for coverage are as follows:

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

Employee Enrollment

1. An individual who is an Eligible Employee on Lake County Board of County Commissioners ' Effective Date must enroll during the Initial Enrollment Period. The Eligible Employee shall become a Covered Employee as of the Effective Date of Lake County Board of County Commissioners. Eligible Dependents may also be enrolled during the Initial Enrollment Period. The Effective Date of coverage for an Eligible Dependent(s) shall be the same as the Covered Employee's 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 enroll before or within the Initial Enrollment Period. The Effective Date of coverage for such individual will begin on the date specified on the Group Application.

Dependent Enrollment

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

1. **Newborn Child** – To enroll a newborn child who is an Eligible Dependent, the Covered Employee must submit a Member Status Change Request form through Lake County Board of County Commissioners prior to or during the 30-day period immediately following the date of birth. The Effective Date of coverage for a newborn child shall be the date of birth.

   Lake County Board of County Commissioners must be notified, in writing, within 30 days after the birth. In the event Lake County Board of County Commissioners is not notified before or within 60 days of the birth of the newborn child, the Covered Employee must make application during an Annual Open Enrollment Period.

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

2. **Adopted Newborn Child** – To enroll an Adopted newborn child, the Covered Employee must submit a Member Status Change Request form through Lake County Board of County Commissioners to BCBSF prior to or during the 30-day period immediately following the date of birth. The Effective Date of coverage for an Adopted newborn child, eligible for coverage, shall be the moment of birth, provided that a written agreement to adopt such child has been entered into by the Covered Plan Participant prior to the birth of such child, whether or not such an agreement is enforceable. Lake County Board of County Commissioners may require the Covered Employee to provide any information and/or documents which BCBSF deems necessary in order to administer this provision.

   In the event Lake County Board of County Commissioners is not notified within 30 days of the date of Placement, the child will be added as of the date of Placement so long as the Covered Employee provides notice to Lake County Board of County Commissioners, and BCBSF receives the Enrollment Form within 60 days of the birth. If the Adopted child is not enrolled within 60 days of the date of Placement, the Adopted child will not be covered and the Covered Employee must make application during an Annual Open Enrollment Period.

   If the Adopted newborn child is not ultimately Placed in the residence of the Covered Employee, there shall be no coverage for the Adopted newborn child. It is the responsibility of the Covered Employee to notify Lake County Board of County Commissioners within ten calendar days if the Adopted newborn child is not Placed in the residence of the Covered Employee.

3. **Adopted/Foster Children** – To enroll an Adopted or Foster Child, the Covered Employee must submit a Member Status Change Request form through Lake County Board of County Commissioners to BCBSF prior to or during the 30-day period immediately following the date of Placement. The Effective Date for an Adopted or Foster child (other than an Adopted newborn child) shall be the date such Adopted or Foster child is Placed in the residence of the

Covered Plan Participant in compliance with Florida law. Lake County Board of County Commissioners may require the Covered Plan Participant to provide any information and/or documents deemed necessary, by BCBSF, in order to properly administer this section.

In the event Lake County Board of County Commissioners is not notified within 30 days of the date of Placement, the child will be added as of the date of Placement so long as the Covered Employee provides notice to the Group, and BCBSF receives the Enrollment Form within 60 days of the date of Placement. If the Adopted or Foster child is not enrolled within 60 days of the date of Placement, the Adopted or Foster child will not be covered and the Covered Employee must make application during an Annual Open Enrollment Period.

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

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

4. **Marital Status** – A Covered Employee may apply for coverage of an Eligible Dependent(s) due to marriage. To apply for coverage, the Covered Employee must complete and submit the Member Status Change Request form through Lake County Board of County Commissioners to BCBSF. The Covered Employee must make application for enrollment within 30 days of the marriage. The Effective Date of coverage for an Eligible Dependent(s) who is enrolled as a result of marriage is the date of the marriage.

5. **Court Order** – A Covered Employee may apply for coverage for an Eligible Dependent outside of the Initial Enrollment Period and Annual Open Enrollment Period if a court has ordered coverage to be provided for a minor child under the Covered Employee's plan. To apply for coverage, the Covered Employee must complete and submit the Member Status Change Request form through Lake County Board of County Commissioners to BCBSF. The Covered Employee must make application for enrollment within 30 days of the court order. The Effective Date of coverage for an Eligible Dependent who is enrolled as a result of a court order is the date required by the court or the next billing date.

Annual Open Enrollment Period

Eligible Employees and/or Eligible Dependents who did not apply for coverage during the Initial Enrollment Period or a Special Enrollment Period may apply for coverage during an Annual Open Enrollment Period. The Eligible Employee may enroll by completing the Application For Group Insurance/Membership form 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 is enrolled due to a special circumstance as outlined in the Special Enrollment Period subsection of this section.

Special Enrollment Period

An Eligible Employee and/or the Employee's Eligible Dependent(s) may apply for coverage outside of the Initial Enrollment Period and Annual Enrollment Period as a result of a special enrollment event. To apply for coverage, the Eligible Employee and/or the Employee's Eligible Dependent(s) must complete the applicable Enrollment Form and forward it to the Group 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 the Group within the indicated time periods:

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

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

   b) the Eligible Employee lost their other coverage under a group health benefit plan or health insurance coverage (except in the case of loss of coverage under a CHIP or Medicaid, see #3 below) as a result of termination of employment, reduction in the number of hours they work, reaching or exceeding the maximum lifetime of all benefits under other health coverage, the employer ceased offering group health coverage, death of their spouse, divorce, legal separation (not recognized in the state of Florida) or employer contributions toward such coverage was terminated; and

   c) the Eligible Employee submits the applicable Enrollment Form to the Group within 30 days of the date their coverage was terminated

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

   or

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

   or

3. If the Eligible Employee or their 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 the Eligible Employee submits the applicable

Enrollment Form to the Group within 60 days of the date such coverage was terminated or the date the Eligible Employee becomes eligible for the optional state premium assistance program.

Other Provisions Regarding Enrollment and Effective Date of Coverage

Rehired Employees

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

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

Termination of a Covered Employee's Coverage

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

1. on the date the Group Health Plan terminates;
2. on the last day of the first month that the Covered Employee fails to continue to meet any of the applicable eligibility requirements;
3. on the date the Covered Employee's coverage is terminated for cause (see the Termination of an Individual Coverage for Cause subsection); or
4. on the date specified by Lake County Board of County Commissioners that the Covered Employee's coverage terminates.

Termination of a Covered Dependent's Coverage

A Covered Dependent's coverage will automatically terminate:

1. at 12:01 a.m. on the date the Group Health Plan terminates;
2. at 12:01 a.m. on the date the Covered Employee's coverage terminates for any reason;
3. the Dependent becomes covered under an alternative health benefits plan which is offered through or in connection with the Group;
4. the 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 an Individual's Coverage for Cause

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

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

Notice of Termination to Covered Plan Participants

It is Lake County Board of County Commissioners' responsibility to immediately notify Covered Plan Participants of termination of the Group Health Plan for any reason.

Certification of Creditable Coverage

In the event coverage terminates for any reason, a written Certification of Creditable Coverage to the Covered Plan Participant will be issued.

The Certification of Creditable Coverage will indicate the period of time the Covered Plan Participant was enrolled in the Group Health Plan. Creditable Coverage may reduce the length of any Pre-existing condition exclusion period by the length of time the Covered Plan Participant had prior Creditable Coverage.

Covered Plan Participants may request another Certification of Creditable Coverage within a 24-month period after termination of coverage. The

Covered Plan Participant may call the customer service phone number indicated in this Evidence of Coverage or on the Covered Plan Participant's Identification Card to request the Certification of Creditable Coverage

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

Section 11: Continuing Coverage Under COBRA

Continuing Coverage under COBRA

Federal continuation of coverage requirements of 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 Lake County Board of County Commissioners, a Covered Plan Participant may be entitled to continue coverage for a limited period of time, if the Covered Plan Participant meets the applicable requirements, makes a timely election, and pays the proper Premiums.

A Covered Plan Participant must contact Lake County Board of County Commissioners to determine if he or she 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 covered employees and dependents of their rights under COBRA. If a Covered Plan Participant fails to meet their obligations under COBRA and the Group Health Plan, BCBSF shall not be liable for any claims incurred by the Covered Plan Participant after his/her termination of coverage.

Solely for informational purposes, a summary of the COBRA rights of a Covered Plan Participant and the general conditions for a Covered Plan Participant's qualification for COBRA continuation coverage is provided below. The duty to meet such obligations remains with Lake County Board of County Commissioners.

Covered Plan Participants may elect, if COBRA applies to Lake County Board of County Commissioners and the Covered Plan Participant is eligible for such coverage, to continue their group health insurance if they qualify under one of the following circumstances:

1. If coverage would otherwise be lost due to the death of a covered active or retired employee of Lake County Board of County Commissioners, the surviving Covered Plan Participants may qualify to elect to continue their group health coverage for a period of time not to exceed 36 months from the date of death.
2. A spouse who would otherwise lose coverage due to a divorce or legal separation (not recognized in the state of Florida) from a covered active or retired employee of Lake County Board of County Commissioners, and dependent children who would otherwise lose coverage due to the divorce or legal separation (not recognized in the state of Florida), may qualify to elect to continue their group health coverage for a period of time not to exceed 36 months from the date of divorce or legal separation (not recognized in the state of Florida).
3. A spouse or dependent child of a covered active or retired employee who would otherwise lose coverage due to the employee's (or retired employee's) entitlement to Medicare, may qualify to elect to continue their group health coverage for a period not to exceed 36 months from the date the employee or covered retiree first becomes entitled to Medicare.
4. Children of a covered active or retired employee, who would otherwise lose coverage due to a failure to meet Lake County Board of County Commissioners' health plan's eligibility requirements (e.g., exceeding the limiting age), may qualify to elect to continue group health coverage for a period not to exceed 36 months from the date the child ceased to meet such eligibility requirements.

5. a. Covered Plan Participants may qualify to elect to continue their group health coverage if coverage would otherwise be lost due to termination of employment with Lake County Board of County Commissioners (other than for reasons of gross misconduct), or due to a reduction in hours of employment with Lake County Board of County Commissioners . This continuation of coverage may continue for a period not to exceed 18 months from the date of termination or reduction in hours.

   b. If the Covered Plan Participant is totally disabled (as defined by the Social Security Administration) at the time of the employee's termination, reduction in hours, or within the first 60 days of COBRA continuation of coverage, an extension of coverage of up to 11 additional months may be available (29 months total), if all notification and eligibility requirements have been met. This extension of coverage will not be provided if the Covered Plan Participant fails to provide Lake County Board of County Commissioners with a copy of the "Determination of Disability" letter from the Social Security Administration within 60 days of the date of the determination of disability. The "Determination of Disability" letter must be provided to Lake County Board of County Commissioners prior to the end of the 18-month COBRA continuation period. If the extension of coverage for the 11 additional months is granted, the extension applies to all non-disabled Covered Plan Participants.

6. If a Covered Plan Participant is receiving continuation of coverage under paragraph 5, such coverage may continue for a period longer than the time stipulated in that paragraph if an event that would otherwise have entitled the Covered Plan Participant to COBRA continuation of coverage (e.g., divorce, legal separation or death) later occurs. But in no case will the Covered Plan Participant receive coverage beyond 36 months from the event that originally made him or her eligible for coverage.

7. If a bankruptcy or other proceeding under Title 11 of the United States Code commences with respect to Lake County Board of County Commissioners, continuation rights shall be provided to the Covered Plan Participant to the extent required under COBRA.

In order for the group health coverage to continue pursuant to COBRA, the following conditions must be met:

1. a. If coverage would be lost due to a reduction in hours or termination of employment (for reasons other than gross misconduct), it is Lake County Board of County Commissioners' responsibility to notify the employee and dependents of their continuation of coverage rights under COBRA within 14 days of the termination of employment or reduction in hours causing loss of coverage.

   b. 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, the employee or dependent must notify Lake County Board of County Commissioners, in writing, within 60 days of any of these events. It is Lake County Board of County Commissioners' responsibility to notify the dependents of their continuation of coverage rights within 14 days of receipt of such notice from the employee or dependent.

2. The qualified Covered Plan Participant must elect to continue the group health insurance within 60 days of the later of the date that

the coverage terminates or the date the notification of continuation of coverage rights is sent by Lake County Board of County Commissioners.

3. The qualified Covered Plan Participant who elects continuation of coverage must not become covered under any other group health insurance plan. However, COBRA coverage may continue if the new group health insurance plan contains exclusions or limitations due to a Pre-existing Condition that would affect the continuant's coverage.

4. The qualified Covered Plan Participant, who elects continuation of coverage, must not become after electing, entitled to Medicare.

5. A totally disabled Covered Plan Participant who is eligible to extend and who elects to extend his or her continuation of coverage may not continue such coverage more than 30 days after a determination by the Social Security Administration that the Covered Plan Participant is no longer disabled. The Covered Plan Participant must inform Lake County Board of County Commissioners of the Social Security determination within 30 days of such determination.

   For purposes of this section, a totally disabled Covered Plan Participant is a Covered Plan Participant who is determined to be disabled under the Social Security Acts (Title II, OASDI or Title XVII, SSI).

6. The qualified Covered Plan Participant electing continuation of coverage must meet all Premium payment requirements, and all other eligibility requirements set forth in COBRA, and, to the extent not inconsistent with COBRA, in the Group Health Plan.

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

The Covered Plan Participant does not need to show insurability to receive COBRA continuation of coverage. However, the Covered Plan Participant must pay the applicable Premiums charged by Lake County Board of County Commissioners.

In the case of a qualified Covered Plan Participant whose maximum period of continuation of coverage expires, it is the responsibility of Lake County Board of County Commissioners, during the 180-day period prior to such expiration date, to provide the qualified Covered Plan Participant the option of enrolling in an individual conversion policy, if applicable, and made available to the Covered Plan Participants of Lake County Board of County Commissioners by BCBSF.

Note: This section shall not be interpreted to grant to any Covered Plan Participant any continuation rights in excess of those required by COBRA and/or Section 4980B of the Internal Revenue Code. Additionally, the Group Health Plan Description 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 12: Conversion Privilege

Eligibility Criteria for Conversion

A Covered Plan Participant may apply for an individual policy (hereinafter referred to as a "converted policy") if:

1. the Covered Plan Participant was continuously covered for at least three months under the Group Health Plan and/or under another group policy, in effect, immediately prior to the Group Health Plan providing similar benefits; and
2. the Covered Plan Participant's coverage has been terminated for any reason, including discontinuance of the Group Health Plan in its entirety and termination of continued coverage under COBRA.

BCBSF will mail to a Covered Plan Participant, within 14 days after the Covered Plan Participant gives proper notice to BCBSF that he/she is considering applying for a converted policy or the Covered Plan Participant requests such information, a converted policy application and premium notice, including an outline of coverage. The outline of coverage will contain a brief description of the benefits and coverage, exclusions and limitations, and the applicable Deductible(s) and Coinsurance provisions.

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

In the event BCBSF does not receive the converted policy application and the initial Premium payment within such 63-day period, the Covered Plan Participant's converted policy application will be denied and the Covered Plan Participant will not be entitled to a converted policy.

Additionally, a Covered Plan Participant is not entitled to a converted policy if:

1. the Covered Plan Participant is eligible for or covered under the Medicare program;
2. the Covered Plan Participant's coverage terminated because the Covered Employee failed to make any Premium contribution payment on a timely basis;
3. coverage was replaced by any group policy, contract, plan, or program, including a self-insured plan or program, that provides benefits similar to the benefits provided under the Group Health Plan Description; or

4 a. the Covered Plan Participant is 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 Evidence of Coverage; or

   b. the Covered Plan Participant is 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 Evidence of Coverage; or

   c. benefits similar to the benefits provided under this Evidence of Coverage are provided for or are available to the Covered Plan Participant pursuant to or in accordance with the requirements of any state or federal law (e.g., COBRA, Medicaid); and

5. the benefits provided under the sources referred to in paragraph 4a. or the benefits provided or available under the source referred to in paragraph 4b. and c. above, together with the benefits provided by BCBSF's converted policy would result in over insurance in accordance with BCBSF's over insurance standards, as determined by BCBSF.

Neither Lake County Board of County Commissioners nor BCBSF has any obligation to notify any Covered Plan Participant of this conversion privilege when the Covered Plan Participant's coverage terminates or at any other time. It is the sole responsibility of the Covered Plan Participant to exercise this conversion privilege by submitting a BCBSF converted policy application and the initial Premium payment to BCBSF on a timely basis. The converted policy may be issued without evidence of insurability and shall be effective the day following the day the individual's coverage hereunder terminated.

Note: BCBSF's 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 Evidence of Coverage. A Covered Plan Participant applying for a BCBSF converted policy has two options: 1) a converted policy providing major medical coverage meeting the requirements of Section 627.6675(10) *Florida Statutes*, and 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, BCBSF shall not be required to issue a converted policy unless required to do so by Florida law.

Section 13: Extension of Benefits

Extension of Benefits

In the event the Group Health Plan is terminated, there is no coverage for any Health Care Service rendered on or after the termination date. The extension of benefits provisions set forth below only apply when the Group Health Plan is terminated. The extension of benefits provided hereunder do not apply when an individual Covered Plan Participant's coverage terminates as long as the Group Health Plan remains in effect. The extension of benefits provisions are subject to all of the other provisions, including the limitations and exclusions.

Note: It is the Covered Plan Participant's responsibility to provide acceptable documentation to BCBSF that the Covered Plan Participant is entitled to an extension of benefits.

1. In the event a Covered Plan Participant is Totally Disabled on the termination date of the Group Health Plan as a result of a specific Accident or illness incurred while the Covered Plan Participant was covered under this Evidence of Coverage, BCBSF will provide a limited extension of benefits for the disabled Covered Plan Participant 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 the opinion of BCBSF, the Covered Plan Participant is unable to work at any gainful job for which the Covered Plan Participant is suited by education, training, or experience, and the Covered Plan Participant requires regular care and attendance by a Physician. For those Covered Plan Participants who do not work (e.g., a student, child, or non-working spouse) such Covered Plan Participant is Totally Disabled only if, in the opinion of BCBSF, such Covered Plan Participant is unable to perform those normal day-to-day activities which they would otherwise perform and such Covered Plan Participant requires regular care and attendance by a Physician.

2. In the event a Covered Plan Participant is receiving covered dental treatment as of the termination date of the Group Health Plan, BCBSF will provide a limited extension of benefits for such covered dental treatment provided:

   a. a course of dental treatment or dental procedures were recommended in writing and commenced in accordance with the terms specified herein while the Covered Plan Participant was covered under the Group Health Plan;

   b. the dental procedures were procedures for other than routine examinations, prophylaxis, x-rays, sealants, or orthodontic services; and

   c. the dental procedures were performed within 90 days after the Covered Plan Participant's coverage terminated under the Group Health Plan, and the termination did not occur as a result of the Covered Employee's voluntary termination of coverage.

   This extension of benefits is for Covered Services necessary to complete the dental treatment only. This extension of benefits will automatically terminate at the end of the 90-day period beginning on the termination date of the Group

Health Plan or on the date the Covered Plan Participant becomes covered under a succeeding insurance, health maintenance organization or self-insured plan providing coverage or services for similar dental procedures. This extension of benefits is not predicated upon the Covered Plan Participant being Totally Disabled.

3. In the event a Covered Plan Participant is pregnant as of the termination date of the Group Health Plan, BCBSF will provide a limited extension of the maternity expense benefits provided by this Evidence of Coverage, provided the pregnancy commenced while the pregnant Covered Plan Participant was covered under the Group Health Plan, as determined by BCBSF. 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. This extension of benefits is not predicated upon the Covered Plan Participant being Totally Disabled.

Section 14: The Effect of Medicare Coverage/Medicare Secondary Payer Provisions

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

Under Medicare, Lake County Board of County Commissioners MAY NOT offer, subsidize, procure or provide a Medicare supplement policy to such Covered Plan Participant. Also, Lake County Board of County Commissioners MAY NOT induce such Covered Plan Participant to decline or terminate his or her group health insurance coverage and elect Medicare as primary payer.

A Covered Plan Participant who becomes 65 or who becomes eligible for Medicare due to End Stage Renal Disease ("ESRD") must notify Lake County Board of County Commissioners.

Individuals With End Stage Renal Disease

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

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

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

Disabled Active Individuals

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

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

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

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

a. the individual turns 65 years of age; or

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

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

3. Entitlement of the Covered Employee and/or his or her Covered Dependents to primary coverage under this sub-section will terminate automatically if the Covered Employee no longer qualifies as such under applicable Medicare regulations and instructions. Lake County Board of County Commissioners shall notify BCBSF, without delay, of any such change in status.

Miscellaneous

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

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

Section 15: Duplication of Coverage Under Other Health Plans/Programs

Coordination of Benefits

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

1. any group insurance, group-type self-insurance, or HMO plan;
2. any group contract issued by any Blue Cross and/or Blue Shield Plan(s);
3. any plan, program or insurance policy, including an automobile PIP insurance policy and/or medical payment coverage;
4. Medicare, as described in The Effect of Medicare Coverage/Medicare Secondary Payer Provisions section.

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

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

1. When the Group Health Plan covers the Covered Plan Participant as a Covered Dependent and the other plan covers the Covered Plan Participant as other than a dependent, the Group Health Plan will be secondary.
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 the Group Health Plan, the Group Health Plan will be secondary.
3. When the Group Health Plan covers a dependent child whose parents are separated or divorced:

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

   b. if the parent with custody has remarried, the plan of the parent with custody is primary; the 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 the Covered Plan Participant as a dependent child and the other plan covers the Covered Plan Participant as a dependent child:

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

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

5. When rules 1, 2, 3, and 4 above do not establish an order of benefits, the plan which has covered the Covered Plan Participant 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 an individual is covered under a COBRA continuation plan as a result of the purchase of coverage as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and also under another group plan, the following order of benefits applies:

   a. first, the plan covering the person as an employee, or as the employee's dependent;

   b. second, the coverage purchased under the plan covering the person as a former employee, or as the former employee's Dependent provided according to the provisions of COBRA.

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

Non-Duplication of Government Programs

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

Section 16: Subrogation

Subrogation

In the event payment is made under the Group Health Plan to or on behalf of a Covered Plan Participant 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 such Covered Plan Participant has against any person or entity. Such subrogation rights shall extend and apply to any settlement of a claim, regardless of whether litigation has been initiated. BCBSF 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 the Participant is able to obtain including, but not limited to uninsured motorists, even if the Covered Plan Participant is not made whole for his/her losses. BCBSF may recover, on behalf of Lake County Board of County Commissioners and/or the Group Health Plan, the amount of any payments made on the Covered Plan Participant's behalf minus BCBSF or Lake County Board of County Commissioners' pro rata share for any costs and attorney fees incurred by the Covered Plan Participant in pursuing and recovering damages. BCBSF 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 the Covered Plan Participant's 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 the Covered Plan Participant is able to obtain even if the Covered Plan Participant or Covered Plan Participant's attorney believes that the Covered Plan Participant has not been made whole for his/her losses or damages by the amount of the recovery or settlement.

The Covered Plan Participant shall promptly execute and deliver such instruments and papers pertaining to such settlement of claims, settlement negotiations, or litigations as may be requested by BCBSF, and shall do whatever is necessary to enable BCBSF to exercise Lake County Board of County Commissioners' subrogation rights and shall do nothing to prejudice such rights. Additionally, the Covered Plan Participant or the Covered Plan Participant's legal representative shall promptly notify BCBSF in writing of any settlement negotiations prior to entering into any settlement agreement, shall disclose to BCBSF any amount recovered from any person or entity that may be liable, and shall not make any distributions of settlement or judgement proceeds without Lake County Board of County Commissioners' prior written consent. No waiver, release of liability, or other documents executed by a Covered Plan Participant without such notice to BCBSF shall be binding upon Lake County Board of County Commissioners.

Section 17: Right of Reimbursement

Right of Reimbursement

If any payment under the Group Health Plan is made to or on behalf of a Covered Plan Participant on account of 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 shall have a right to be reimbursed by the Covered Plan Participant (out of any settlement or judgments recovered which include payment for medical expenses) one dollar ($1.00) for each dollar paid under the terms of the Group Health Plan Description without reduction for attorney's fees or costs incurred by the Covered Plan Participant in obtaining such settlements or judgments.

Lake County Board of County Commissioners' and/or the Group Health Plan's right of reimbursement shall be in addition to any subrogation right or claim available to Lake County Board of County Commissioners, and the Covered Plan Participant shall execute and deliver such instruments or papers pertaining to any settlement or claim, settlement negotiations, or litigation as may be requested by BCBSF, on behalf of 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. No waiver, release of liability, or other documents executed by the Covered Plan Participant, without notice to and written consent of BCBSF, acting on behalf of Lake County Board of County Commissioners, shall be binding upon Lake County Board of County Commissioners.

Section 18: Claims Processing

Introduction

This section is intended to:

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

Under no circumstances will BCBSF be held responsible for, nor will BCBSF accept liability relating to, the failure of the Covered Plan Participant's Group Health Plan's sponsor or plan administrator to: 1) comply with any applicable disclosure requirements; 2) provide the Covered Plan Participant with a Summary Plan Description (SPD); or 3) comply with any other legal requirements. The Covered Plan Participant should contact the plan sponsor or administrator with questions relating to the Group Plan's SPD. BCBSF is not the Covered Plan Participant's 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 the Evidence of Coverage, there are three types of claims: 1) Pre-Service Claims; 2) Post-Service Claims; and 3) Claims Involving Urgent Care. It is important that the Covered Plan Participant become familiar with the types of claims that can be submitted to BCBSF and the timeframes and other requirements that apply.

Post-Service Claims

How to File a Post-Service Claim

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

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

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

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

1. the date the service was provided;
2. a description of the service including any applicable procedure code(s);

3. the amount actually charged by the Provider;
4. the diagnosis including any applicable diagnosis code(s);
5. the Provider's name and address;
6. the name of the individual who received the service; and
7. the Covered Employee's name and contract number as they appear on the ID Card.

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

Note: If your plan has retail pharmacy 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 received outside the state of Florida under the BlueCard® Program (See the BlueCard® Program section of the Evidence of Coverage).

The Processing of Post-Service Claims

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

- Payment for Post-Service Claims

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

- Contested Post-Service Claims

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

- Denial of Post-Service Claims

In the event BCBSF denies a Post-Service Claim submitted electronically, BCBSF will use its best efforts to provide notice, within 20 days of receipt, that the claim or a portion of the claim is denied. In the event BCBSF denies a paper Post-Service Claim, BCSBF will use its best efforts to provide notice, within 30 days of receipt, that the claim or a portion of the claim is denied. The notice may identify the denied portion(s) of the claim and the reason(s) for denial. It is the Covered Plan Participant's responsibility to ensure that BCBSF receives all information determined by BCBSF as necessary to adjudicate a Post-Service Claim. **If BCBSF**

does not receive the necessary information, the claim or a portion of the claim may be denied.

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

Additional Processing Information for Post-Service Claims

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

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

Pre-Service Claims

How to File A Pre-Service Claim

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

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

Benefit Determinations on Pre-Service Claims Involving Urgent Care

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

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

BCBSF will use its best efforts to provide notice of a decision on a Pre-Service Claim not

involving urgent care within 15 days of receipt provided additional information is not required for a coverage decision. BCBSF may extend this 15-day determination period one time for up to an additional 15 days. If such an extension is necessary, BCBSF will use its best efforts to provide notice of the extension and reasons for it. BCBSF will use its best efforts to provide notification of the decision on the Covered Plan Participant's Pre-Service claim within a total of 30 days of the initial receipt of the claim, if an extension of time was taken by BCBSF.

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

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

Concurrent Care Decisions

Reduction or Termination of Coverage or Benefits for Services

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

- BCBSF and/or the Employer 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 services; and
- the reduction or termination of coverage or benefits by BCBSF and/or the Employer was not due to an amendment of the Evidence of Coverage or termination of the Covered Plan Participant's coverage as provided by the Evidence of Coverage.

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

Requests for Extension of Services

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

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

Standards for Adverse Benefit Determinations

Manner and Content of a Notification of an Adverse Benefit Determination

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

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

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

How to Appeal an Adverse Benefit Determination

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

- BCBSF must receive the Covered Plan Participant's appeal of an Adverse Benefit Determination in person or in writing;
- The Covered Plan Participant may request to review pertinent documents, such as any internal rule, guideline, protocol, or similar

criterion relied upon to make the determination, and submit issues or comments in writing;

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

Requests for an appeal should be sent to the address below:

Blue Cross and Blue Shield of Florida, Inc.
Attention: Member Appeals
P.O. Box 44197
Jacksonville, Florida 32231-4197

<u>Timing of Appeal Review on Adverse Benefit Determinations by BCBSF</u>

BCBSF will use its best efforts to review a Covered Plan Participant's appeal of an Adverse Benefit Determination and communicate the decision in accordance with the following time frames:

- Pre-Service Claims-- within 30 days of the receipt of the Covered Plan Participant's appeal;
- Post-Service Claims-- within 60 days of the receipt of the Covered Plan Participant's appeal; or
- Claims Involving Urgent Care (and requests to extend concurrent care services made within 24 hours prior to the termination of the services)-- within 72 hours of receipt of the Covered Plan Participant's request. If additional information is necessary BCBSF will notify the Covered Plan Participant within 24 hours and BCBSF must receive the requested additional information within 48 hours of the request. After BCBSF receives the additional information, BCBSF will have an additional 48 hours to make a final determination.

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

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

How to Request External Review of BCBSF's Appeal Decision

If the Covered Plan Participant is not satisfied with BCBSF's internal review of his or her appeal of an Adverse Benefit Determination, please refer to the Adverse Benefit Determination notice or call the customer service phone number on the Covered Plan Participant's ID Card for information on how to request an external review.

Additional Claims Processing Provisions

1. Release of Information/Cooperation:

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

2. Physical Examination:

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

3. Legal Actions:

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

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

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

5. Explanation of Benefits Form:

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

   a. the specific reason or reasons for the Adverse Benefit Determination;

   b. reference to the specific Evidence of Coverage provisions upon which the Adverse Benefit Determination is based

as well as any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination;

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 the Covered Plan Participant how they can obtain the specific explanation of the scientific or clinical judgment for the determination.

6. Circumstances Beyond the Control of BCBSF:

   To the extent that natural disaster, war, riot, civil insurrection, epidemic, or other emergency or similar event not within the control of BCBSF, results in facilities, personnel or financial resources of BCBSF being unable to process claims for Covered Services, BCBSF will have no liability or obligation for any delay in the payment of claims for Covered Services, except that BCBSF will make a good faith effort to make payment for such services, taking into account the impact of the event. For the purposes of this paragraph, an event is not within the control of BCBSF if BCBSF cannot effectively exercise influence or dominion over its occurrence or non-occurrence.

Section 19: Relationships Between the Parties

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

Neither BCBSF nor Lake County Board of County Commissioners nor any of their officers, directors or employees provide Health Care Services to Covered Plan Participants. Rather, BCBSF and Lake County Board of County Commissioners and such individuals are engaged in making coverage and/or benefit decisions under this Evidence of Coverage. By accepting coverage and/or benefits under the Group Health Plan, Covered Plan Participants agree that making such coverage and/or benefit decisions does not constitute the rendering of Health Care Services and that health care Providers rendering Health Care Services are not the employees or agents of BCBSF or Lake County Board of County Commissioners. **In this regard, BCBSF and Lake County Board of County Commissioners hereby expressly disclaim any agency relationship, actual or implied, with any health care Provider.** BCBSF 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 this Group Health Plan concerning appropriateness of setting, or whether any service is Medically Necessary, shall be deemed to be made solely for purposes of determining whether such services are covered, and not for purposes of recommending any treatment or non-treatment. Neither BCBSF nor 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.

BCBSF and Lake County Board of County Commissioners

Neither Lake County Board of County Commissioners nor any Covered Plan Participant is the agent or representative of BCBSF, and neither shall be liable for any acts or omissions of BCBSF, its agents, servants, or employees. Additionally, neither Lake County Board of County Commissioners, any Covered Plan Participant, nor BCBSF shall be liable, whether in tort or contract or otherwise, for any acts or omissions of any other person or organization with which BCBSF has made or hereafter makes arrangements for the provision of Covered Services. BCBSF is not the agent, servant, or representative of Lake County Board of County Commissioners or any Covered Plan Participant, and shall not be liable for any acts or omissions of Lake County Board of County Commissioners, its agents, servants, employees, any Covered Plan Participant, 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/or benefits hereunder, each Covered Plan Participant agrees to the foregoing.

Medical Decisions - Responsibility of a Covered Plan Participant's Physician, Not BCBSF

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

Section 20: General Provisions

Access to Information

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

Compliance with Applicable Laws and Regulations

The terms of coverage and/or benefits to be provided under the Group Health Plan Description shall be deemed to have been modified by the parties, and shall be interpreted, so as to comply with applicable laws and regulations dealing with rates, benefits, eligibility, enrollment, termination, conversion, or other rights and duties of a Covered Plan Participant, Lake County Board of County Commissioners, or BCBSF.

Confidentiality

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

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

Identification Cards

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

Modification of Provider Networks and the Participation Status

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

Non-Waiver of Defaults

Any failure by Lake County Board of County Commissioners or BCBSF at any time, or from time to time, to enforce or to require the strict adherence to any of the terms or conditions set forth herein, shall in no event constitute a waiver of any such terms or conditions. Further, it shall not affect the right of Lake County Board of County Commissioners or BCBSF at any time to enforce or avail itself of any such remedies as it may be entitled to under applicable law.

Notices

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

If to BCBSF:

To the address printed on the Identification Card.

If to a Covered Plan Participant:

To the latest address provided by the Covered Plan Participant or to the Covered Employee's latest address on the Application for Group Insurance/Membership, if applicable, or change of address form actually delivered to BCBSF.

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

Proof of Coverage

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

Promissory Estoppel

No oral statements, representations, or understanding by any person can change, alter, delete, add, or otherwise modify the express written terms of this Evidence of Coverage.

Right to Receive Necessary Information

In order to administer coverage and/or benefits, BCBSF 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 any Covered Plan Participant or applicant for enrollment which BCBSF or Lake County Board of County Commissioners deems to be necessary.

Right to Recovery

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

Service Mark

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

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 web site address www.floridahealthfinder.gov, may be accessed through the link provided on the Blue Cross and Blue Shield of Florida's corporate web site at www.FloridaBlue.com.

Third Party Beneficiary

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

Customer Rewards Programs

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

Section 21: Glossary of Terms

For purposes of this Evidence of Coverage and any Endorsements, the following terms shall have the meanings set forth below. Additional definitions pertaining to Providers may be found in the Health Care Provider Alternatives and Reimbursement Rules section of this Evidence of Coverage.

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

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

Administrative Services Only Agreement or ASO Agreement means the agreement between Lake County Board of County Commissioners and BCBSF. Under the Administrative Services Only Agreement, BCBSF provides claims processing and payment services, customer service, utilization review services and access to its statewide preferred provider organization ("PPO") and Traditional Insurance Providers.

Adoption or Adopt(ed) means the process and act of creating a legal parent/child relationship declaring that the child is legally the child of the adoptive parents and their heir-at-law and entitled to all the rights and privileges and subject to all the obligations of a child born to such adoptive parents, or as otherwise defined by *Florida Statutes* or the similar applicable laws of another state.

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

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

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

Blue is unable to pass on its negotiated price due to the terms of its Provider contracts. See the BlueCard® Program section for more details.

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

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

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

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

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

Ambulatory Surgical Center means a facility properly licensed pursuant to Chapter 395 of the *Florida Statutes*, or a similar applicable law of another state, the primary purpose of which is to provide elective surgical care to a patient, admitted to, and discharged from such facility

within the same working day. As used herein an Ambulatory Surgical Center cannot be a part of a Hospital.

Anniversary Date means the date, one year after the Effective Date and subsequent annual anniversaries of that date.

Application For Group Insurance/Membership means the BCBSF form that individual(s) must submit to Lake County Board of County Commissioners when applying for coverage during the 30-day period immediately following the date that individual(s) first became eligible for coverage under the Group Health Plan, or as part of the initial enrollment of Lake County Board of County Commissioners.

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

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

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

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

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

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

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

Bone Marrow Transplant means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative or non-ablative therapy with curative or life-prolonging intent. Human blood precursor cells may be obtained from the patient in an autologous transplant, or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "Bone Marrow Transplant" includes the transplantation as well as the administration of chemotherapy and the chemotherapy drugs. The term "Bone Marrow Transplant" also includes any services or

supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells and includes any and all Hospital, Physician or other health care Provider Health Care Services which are rendered in order to treat the effects of, or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells (e.g., Hospital room and board and ancillary services).

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

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

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

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

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

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

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

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

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

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

Copayment (if applicable) means the dollar amount established which is required to be paid to a health care Provider by a Covered Plan Participant at the time certain Covered Services are rendered by that Provider. While this amount may vary depending on, among other things, the contracting status of the health care Provider rendering the service and the type of service being rendered, in no event will such

amount exceed the amount specified in the Schedule of Benefits for the service. Except as otherwise established, if more than one Covered Service is rendered by a health care Provider during a single office visit, the Copayment shall not exceed the highest Copayment specified in the Schedule of Benefits for any of the services rendered during such office visit, regardless of the number of services rendered during such office visit.

Cost Share means the dollar or percentage amount established solely by us, which must be paid to a health care Provider by the Covered Plan Participant at the time Covered Services are rendered by that Provider. Cost Share may include, but is not limited to Coinsurance, Copayment, Deductible and/or Per Admission Deductible (PAD) amounts. Applicable Cost Share amounts are identified in the Schedule of Benefits.

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

Covered Plan Participant means the Covered Employee or Covered Dependent who meets and continues to meet the applicable eligibility requirements of Lake County Board of County Commissioners and is actually covered under the Group Health Plan.

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

Creditable Coverage means health care coverage which is continuous to a date within 63 days of the Covered Plan Participant's Enrollment Date. Such health care coverage may include any of the following:

1. a group health plan;
2. individual health insurance;
3. Medicare Part A and Part B;
4. Medicaid;
5. benefits to members and certain former members of the uniformed services and their dependents;
6. a medical care program of the Indian Health Service or of a tribal organization;
7. a State health benefits risk pool;
8. a health plan offered under chapter 89 of Title 5, United States Code;
9. a public health plan;
10. a health benefit plan of the Peace Corps;
11. State Children's Health Insurance Program (CHIP);
12. public health plans established by the federal government; or
13. public health plans established by foreign governments.

Custodial or Custodial Care means care that serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing,

feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving Custodial Care, consideration is given to the frequency, intensity and level of care and medical supervision required and furnished. A determination that care received is custodial is not based on the patient's diagnosis, type of Condition, degree of functional limitation, or rehabilitation potential.

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

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

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

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

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

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

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

Effective Date with respect to Lake County Board of County Commissioners and to Covered Plan Participants properly enrolled when coverage first becomes effective, means 12:01 a.m. on the date so specified on the cover of this Group Health Plan Description; and with respect to Covered Plan Participants who are subsequently enrolled, means 12:01 a.m. on the date on which coverage will commence as specified in the Enrollment and Effective Date of Coverage section of this Evidence of Coverage.

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

Eligible Employee means an employee who meets all of the eligibility requirements set forth in the Eligibility Requirements for Covered Employees subsection of the Eligibility for Coverage section, and is eligible to enroll as a Covered Plan Participant. Any individual who is

an Eligible Employee is not a Covered Employee until such individual has actually enrolled with, and been accepted for coverage as a Covered Employee.

Employer means Lake County Board of County Commissioners which has established this plan for the purpose of providing coverage and/or benefits to Covered Plan Participants.

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

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

Enrollment Forms means those forms, which are used to maintain accurate enrollment files under the Group Health Plan. Such forms include: the Application for Group Insurance/ Membership form and the Member Status Change Request form.

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

1. such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the United States Food and Drug Administration or the Florida Department of Health and approval for marketing has not, in fact, been given at the time such is furnished to the Covered Plan Participant;
2. such evaluation, treatment, therapy, or device is provided pursuant to a written protocol which describes as among its objectives the following: determinations of safety, efficacy, or efficacy in comparison to the standard evaluation, treatment, therapy, or device;
3. such evaluation, treatment, therapy, or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations;
4. credible scientific evidence shows that such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical investigation, or the experimental or research arm of a Phase III clinical investigation, or under study to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
5. credible scientific evidence shows that the consensus of opinion among experts is that further studies, research, or clinical investigations are necessary to determine: maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the Condition in question;
6. credible scientific evidence shows that such evaluation, treatment, therapy, or device has not been proven safe and effective for treatment of the Condition in question, as evidenced in the most recently published Medical Literature in the United States, Canada, or Great Britain, using generally accepted scientific, medical, or public health methodologies or statistical practices;
7. there is no consensus among practicing Physicians that the treatment, therapy, or device is safe and effective for the Condition in question; or
8. such evaluation, treatment, therapy, or device is not the standard treatment, therapy, or device utilized by practicing Physicians in treating other patients with the same or similar Condition.

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

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

   Note: Health Care Services which are determined by Lake County Board of County Commissioners or BCBSF to be Experimental or Investigational are excluded (see the Covered Services section). In determining whether a Health Care Service is Experimental or Investigational, BCBSF 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 under the age of 18 who is placed in the Covered Employee's residence and care by the Florida Department of Health & Rehabilitative Services in compliance with *Florida Statutes* or by a similar regulatory agency of another state in compliance with that state's applicable laws.

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

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

Gestational 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.

Group Health Plan Description means the written document whereby coverage and/or benefits will be provided to Covered Plan Participants. The Group Health Plan Description

includes the Evidence of Coverage (including the Schedule of Benefits), the Application for Group Insurance/Membership, the Member Status Change Request form, and any Endorsements to the Group Health Plan Description or the Evidence of Coverage.

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

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

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

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

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

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

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

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

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

Independent Diagnostic Testing Facility means a facility, independent of a hospital or physician's office, which is a fixed location, a mobile entity, or an individual non-physician

practitioner where diagnostic tests are performed by a licensed physician or by a licensed, certified non-physician personnel under appropriate physician supervision. An Independent Diagnostic Testing Facility must be appropriately registered with the Agency for Health Care Administration and must comply with all applicable Florida law or laws of the State in which it operates. Further, such an entity must meet BCBSF's criteria for eligibility as an Independent Diagnostic Testing Facility.

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

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

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

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

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

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

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

Medical Emergency means the sudden and unexpected onset of a medical or psychiatric Condition or an injury that in the absence of medical care could reasonably be expected to endanger your life or result in serious injury or disability.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Outpatient Rehabilitation Facility means an entity which renders, through providers properly licensed pursuant to Florida law or the similar law or laws of another state: outpatient physical therapy; outpatient speech therapy; outpatient occupational therapy; outpatient cardiac rehabilitation therapy; and outpatient massage for the primary purpose of restoring or improving a bodily function impaired or eliminated by a

Condition. Further, such an entity must meet BCBSF's criteria for eligibility as an Outpatient Rehabilitation Facility. The term Outpatient Rehabilitation Facility, as used herein, shall not include any Hospital including a general acute care Hospital, or any separately organized unit of a Hospital, which provides comprehensive medical rehabilitation inpatient services, or rehabilitation outpatient services, including, but not limited to, a Class III "specialty rehabilitation hospital" described in Chapter 59A, *Florida Administrative Code* or the similar law or laws of another state.

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.

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.

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

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

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

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

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

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

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

PPO Provider means, or refers to, any health care Provider who or which, at the time Health Care Services were rendered to a Covered Plan Participant, was under contract with BCBSF to participate in BCBSF's network of preferred Providers, such Providers also known as "Preferred Patient Care^{sm}" or "PPC^{sm}" Providers or BCBSF PPC^{sm} Providers. The term PPO Provider also refers, when applicable, to health care Providers in certain counties who or which, at the time Health Care Services were rendered to a Covered Plan Participant, were under contract to participate as PPC^{sm} Providers. A Covered Plan Participant, when receiving Covered Services from any PPC^{sm} Provider, is also considered a policyholder, as that term is defined and used in the applicable PPC Provider agreement between such Provider and BCBSF. For purposes of this Evidence of Coverage, the term PPO Provider also refers, when applicable,

to any health care Provider located outside the state of Florida who or which, at the time Health Care Services were rendered to a Covered Plan Participant, participated as Host Plan PPO Providers under the Blue Cross and Blue Shield Association's BlueCard® Program.

PPO Schedule Amount means the amount on which payment will be based for a Covered Service rendered by a health care Provider who, at the time the Covered Service was rendered, was a BCBSF PPC Provider. This amount is determined and established by BCBSF and is a pre-established maximum schedule amount which may vary by geographical area.

The amount of charges credited to the Deductible requirement will not exceed the Allowed Amount.

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

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

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

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

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

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

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

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

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

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

Residential Treatment Facility means a facility properly licensed under Florida law or a similar applicable law of another state, to provide care

and treatment of Mental and Nervous Disorders and Substance Dependency and meets all of the following requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Waiting Period means the period of time specified if any, which must follow the date an individual is initially employed by Lake County Board of County Commissioners before such individual may become a Covered Plan Participant.

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.