STARK COUNTY SCHOOLS

Traditional Comprehensive Major Medical (CMM) Preferred Provider Organization (PPO) Dental Coverage Prescription Coverage Vision Coverage

HEALTH BENEFITS PLAN

for

STARK COUNTY SCHOOLS COUNCIL OF GOVERNMENTS

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Section I

Introduction

In order to utilize your premium dollars to the best advantage and secure prompt, efficient claims service, Stark County Schools has elected to "Self-Fund" your health Plan and retain Medical Mutual Services of Cleveland, Ohio and AultCare of Canton, Ohio to perform the necessary claims processing and administrative services.

This booklet provides you with a summary of your Health Benefit Plan. You will notice that a brief description of your benefits is provided for your convenience. Should you have further or more detailed questions regarding the Plan, you are urged to contact your Claims Administrator.

Non-Grandfathered Health Plan Disclosure
Under the Patient Protection and Affordable Care Act (PPACA), plans are either “grandfathered” or “non-grandfathered.” This determination affects which provisions of PPACA apply to the Traditional and PPO Plans.

The Claims Administrators believe the Traditional and PPO Plans are “non-grandfathered” under PPACA. As stated by PPACA, a non-grandfathered health must comply with certain health coverage, for example, the requirement for the provision of preventive health services without any cost sharing or annual dollar maximums.

Questions regarding which protections apply to a non-grandfathered health plan can be directed to your group official or your Claims Administrator. You may also contact the U.S. Department of Health and Human Services at www.healthcare.gov/law/index.html.

Section II

Schedule of Benefits

Traditional Comprehensive Major Medical Schedule of Benefits (CMM)

(not available to new enrollees after 8/1/09)

Overall Lifetime Maximum Benefits..... Unlimited

Calendar Year Deductible Amount (p.26)

- Individual $250.00
- Family $500.00

Coinsurance (after the Deductible is satisfied) (p.27)..... 80%

Calendar Year Coinsurance Out of Pocket limit (p.27)

- Individual $750.00
- Family $1,500.00
- (Excludes the Deductible)

Calendar Year Maximum Out of Pocket Limit (p. 27)

- Indvidual $1,000.00
- Family $2,000.00
- (Sum of Deductible and Coinsurance)

Preventive Care.....100%

Eligible preventive services have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations.

- Routine Physical Exam
  (one per Calendar Year, age 21 and older)
- Routine GYN Exam
  (two per Calendar Year)
- Routine Pap Test
  (one per Calendar Year)
- Routine Mammography
  (one per Calendar Year)
- Well Child Care
  (including immunizations up to 21 years of age)
- Routine Colonoscopy
  (Age 50 and over)

Routine Adult Immunizations
(Age 21 and older)

Prostate Screening
(one per calendar year) 80%

Mental Health/Substance Abuse
Inpatient and Outpatient .....Based on corresponding medical benefits

Covered Services will be reimbursed based on the Allowed Amount.

Preferred Provider Organization (PPO)
Schedule of Benefits

Overall Lifetime Maximum Benefits..... Unlimited

	In Network	Out of Network
Calendar Year Deductible Amount (p.26)		
Individual	$250.00	$500.00
Family	$500.00	$1,000.00
Coinsurance (after the Deductible is satisfied) (p.27).....	90%	80%
Calendar Year Coinsurance Out of Pocket Limit (p.27)		
Individual	$750.00	$1,500.00
Family ..... (Excludes the Deductible)	$1,500.00	$3,000.00
Calendar Year Maximum Out of Pocket Limit (p.27)		
Individual	$1,000.00	$2,000.00
Family ..... (Sum of Deductible and Coinsurance)	$2,000.00	$4,000.00

PREVENTIVE CARE

Eligible preventive services have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations.

Routine Physical Exam ..... (one per Calendar Year, age 21 and older)	100%	80%**
Routine GYN Exam..... (two per Calendar Year)	100%	80%**
Routine Pap Test..... (one per Calendar Year)	100%	80%**
Routine Mammography..... (one per calendar year)	100%	80%**
Prostate Screening ..... (one per Calendar Year)	100%	80%**
Well Child Care ..... (including immunizations up to 21 years of age)	100%	80%**

	In Network	Out of Network
Routine Colonoscopy (Age 50 and over)	100%	80%**
Routine Adult Immunizations (Age 21 and over)	100%	80%**
PHYSICIAN'S OFFICE		
Allergy Testing/Injections	90%	80%**
Visits for Illness	90%	80%**
Emergency Care	90%	80%**
Minor Surgery	90%	80%**
Diagnostic Testing	90%	80%**
Speech/Occupational Therapy (Illness/Injury related)	90%	80%**
Physical/Rehabilitative Therapy (Illness/Injury related)	90%	80%**
Respiratory Therapy	90%	80%**
AFFILIATES		
Chiropractors	90%	80%**
Podiatrists	90%	80%**
MENTAL HEALTH/SUBSTANCE ABUSE		
Inpatient and Outpatient	Based on corresponding medical benefits	

****The level of benefits payable under this Plan depends upon whether you choose to obtain medical care from an In-Network or Out-of-Network Provider. The Plan encourages you to utilize In-Network Providers in order to receive the highest level of benefits payable. Covered Services will be reimbursed based on the Allowed Amount. In-Network Providers will not hold you responsible for amounts exceeing the Allowed Amount.**

Dental Expense Benefits

Calendar Year Deductible Amount
Individual (p.46) $25.00
Family (p.46)..... $75.00

Coinsurance (After Deductible is Satisfied)

**Preventive and Diagnostic Services (p.47) .....100% of R & C

Basic Restorative Services (p.47) ..... 80% of R & C

Major Restorative Services (p.48) ..... 80% of R & C

**Orthodontic Services (p.49) ..... 60% of R & C

****The Dental Deductible Amount is waived for Preventive and Diagnostic Services and Orthodontic Services**

Overall Calendar Year
Maximum Benefit (p.46) ..... $2,500.00 per person

Orthodontic Lifetime
Maximum Benefit (p.46) ..... $1,200.00 per person

Vision Expense Benefits

Eye Examinations
One regular eye examination in each 12 consecutive month period by an ophthalmologist, optician or optometrist is provided for each person covered under the program. The maximum payment is $40.00 per exam.

Lenses
One pair in each 12 consecutive month period is covered. Payment is made for the actual charge for one or two lenses or contact lenses, but not more than:

	Per Lens	Per Pair
Single Vision	$ 20.00	$ 40.00
Bifocals	$ 30.00	$ 60.00
Trifocals	$ 40.00	$ 80.00
Lenticular	$100.00	$200.00
Contact Lenses (cosmetic)	$ 35.00	$ 70.00
Contact Lenses (medically necessary)	$200.00	$400.00

*NOTE: The amount for a single lens is fifty percent (50%) of the amount for a pair of lenses.

The allowance for medically necessary contact lenses will be paid only if: (a) the lenses are necessary following cataract surgery; (b) visual acuity cannot be correct to 20/70 in either eye with other lenses, but can be correct to at least 20/70 in either eye with contact lenses; or (c) the lenses are necessary for the treatment of anisometropia for keratoconus.

Should an individual select contact lenses instead of conventional lenses, when the latter is all that is needed, the program will pay the amount equal to the single lenses plus the frames toward the cost of the contact lenses.

Maximum

The Plan will pay the actual charge for the services and supplies up to the maximum, the difference will be added to the maximum amount applicable to any other service or supply for which a charge is incurred within sixty days.

Frames
One set of frames is covered every 24 consecutive month period provided the frames are used with lenses prescribed after an eye examination. Frame allowance: $30.00. When new frames are not required, the payment allowed for frames may be applied toward the cost of lenses.

Limitations and Exclusions
Services for which vision care coverage does not provide benefits include:

- Sunglasses, whether or not a prescription is required.
- Drugs or medication
- Employer furnished services or supplies or those covered under Worker's Compensation laws, occupational disease laws or similar legislation
- Services and supplies rendered or furnished as a result of loss, theft, or breakage of lenses, contact lenses or frames for which benefits were paid under the Group Contract and benefits
- Orthoptics or vision training
- Aniseikonic lenses
- Coated lenses

Vision care does not provide full benefits for cosmetic vision needs. This distinction applies particularly to frames and contact lenses.

Section III

Prescription Drug Coverage

Your prescription drug benefit is administered by CVS/Caremark.

	Retail	Mail Order
When to use your benefit:	For immediate or short-term medications	For maintenance or long-term medications**
Where:	To locate a CVS/ Caremark participating retail network pharmacy in your area, simply click on "Find a Local Pharmacy" at www.caremark.com or call a Customer Care representative toll-free at 1-888-202-1654	Simply mail your original prescription and the mail service order form to CVS/ Caremark. Your medicines will be sent directly to a location of your choice.
Your Coinsurance (financial responsibility):	20% of the cost of the medication for generics and brand drugs without a generic. **100% of the cost of brand drugs if a generic is available.** **100% of the cost of long-term** drugs that are filled at a retail pharmacy more than 2 times.** **You must present your I.D. number at the CVS/ Caremark Pharmacy and may not submit a paper claim for primary coverage. Failure to do so will result in you paying 100% of the prescription price.**	
Refill Limits:	One initial fill plus 1 refill for long-term medications**	
Days Supply:	34 Days	90 Days

**A long-term medicine is taken regularly for chronic conditions or long-term therapy. A few examples include medicines for managing high blood pressure, asthma, diabetes, or high cholesterol.

When you need to take your maintenance medicine right away, ask your doctor for two prescriptions:

1. The first for up to a 34-day supply at retail and one refill at retail.
2. The second for up to a 90-day supply at mail order with refills when clinically appropriate.

Have the short-term supply filled immediately at a CVS/Caremark participating retail pharmacy and send the 90-day supply prescription to the CVS/Caremark Mail Service Pharmacy.

Getting Your Short-Term Prescription Filled at a Retail Pharmacy

Day Supply Limit
You can get up to a 34-day supply of medicine each time you have a prescription filled at a participating retail pharmacy. Ask your doctor to write a prescription for up to a 34-day supply plus refills, when clinically appropriate. Keep in mind; if you are taking long-term medications each one must be filled at CVS/Caremark's mail order facility after the initial fill plus 1 refill.

If You Use a Non-Caremark Pharmacy
You must pay 100 percent of the prescription price. You will then need to submit a paper claim form along with the original prescription receipt(s) to CVS/Caremark for reimbursement of Covered Services. You can download and print a claim form when you log in to www.caremark.com or call the Customer Care toll-free number (available 24/7) on your benefit I.D. card. You must have met your deductible to be reimbursed the 80%.

If You Use a Caremark Pharmacy
If you use a Caremark Pharmacy but do not identify yourself as a member of your school's health Plan program (present your I.D. card or Member I.D. number), you may not file a paper claim for reimbursement for primary coverage.

For Reimbursement under the Medical Plan
You do not need to file a claim with the Claims Administrator in order for your prescription costs to be credited toward your Coinsurance out-of-pocket maximum. Prescription drug information is sent by CVS/Caremark to the Claims Administrator on a regular basis. The Claims Administrators process the claims. If your coinsurance out of pocket maximum has been met, you will be reimbursed in accordance with your Plan parameters.

Getting Your Prescription Filled Through CVS/Caremark's Mail Order Program

To ensure your safety, CVS Caremark's mail service pharmacies are staffed by registered pharmacists. Just like your neighborhood pharmacist, CVS Caremark's pharmacists check each prescription to make sure it is filled correctly. In addition, your prescription history is reviewed to identify any possible problems with new medicines you may be prescribed.

Day Supply Limit
You can get up to a 90-day supply of medicine when you get your prescription filled through the CVS Caremark Mail Service Pharmacy. Ask your doctor to write a prescription for a 90-day supply plus refills, when clinically appropriate.

Please Note: *By law, CVS Caremark must fill your prescription for the exact quantity of medicine prescribed by your doctor, up to the 90-day supply limit.*

Payment Options
While checks and money orders are accepted, CVS Caremark's preferred method of payment is by credit card. For credit card payments, simply include your VISA®, Discover®, MasterCard® or American Express® number and expiration date in the space provided on the mail service order form.

Convenient Home Delivery
You can expect your medicine to arrive approximately 10 calendar days after CVS Caremark receives your prescription. Your package will include a new mail service order form and an invoice, if applicable. You will also receive the same type of information about your prescribed medicine that you would receive from a retail pharmacy.

Eligibility
Prescription drug coverage is available to the Employee and any Dependents who are "primary" under the Employee's coverage. For definition of "primary" see the Coordination of Benefits sectiion.

Secondary Coverage
To file a claim for secondary coverage, you will need to submit a **paper claim form** along with the original prescription receipt(s) and primary coverage Explanation of Benefits or receipt to AultCare or Medical Mutual for reimbursement of Covered Services.

Specialty Drugs
For Specialty medications, please contact CVS/Caremark at 800-237-2767.

Additional Covered Services
This is a summary of the Affordable Care Act Preventive Care requirements and not intended to be an exhaustive list. This list is subject to change upon issuance of additional regulations and guidance.

- The following prescription drugs are not subject to the prescription drug coinsurance when filled by a CVS/Caremark network pharmacy:
  - Prescribed generic prescription drug contraceptives or brand name prescription drug contraceptives when an equivalent generic prescription drug contraceptive is not available
  - Preventive care vaccines, including immunizations for flu (i.e. Fluzone) and shingles (i.e. Zostavax)
- The following over the counter preventive drugs, with a Physician's prescription
  - Aspirin for members age 45 and over up to 100 units per fill
  - Fluoride is covered for members age 6 and under
  - Folic acid for women age 55 and under up to 100 units per fill
  - Iron is covered for children up to 12 month old
  - Tobacco-cessation aids up to 168 days of medication per year
  - Vitamin D is covered for members age 65 and older
  - Bowel preparation medicine before colonoscopy procedures for members age 50 to 74
  - Breast cancer prevention for female members age 35 and older at increased risk

Non-Covered Services

- Male contraceptive and over the counter birth control without a prescription
- Over the counter drugs or supplies
- Anorexiants (diet pills)
- Medical devices or supplies
- Rogaine
- Retin A over age 26
- Growth Hormones
- Cosmetic
- Diabetic Supplies – unless enrolled in diabetic wellness program
- Non insulin needles and syringes
- Specialty Drugs that are not obtained through CVS/Caremark's Specialty Pharmacy
- Long-Term medications filled at a retail pharmacy beyond the initial fill plus 1 refills
- Brand drugs that have a generic equivalent
- Drugs purchased at CVS/Caremark Retail Pharmacy when insurance I.D. is not used for primary coverage (no reimbursement for paper claim)

Section IV

Pre-Certification

Pre-Admission Certification and Concurrent Review administered by Medical Mutual Services and AultCare includes three separate components designed to ensure that you receive quality medical care and that your Hospital related care is provided in the most cost-effective manner possible.

Pre-certification does not apply to those participants for whom Stark County Schools COG coverage is secondary insurance.

Pre-certification will monitor the cost-effectiveness of your health care through its Pre-Admission Certification/Concurrent Review, Second Surgical Opinion and Case Management Program described below.

Under the Pre-Admission Certification/Concurrent Review Program, your doctor's recommendation for non-emergency hospitalization is reviewed and "pre-certified" before you are admitted to the Hospital. Any elective non-emergency Hospital stay (including mental health and substance abuse admissions) must be pre-certified.

Pre-certification ensures that a Hospital admission is necessary for the care recommended and that the efficient scheduling of service occurs. The result is less costly and more effective use of Hospital services and less inconvenience for you and your family.

Here's how it works: If your doctor recommends that you or a covered family member be admitted to the Hospital for a non-emergency reason, the doctor will contact the Claims Administrator for Pre-certification of your stay approximately two weeks before the anticipated admission.

At that time, your doctor will indicate the treatment involved and the anticipated length of stay in the Hospital.

If your doctor forgets to contact the Claims Administrator for Pre-certification, the information can be called in by the Physician's staff to Medical Mutual Services or AultCare at the toll free numbers listed later in this section. You or a family

member may call the Pre-certification Department to begin the process. A nurse reviewer will then contact your doctor for the necessary information.

In the case of an Emergency admission, your doctor should notify the Claims Administrator's Pre-Certification Department of the hospitalization within one working day of admission. The review of the course of treatment during hospitalization is called "concurrent review." Concurrent review verifies that Hospital admission already in progress does not exceed the number of days that are medically required.

The Pre-Admission certification and concurrent review procedures required for full benefit under your health Plan are described more fully below:

- A registered nurse reviewer familiar with the Hospital procedures will review the number of days your Physician recommended for hospitalization. Usually that recommendation is approved without question. In those cases where it appears that length of the Hospital stay could be less than your Physician has recommended, a Physician reviewer will contact your doctor to discuss the need for the extended stay.
- Your Physician and the Hospital will be notified in writing of the initial number of days that have been approved for reimbursement under your medical Plan.
- During a Hospital stay, a nurse reviewer will contact the Hospital. If the Hospital stay exceeds or is expected to exceed the approved number of days, a nurse reviewer will contact your Physician to verify the medical necessity of the additional days.

NOTE: FAILURE TO FOLLOW THE PRE-CERTIFICATION PROCEDURE MAY RESULT IN THE PATIENT PAYING THE FIRST $200 OF ROOM AND BOARD CHARGES.

CASE MANAGEMENT
Case Management is an economical, common sense approach to health care benefits. Sometimes patients, who can safely be treated at home or in another setting, remain hospitalized because relatively inexpensive and practical alternative care or equipment does not appear to be covered by health insurance. The Case Management Program is designed to help in these instances.

HOW CASE MANAGEMENT WORKS
In the process of the Concurrent Review Program described above, the nurse reviewer will identify cases that may be appropriate for care in an alternative site. The nurse reviewer will contact the patient's attending Physician to discuss the alternative, support care and equipment which might make discharge from the Hospital possible. For example, a ramp built in the home of a patient confined to a wheelchair may make it possible for the patient to return home rather than continuing to stay in the Hospital. In this case, the nurse reviewer would discuss that alternative and obtain authorization for reimbursement for the ramp from the Plan. Case Management also provides assistance to families of terminally ill patients regarding Hospice care. The Case Management Program is designed to identify the best-possible care options for each individual patient and meet that individual's unique needs.

CALL THE CLAIMS ADMINISTRATOR'S PRE-CERTIFICATION DEPARTMENT ABOUT CASE MANAGEMENT
If you or a family member are hospitalized, you may call the Pre-Certification Department listed later in this section to discuss possible alternatives to hospitalization with a nurse reviewer.

Case Management works because quality care can be more cost-effective when care is personally and professionally managed.

PRE-CERTIFICATION SUMMARIZED
Pre-certification does not limit or restrict your choice of Hospital or Physician.

Pre-certification does not apply where Medicare or any other coverage is your primary insurance.

WHAT NEEDS TO BE DONE

Notify your Physician that your medical Plan includes participation in a Pre-Certification program.

REMEMBER — Your Physician MUST call the Pre-Certification Department before admission when elective hospitalization is anticipated or within one working day of any Emergency admission.

If elective surgery has been recommended or if you have any questions, contact the Claims Administrators Pre-Certification Department.

Medical Mutual	
Pre-Certification Department	1-800-338-4114
(Traditional or SuperMed Plus)	8:00 am - 4:30 pm
AultCare Pre-Certification Department	1-800-344-8858
	or
	1-330-363-6397
	7:30 am - 5:00 pm

Calls before or after these hours will be recorded and returned.

Section V

Eligibility

Who is Eligible for Coverage?

An Eligible Employee is a person who is regularly scheduled to work the number of hours specified in the respective bargaining unit agreements. Contact the school office for eligibility information.

An Eligible Dependent is:

A legal spouse of the Employee not divorced or legally separated.

Spouses of District/Entity employees who are eligible for health insurance coverage from their own employer must enroll in that coverage. District/Entity employees must certify whether or not their spouse is eligible for coverage through the spouse's employer by completing a Spouse Eligibility Certification form. Forms can be obtained from the Treasurer/Fiscal office.

Federal Law applicable to medical coverage only

Coverage for Employee's or spouse's children can be provided to age 26, for:

1) Natural children
2) Stepchildren
3) Children placed for adoption and legally adopted children
4) Children for whom either the Employee or the Employee's spouse is the Legal Guardian or Custodian
5) Any children who, by court order, must be provided health care coverage by the Employee or Employee's spouse.

Ohio Law applicable to medical coverage only (expires July 1, 2016)

At the option of the Employee and at the Employee's expense, coverage for children can be provide to age 28, if the eligible dependent child is:

1) not married;

2) the natural child, stepchild or adopted child of the Employee or the Employee's spouse;
3) a resident of Ohio;
4) if not an Ohio resident, a full time student at an accredited public or private institution of higher education;
5) not employed by an employer that offers any health benefit plan under which the child is eligible for coverage;
6) not eligible for coverage under Medicaid and Medicare.

Dependent Age applicable to Dental and Vision coverage only

Dependent children are covered to the end of the month of the 19th birthday or the end of the month of the 26th birthday if the dependent is a full-time student.

Coverage will continue past the age limit for Dependents who are unmarried and dependent upon the Employee for support due to a physical or intellectual disability. Proof of such incapacity and dependency must be furnished to the Plan within 31 days of reaching the limiting age. The Claims Administrator may require, at reasonable intervals, subsequent proof of the child's incapacity and dependency. The Plan reserves the right to have such dependent examined by a Physician of the Plan's choice to determine the existence of such incapacity.

When Does Coverage Begin?

Each Employee will be eligible on their first day of active employment.

Coverage will become effective on the date the Employee becomes eligible provided the Employee has enrolled for coverage within 30 days of their initial date of eligibility.

Newborn Dependent child will be eligible on the date of birth provided that Dependent has been enrolled within 30 days of birth.

Coverage for Dependents will become effective on the date the Employee's coverage becomes effective provided the Employee has enrolled for Dependent coverage within 30 days of the Dependents date of eligibility.

If Dependents are added after the Employee's effective date, and the Employee had no Dependents previously, they will be covered on the date that they become an eligible person provided the election of coverage is made within 30 days of the date of eligibility.

If additional Dependents are added while the individual has Dependent coverage, they will be covered on the date that they become eligible provided the election of coverage is made within 30 days of the date of eligibility.

Late Enrollees
Employees and Dependents who do not enroll for coverage when first eligible will be late enrollees. Late enrollees who subsequently wish to enroll for coverage may do so during the Open Enrollment Period. The Open Enrollment Period will be November 1 through November 30 for a coverage effective date of January 1.

Late enrollees who subsequently wish to enroll for coverage due to the involuntary termination of other coverage will be covered on the date the other coverage terminated provided the Employee has enrolled within 30 days of the date the other coverage ceases.

If Dependents are added after the Employee's effective date, and the Employee had no Dependents previously, they will be covered, on the date that they become an eligible person provided they have been enrolled within 30 days of eligibility.

If additional Dependents are added while the individual has Dependent coverage, they will be covered on the date that they become eligible provided they have been enrolled within 30 days of eligibility.

In the case of a newborn child, coverage will become effective on the newborn child's date of birth provided the newborn child is enrolled within 30 day's from the date of birth.

Special Enrollment
You or your Eligible Dependent who has declined the coverage provided by this Benefit Book may enroll for coverage under this Benefit Book during any special enrollment period if you lose coverage or add a dependent for the following reasons, as well as any other event that may be added by federal regulations:

1. In order to qualify for special enrollment rights because of loss of coverage, you or your Eligible Dependent must have had other group health plan coverage at the time coverage under this Benefit Book was previously offered. You or your Eligible Dependent must have also stated, in writing, at that time that coverage was declined because of the other cover-

age, but only if the Claims Administrator required such a statement at the time coverage was declined, and you were notified of this requirement and the consequences of declining coverage at that time.

2. If coverage was non-COBRA, loss of eligibility or the Group's contributions must end. A loss of eligibility for special enrollment includes:
   a. Loss of eligibility for coverage as a result of divorce or legal separation
   b. Cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the Benefit Book)
   c. Death of an Eligible Employee
   d. Termination of employment
   e. Reduction in the number of hours of employment that results in a loss of eligibility for plan participation (including a strike, layoff or lock-out)
   f. Loss of coverage that was one of multiple health insurance plans offered by an employer, and the Eligible Employee elects a different plan during an open enrollment period
   g. An individual no longer resides, lives, or works in an HMO Service Area (whether or not within the choice of the individual), and no other benefit package is available to the individual through the other employer
   h. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual
   i. A situation in which an individual incurs a claim that would meet or exceed a medical plan lifetime limit on all benefits (additional requirements apply)
   j. Termination of an employee's or dependent's coverage under Medicaid or under a state child health insurance plan (CHIP)
   k. The employee or dependent is determined to be eligible for premium assistance in the Group's plan under a Medicaid or CHIP plan
3. If you or your Eligible Dependent has COBRA coverage, the coverage must be exhausted in order to trigger a special enrollment right. Generally, this means the entire 18, 29 or

36-month COBRA period must be completed in order to trigger a special enrollment for loss of other coverage.

4. Enrollment must be supported by written documentation of the termination of the other coverage with the effective date of said termination stated therein. With the exception of items "j" (termination of Medicaid or CHIP coverage) and "k" (eligibility for premium assistance) above, notice of intent to enroll must be provided to the Claims Administrator by the Group no later than thirty-one (31) days following the triggering event with coverage to become effective on the date the other coverage terminated. For items "j" and "k" above, notice of intent to enroll must be provided to the Claims Administrator by the Group within sixty (60) days following the triggering event, with coverage to become effective on the date of the qualifying event.

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Eligible Dependents, provided that you request enrollment within thirty-one (31) days after the marriage, birth, adoption or placement for adoption.

Termination of Coverage

An Employee's coverage will terminate on the earliest of: (1) the date the Plan terminates; (2) the last day of the month the Employee ceases to be an eligible Employee; (3) the date all coverage or certain benefits are terminated for the Employee due to modification of the Plan; (4) the date the Employee becomes a full-time member of the Armed Forces of any country; (5) the date the Employee fails to make any required contribution.

A Dependent’s coverage will terminate on the earliest of: (1) the date the Plan terminates; (2) the date the Employee's coverage terminates; (3) the date the Dependent becomes a full-time member of the Armed Forces of any country; (4) the date the Dependent fails to make any required contribution; or (5) the end of the month in which the Dependent no longer meets the Plan's definition of Dependent.

Continuation of Benefits (COBRA)

On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) was enacted. This law gives

you and your beneficiaries the opportunity to receive the same options for health care benefits that you currently have at the group rate should your status with the company change or if there is a change in your relationship with your family.

You can become eligible for continued health care benefits by purchasing them at the group rate if you or your beneficiaries fall into one of the following categories. The duration of coverage depends on the condition of eligibility.

CONDITION OF ELIGIBILITY	DURATION OF COVERAGE OFFERED
Widowed spouse and Dependent children (up to age 26).	36 months
Employees, their spouses and Dependent children who have been terminated (voluntary or involuntary except for reason of gross misconduct).	18 months
Employees, their spouses and Dependent children, if their hours have been reduced resulting in lost coverage.	18 months
Divorced or legally separated spouse and their Dependent children.	36 months
Medicare ineligible spouses.	36 months
Dependent children who no longer meet the Plan's definition of eligibility.	36 months

You will be responsible for paying both the employer and the Employee contributions to receive this continued coverage, plus up to 2 percent to cover administrative costs.

Your eligibility for coverage may end earlier if:

1. You receive health insurance through another employer or Medicare.
2. The premium for continuation of coverage is not paid on time.
3. The company no longer sponsors group health coverage for any of its Employees.

If you are terminated, your hours are reduced to part time, or you become a widowed spouse of an Employee, you will be notified that you are eligible for continued coverage under COBRA. Should a person become eligible for any other reason, it is his or her responsibility to notify the Personnel Department of the qualifying event.

Rescission of Coverage

A rescission of coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide a person with coverage, just as if that person never had coverage under the Plan. Coverage can only be rescinded if a Covered Person (or a person seeking coverage on behalf of that Covered Person), performs an act, practice, or omission that constitutes fraud; or unless a Covered Person (or a person seeking coverage on behalf of that Covered Person) makes an intentional misrepresentation of material fact, as prohibited by the terms of this Plan. Coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by the Covered Person's employer.

Such person will be provided with thirty (30) calendar days' advance notice before the coverage is rescinded. Such a person has the right to request an internal appeal of a rescission of coverage. Once the internal appeal process is exhausted, such person has the additional right to request an independent external review.

Section VI

Description of Medical Benefits

Your medical Plan shares the cost of your health care expenses with you. This section explains what services are covered, what portion of the cost of these services is payable by the Plan and what portion of the cost of these services is payable by you.

The medical Plan pays for Covered Services rendered by Hospitals, Physicians, and other providers. Covered Services are those for which Medical Necessity has been established. The fact that your Physician may prescribe, recommend or provide treatment does not necessarily mean that the treatment is Medically Necessary. To be Medically Necessary, your tests, treatments, services and supplies must:

- be consistent with the symptoms, diagnosis and treatment of your Illness or Injury;
- be given to you as an Inpatient only when the services cannot be safely provided as an Outpatient;
- not be provided solely for the convenience of your Physician, Hospital, other provider, or you.

Deductible Amount
Before the Plan will pay, the Calendar Year Deductible amount must be met. This means that the first dollar benefits of covered major medical expenses submitted will be applied to the satisfaction of the Deductible amount.

The family Deductible will be met when any combination of family members meet the family Deductible amount. Please refer to Schedule of Benefits on pages (3-7) for Deductible amounts which apply to your benefit Plan.

If during the last three months of a Calendar Year a Covered Person/family incurs major medical Covered Services applicable to the Deductible, such expense shall also be applicable to the Deductible for the next succeeding Calendar Year. This is referred to as "Carry-over-Deductible."

If two or more Covered Persons in the same family are injured in a common accident, the Deductible applicable in the Calendar Year of the common accident shall be limited to a single Deductible amount for the Calendar Year for Covered Services, related to that accident, which are incurred by all family members.

Coinsurance
After the individual/family Deductible amount is satisfied, the Traditional Plan will pay 80% of the Allowed Amount in excess of the Deductible amount until the individual/family Coinsurance out-of-pocket limit is satisfied. The PPO Plan will pay 90% in-network and 80% out-of-network of the Allowed Amount. All Plans will pay 100% of the Allowed Amount for Covered Services after the maximum out-of-pocket limit has been satisfied.

Maximum Out-Of-Pocket Limit
This provision limits the maximum amount which an individual will have to pay in a Calendar Year. The maximum amount a family will have to pay is indicated in the Schedule of Benefits. The maximum out-of-pocket amount includes the Deductible and Coinsurance amount but excludes any non-covered amounts.

Covered Comprehensive Major Medical Services Include:

1. Covered Services by a Hospital for semi-private room and board and Miscellaneous Services (including Special Care Unit). Private room rates will be limited to the Hospital's Semi-Private Room rate unless certified as Medically Necessary by the Claims Administrator.

NOTE: Please refer to Section IV for information regarding the Pre-Certification requirements for Hospital admissions.

2. Covered Services for treatment of Drug Abuse or Alcoholism and Mental Illness as follows:

   Detoxification and rehabilitation services are provided for the treatment of Drug Abuse or Alcoholism. In addition, the following services are also covered for the treatment of Drug Abuse or Alcoholism:

   - individual and group psychotherapy;
   - psychological testing; and

- counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Covered Persons under this Benefit Book.

Mental Illness services will also be covered when you have a medical Condition that requires Medically Necessary behavioral health treatment.

- individual and group psychotherapy;
- electroshock therapy and related anesthesia only if given in a Hospital or Psychiatric Hospital;
- psychological testing;
- counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Covered Persons under this Benefit Book. Charges will be applied to the Covered Person who is receiving family counseling services, not necessarily the patient.
- In addition, as provided in the Claims Administrator's medical policy guidelines, certain behavioral assessment and intervention services for individual, family and group psychotherapy will also be covered for a medical Condition.

Services for autism, developmental delay and intellectual disability, other than those necessary to evaluate or diagnose these Conditions, are not covered. Services for the treatment of attention deficit disorder are covered.

Inpatient admissions to a Hospital Provider or Residential Treatment Facility Provider must be preauthorized. The telephone number for preauthorization is listed on the back of your identification card. Contracting Providers in Ohio will assure this preauthorization is done; and since the Provider is responsible for obtaining the preauthorization, there is no penalty to you if this is not done. For Non-Contracting Providers or Providers outside of Ohio, you are responsible for obtaining preauthorization. If you do not preauthorize these admissions and it is later determined that the admission was not Medically Necessary or not covered for any reason, you will be responsible for all Billed Charges.

3. Covered Services by a Physician for diagnosis, treatment and surgery (except as specifically excluded in the Exclusions and Limitations Section). This includes follow-up therapy in the treatment of allergies and routine newborn care while baby is confined as an Inpatient.
4. Covered Services by a Registered Nurse (R.N.), or a Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.) for private duty nursing, provided such services are certified as Medically Necessary by the Claims Administrator and are not rendered by a person who is related to the Covered Person by blood or marriage. Such services shall include a R.N., mid-wife acting within the scope of her license. Private duty nursing services are covered either in a Hospital, a Skilled Nursing Facility, or the Covered Person's home.
5. The following Illness and/or Injury medical services or supplies ordered by a Physician:
    a. Anesthetics, including the administration;
    b. X-ray examination, microscopic and laboratory tests and other diagnostic services;
    c. Radiation therapy and chemotherapy;
    d. Blood and blood plasma (if not replaced) and other fluids to be injected into the circulatory system;
    e. Physical therapy;
    f. Braces, crutches, casts, splints, trusses and surgical dressings;
    g. The initial artificial limb, or a replacement if occasioned by the natural growth and development of a Covered Person.
    h. The rental or purchase, whichever is the least expensive, of Hospital type equipment, including wheelchairs, Hospital beds, iron lungs, and other medical equipment used exclusively for therapeutic treatment.
    i. Drugs and medicines requiring the written prescription of a Physician.
    j. Magnetic Resonance Imagery (MRI) testing is covered if Medical Necessity has been determined by the Pre-Certification process. You may contact customer service to begin this process.
    k. Second surgical opinion services are covered if the

examination or consultation is performed by a Physician who is not affiliated with the attending Physician. Second surgical opinions are recommended but not mandatory.

6. The following routine or preventive services ordered by a Physician:
   a. One routine Pap test per Calendar Year.
   b. One routine mammogram per Calendar Year (unless additional mammogram(s) are deemed Medically Necessary).
   c. One routine prostate screening per Calendar Year.
   d. The exam associated with items a, b, or c as shown above.
   e. Well Child Care Services
      Coverage for well child care services will be provided for Covered Persons under the age of 21. Coverage for immunizations is also provided for Covered Persons under the age of 21. Well child care services include a review performed in accordance with the recommendations of the American Academy of Pediatrics. This review includes a history, complete physical examination, routine newborn hearing screening and developmental assessment. Vision tests, hearing tests and the developmental assessment must be included as part of the physical examination in order to be provided as part of this benefit. This review also includes anticipatory guidance, laboratory tests and appropriate immunizations.
   f. Women's Preventive Services
      These services will be provided in accordance with the requirements of the Affordable Care Act, including, but not limited to: well-woman visits; screening for gestational diabetes, human papillomavirus (HPV), human immunodeficiency virus (HIV) and sexually transmitted disease; and counseling for contraceptive methods, breastfeeding and domestic violence. Coverage is provided for FDA-approved contraceptive methods and counseling. Prescribed contraceptive medication will be paid in accordance with any applicable Prescription Drug benefit.
   g. Additional Preventive Services
      If not shown above as a Covered Service, the following services will also be covered without regard to any

Deductible or Coinsurance requirement that would otherwise apply:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
- With respect to Covered Persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Service Administration.

Please refer to the Claim Administrator phone number on your identification card if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive services, please visit www.healthcare.gov/prevention/index.html. Newly added preventive services added by the advisory entities referenced by the Affordable Care Act will start to be covered on the first plan year beginning on or after the date that is one year after the new recommendations or guideline, went into effect.

7. Covered Services by a professional ambulance service for transportation to or returning from the nearest Hospital or other covered institution equipped to provide the medical treatment recommended by the attending Physician.
8. Covered Services by a Hospital, Ambulatory Care Center, Emergency Care Center or a Physician's office for supplies and services in connection with:
    a. surgical procedures;
    b. Emergency Accident care;
    c. acute medical Emergency care;
    d. X-ray exams, microscopic and laboratory tests and other diagnostic services.

9. Covered Services by a Skilled Nursing Facility. These services must be Skilled Care, and your Physician must certify all services initially and continue to certify that you are receiving Skilled Care and not Custodial Care as requested by the Claims Administrator. All Covered Services will be provided according to your Physician's treatment plan and as authorized by the Claims Administrator.

   No benefits are provided:

   - once a patient can no longer significantly improve from treatment for the current Condition unless it is determined to be Medically Necessary by the Claims Administrator;
   - for Custodial Care, rest care or care which is only for someone's convenience; and
   - for the treatment of Mental Illness, Drug Abuse or Alcoholism.

10. Covered Services by a Hospice for Room and Board and other services to a terminally ill Covered Person whose life expectancy is six months or less, as certified by a Physician.
11. Covered Services for home health care provided such services are certified as Medically Necessary by the Claims Administrator. Services must be performed by a Home Health Agency.
12. Covered Services for maternity care will be covered the same as for any other Illness. Covered Services on behalf of the newborn child (well-child care) will be covered the same as any other Illness, provided the newborn child is a Covered Person under the Plan and confined as an Inpatient. All provisions of the Plan will apply separately from that of the mother. Well-child care is limited to routine nursery services and services relating to circumcision.

    Hospital, medical and surgical services for a normal pregnancy, complications of pregnancy, miscarriage and routine nursery care for a well newborn are covered.

    Coverage for the Inpatient postpartum stay for the mother and the newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a caesarean section. It will be for the length of stay recommended by the American Academy of Pediatrics and the American College

of Obstetricians and Gynecologists in their Guidelines for Perinatal Care. Please note that neither you nor your Provider is required to obtain pre-certification of an Inpatient maternity stay that falls within these timeframes.

Physician-directed, follow-up care services are covered after discharge including:

- parent education;
- physical assessments of the mother and newborn;
- assessment of the home support system;
- assistance and training in breast or bottle feeding;
- performance of any Medically Necessary and appropriate clinical tests; and
- any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

Covered Services will be provided whether received in a medical setting or through home health care visits. Home health care visits are only covered if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

If requested by the mother, coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the attending Physician or the nurse midwife in applicable cases, determines further Inpatient postpartum care is not necessary for the mother or newborn child, provided the following are met:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon the evaluation of:
    - the antepartum, intrapartum and postpartum course of the mother and infant;
    - the gestational stage, birth weight and clinical condition of the infant;
    - the demonstrated ability of the mother to care for the infant after discharge; and
    - the availability of post-discharge follow up to verify the condition of the infant after discharge.

When a decision is made to discharge a mother or newborn prior to the expiration of the applicable number of hours of Inpatient care required to be covered, at home post delivery follow up care visits are covered for you at your residence by a Physician or nurse when performed no later than 72 hours following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

- parent education;
- physical assessments;
- assessment of the home support system;
- assistance and training in breast or bottle feeding; and
- performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the mother or newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At the mother's discretion, this visit may occur at the facility of the provider.

Sterilization procedures and therapeutic abortions will also be covered the same as any other Illness.

13. Covered therapy services are services and supplies used to promote recovery from a Condition. Therapy services must be ordered by a Physician or other professional provider to be covered. Covered Services are limited to the therapy services listed below:

    Chiropractic Visits – After the 25th visit, the Claims Administrator must certify that additional treatments are Medically Necessary (combined with Physical Therapy). The treatment given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part, by a chiropractor. These Covered Services include, but are not limited to, office visits, physical treatments, hydrotherapy, heat or similar methods, physical agents, biomechanical and neurophysiological principles and may include devices. Braces and molds are not covered under this benefit.

    Physical Therapy – After the 25th visit, the Claims Administrator must certify that additional treatments are Medically Necessary (combined with Chiropractic visits).

The treatment given to relieve pain, restore maximum function and to prevent disability following disease, injury or loss of a body part. These Covered Services include physical treatments, hydrotherapy, heat or similar methods, physical agents, biomechanical and neurophysiological principles and may include devices. Braces and molds are not covered under this benefit.

All physical therapy services must be performed by a certified, licensed physical therapist.

Speech Therapy - In order to be considered a Covered Service, this therapy must be performed by a certified, licensed therapist and be Medically Necessary due to a medical Condition such as:
• a stroke;
• aphasia;
• dysphasia; or
• post-laryngectomy.

No benefits will be provided for therapy services once a patient can no longer significantly improve from treatment for the current Condition unless it is determined to be Medically Necessary by the Claims Administrator.

14. Covered Services for Medical Supplies and Durable Medical Equipment as follows:

Medical and Surgical Supplies - Disposable supplies which serve a specific therapeutic purpose are covered. These include:
- syringes;
- needles;
- oxygen; and
- surgical dressings and other similar items.

Items usually stocked in the home for general use are not covered. These include, but are not limited to:
- elastic bandages;
- thermometers;
- corn and bunion pads; and
- Jobst stockings and support/compression stockings.

Durable Medical Equipment (DME) - Equipment which serves only a medical purpose and must be able to withstand repeated use is covered. Upon request, your Physician must provide a written treatment plan that shows

how the prescribed equipment is Medically Necessary for the diagnosis or treatment of a Condition or how it will improve the function of a malfunctioning body part. If you need to use this equipment for more than six months, your Physician may be required to recertify that continued use is Medically Necessary.

You may rent or purchase DME; however, for each Condition, the Plan will not cover more in total rental costs than the customary purchase price as determined by the Claims Administrator. For example, if you submit claims for the monthly rental fee and by the third month the total in rental dollars meets or exceeds the customary purchase price, you will have exhausted your benefit for that piece of DME.

When it has been determined that you require DME, before you decide whether to rent or purchase, estimate what the rental cost will be for the time period during which you will use the DME. If the estimated rental cost exceeds the purchase price, then you should consider purchasing the DME. Covered DME includes:

- blood glucose monitors;
- respirators;
- home dialysis equipment;
- wheelchairs;
- hospital beds;
- crutches; and
- mastectomy bras.

Non-covered equipment includes, but is not limited to:

- rental costs if you are in a facility which provides such equipment;
- repair costs which are more than the rental price of another unit for the estimated period of use, or more than the purchase price of a new unit;
- Physician's equipment, such as a blood pressure cuff or stethoscope;
- deluxe equipment such as specially designed wheelchairs for use in sporting events; and
- items not primarily medical in nature such as:
- an exercycle, treadmill, bidet toilet seat, elevator and chair lifts, lifts for vans for motorized wheelchairs and scooters;
- items for comfort and convenience;

- disposable supplies and hygienic equipment;
- self-help devices such as: bedboards, bathtubs, sauna baths, overbed tables, adjustable beds, special mattresses, telephone arms, air conditioners and electric cooling units;
- other compression devices.

Orthotic Devices - Rigid or semi-rigid supportive devices which limit or stop the motion of a weak or diseased body part are covered. These devices include:

- braces for the leg, arm, neck or back;
- trusses; and
- back and special surgical corsets.

Non-covered devices include, but are not limited to:

- garter belts, arch supports, corsets and corn and bunion pads;
- corrective shoes, except with accompanying orthopedic braces; and
- arch supports and other foot care or foot support devices only to improve comfort or appearance. These include, but are not limited to care for flat feet and subluxations, corns, bunions, calluses and toenails.

Prosthetic Appliances - Your coverage includes the purchase, fitting, adjustments, repairs and replacements of prosthetic devices which are artificial substitutes and necessary supplies that:

- replace all or part of a missing body organ or limb and its adjoining tissues; or
- replace all or part of the function of a permanently useless or malfunctioning body organ or limb.

Covered prosthetic appliances include:

- artificial hands, arms, feet, legs and eyes, including permanent lenses; and
- appliances needed to effectively use artificial limbs or corrective braces.

Non-covered appliances include, but are not limited to:

- dentures, unless as a necessary part of a covered prosthesis;
- dental appliances;
- eyeglasses, including lenses or frames, unless used to replace an absent lens of the eye;

- replacement of cataract lenses unless needed because of a lens prescription change;
- taxes included in the purchase of a covered prosthetic appliance;
- deluxe prosthetics that are specially designed for uses such as sporting events; and
- wigs and hair pieces.

15. **Clinical Trial Programs**

Benefits are provided for Routine Patient Care administered to a Covered Person participating in any stage of an Approved Clinical Trail, if that care would be covered under the Plan if the Covered Person was not participating in a clinical trial.

In order to be eligible for benefits, the Covered Person must meet the following conditions (number 2 below is not required for cancer clinical trials in Ohio):

1. The Covered Person is eligible to participate in an Approved Clinical Trial, according to the trial protocol with respect to treatment of cancer or other Life-threatening Conditions.
2. Either:
   a. The referring Provider is a PPO Network Provider and has concluded that the Covered Person's participation in such trial would be appropriate based upon the Covered Person meeting the conditions described in "1" above; or
   b. The Covered Person provides medical and scientific information establishing that his or her participation in such trial would be appropriate based upon the Covered Person meeting the conditions described in "1" above.

If the clinical trial is not available from an In-Network Provider, the Covered Person may participate in an Approved Clinical Trial administered by a Non-Contracting Provider. However, the Routine Patient Costs will be covered at the Non-Contracting Amount, and the Covered Person may be subject to balance billing up to the Provider's Billed Charges for the services.

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to

the prevention, detection, or treatment of cancer or other life-threatening disease or Condition and is described in any of the following:

- A federally funded trial.
- The study or investigation is conducted under an Investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an Investigational new drug application.

"Life-threatening Condition" means any disease or Condition from which the likelihood of death is probable unless the course of the disease or Condition is interrupted.

“Routine Patient Costs” means all health care services that are otherwise covered under the Plan for the treatment of cancer or other Life-threatening Condition that is typically covered for a patient who is not enrolled in an Approved Clinical Trial.

“Subject of a clinical trial” means the health care service, item, or drug that is being evaluated in the Approved Clinical Trial and that is not a Routine Patient Care.

No benefits are payable for the following:

- A health care service, item, or drug that is the subject of the Approved Clinical Trial;
- A health care service, item, or drug provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;
- An Experimental or Investigational drug or device that has not been approved for market by the United States Food and Drug Administration;
- Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the Approved Clinical Trial;
- An item or drug provided by the Approved Clinical Trial sponsors free of charge for any patient; and
- A service, item, or drug that is eligible for reimbursement by an entity other than Claims Administrator, including the sponsor of the Approved Clinical Trial.

- A service, item, or drug that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

16. **Infertility Services**

    Infertility services include laboratory services, X-rays, therapeutic injection of drugs, hormone shots and surgery. The Plan will provide coverage for embryo transplants on a self-donor basis. This coverage will include all stages of the transplant procedure.

    The Plan excludes coverage for embryo transplants in the case of “other” donor. “Other” donor may include non-spouse sperm donor and non-genetic mother.

17. A program to manage diabetes shall be made available to both insulin and non-insulin dependent diabetics.

18. **Emergency Services**

    You are covered for Medically Necessary Emergency Services for an Emergency Medical Condition. Emergency Services are available 24 hours a day, seven days a week. If you are experiencing an Emergency Medical Condition, call 9-1-1 or go to the nearest Hospital to obtain Emergency Services. Care and treatment once you are Stabilized are not Emergency Services. Continuation of care beyond that needed to evaluate or Stabilize your Emergency Medical Condition will be covered according to your Schedule of Benefits. Please refer to your Schedule of Benefits for a detailed coverage explanation.

    For Emergency Services received from an out-of- Network Provider, the Claims Administator pays for benefits in an amount equal to the greatest of the following:

    1. The Negotiated Amount. If more than one amount is negotiated with In-Network Providers for the Emergency Service, the amount payable is the median of these amounts.
    2. The Non-Contracting Amount.
    3. The amount that would be paid under Medicare for the Emergency Service.

    Any charges exceeding the Allowed Amount, Non-Contracting Amount or the amount payable for out-of Network Emergency Services described above will not apply toward any Deductible, Coinsurance Limit or benefit maximum accumulation.

19. **Organ Transplant Services**

Coverage includes benefits for the following Medically Necessary human organ transplants:

- bone marrow;
- cornea;
- heart;
- heart and lung;
- kidney;
- liver;
- lung;
- pancreas; and
- pancreas and kidney

Additional organ transplants will be considered for coverage provided that the transplant is Medically Necessary, not Experimental and is considered accepted medical practice for your Condition.

Organ Transplant Preauthorization

In order for an organ transplant to be a Covered Service, the Inpatient stay must be preauthorized. In addition, the proposed course of treatment must be approved by the Claims Administrator. In the event you do not obtain preauthorization, or your organ transplant is determined to not be Medically Necessary or is determined to be Experimental/Investigational, you may be responsible for all Billed Charges for that organ transplant.

After your Physician has examined you, he must provide the Claims Administrator with:

- the proposed course of treatment for the transplant;
- the name and location of the proposed Transplant Center; and
- copies of your medical records, including diagnostic reports for Claims Administrator to determine the suitability and Medical Necessity of the transplant services. This determination will be made in accordance with uniform medical criteria that has been specifically tailored to each organ. You may also be required to undergo an examination by a Physician chosen by the Claims Administrator. You and your Physician will then be notified of the Claims Administrator's decision.

Obtaining Donor Organs
The following services will be Covered Services when they are necessary in order to acquire a legally obtained human organ:

- evaluation of the organ;
- removal of the organ from the donor; and
- transportation of the organ to the Transplant Center.

Donor Benefits
Benefits necessary for obtaining an organ from a living donor or cadaver are provided. Donor benefits are provided and processed under the transplant recipient's coverage only and are subject to any applicable limitations and exclusions. Donor benefits include treatment of immediate post operative complications if Medically Necessary as determined by the Claims Administrator. Such coverage is available only so long as the recipient's coverage is in effect.

The Plan does not provide organ transplant benefits for services, supplies or Charges:

- that are not furnished through a course of treatment which has been approved by the Claims Administrator;
- for other than a legally obtained organ;
- for travel time and the travel-related expenses of a Provider;
- that are related to other than human organ.

Section VII

Exclusions and Limitations For Medical Benefits

Coverage is not provided for the following services and supplies:

1. Not specifically included as Covered Services.
2. Incurred prior to the effective date of coverage under the Plan.
3. Incurred after the termination date of coverage under the Plan.
4. Not Medically Necessary for the diagnosis or treatment of an active Illness or Injury except as specifically included as Covered Services.
5. In excess of the Allowed Amount.
6. Not prescribed or recommended by a Physician.
7. For which benefits may be claimed under the Workers' Compensation act or similar legislation, or which are due to the treatment of an Illness or Injury arising out of or in the course of any occupation or employment for wage or profit.
8. For surgery, therapy, treatment or drugs considered to be experimental or investigative in nature.
9. For treatment provided or furnished by the United States Government or the government of any other country.
10. For services or supplies that cannot reasonably be expected to lessen the patient's disability or to enable him to live outside of an institution.
11. For care or treatment resulting from war, an act of war (declared or undeclared) or arising out of a Covered Person's participation in a riot.
12. For the care or treatment as a result of being engaged in an illegal occupation or commission of or attempted commission of a felony or assault.
13. For care or treatment while a member of the armed forces of any state or country.

14. by persons who ordinarily reside in the same household with the Covered Person or who are related by blood or marriage or legal adoption to the Covered Person.
15. For which the Covered Person is not legally required to pay or which would not have been made if no coverage had existed.
16. For Custodial Care.
17. For personal convenience items including, but not limited to TV and telephone, guest trays, guest beds, admission kits and reading material.
18. For embryo transplants; artificial insemination, and invitro fertilization except as defined, in Section VI, No. 16.
19. For vaccinations, inoculations and preventive shots, except as defined, in Section VI, No. 6.
20. For hearing aids, glasses, eye examinations, or the fitting thereof, except as specifically included as Covered Services.
21. For cosmetic surgery except as the Covered Services relate to such surgery to correct a congenital defect in a newborn child, to repair the effects of an Injury or for reconstructive breast surgery.
22. For the treatment of corns, calluses, or toenails, unless the Covered Services are for the removal of nail roots or in conjunction with the treatment of a metabolic or peripheral vascular disease.
23. For any care or treatment of teeth, gums, alveolar process, or gingival tissues (including the prevention or correction of teeth irregularities and malocclusion of the jaw by wire appliances, braces or other mechanical aids) unless such Covered Services are for the professional services of a Physician or qualified oral surgeon in rendering any of the following treatments:
    a. treatment for the excision of impacted unerupted teeth or of a tumor or cyst, or the incision and drainage of an abscess or cyst.
    b. treatment or excision of a tooth root (without extraction of entire tooth) but not including root canal therapy.
    c. surgical treatment of temporal mandibular joint syndrome (TMJ). Therapy services incurred due to TMJ shall be allowed as a major medical benefit provided

that sufficient documented medical evidence complies with guidelines.

d. surgical treatment to correct a congenital defect in a new born child.

24. For transportation except as specifically included as Covered Services.
25. For drugs except as specifically included as Covered Services.
26. For sterilization reversal or any complications thereof.
27. For sexual conversion surgery, or any other services related to gender reassignment or disturbances of gender identification, or any complications thereof.
28. For biofeedback training.
29. For marital counseling.
30. For hair replacement, transplant, or removal.
31. For weight reduction procedures, surgical or otherwise, or any complications thereof.
32. For the completion of claim forms, medical reports, or certifications required by the Plan.
33. For diagnostic X-ray exams and laboratory tests, ECG's, EKG's, and other diagnostic tests not related to a specific Injury or sickness or a definite set of symptoms except as specifically included as Covered Services.
34. For a Hospital admission when the primary reason for admission is to perform diagnostic X-ray exams and other diagnostic tests which could have been performed on an Outpatient basis unless certified as Medically Necessary by the attending Physician.
35. For routine physical examinations and health check-ups except as specifically included as Covered Services, Section VI, No. 6.
36. For hearing or vision therapy and any related diagnostic testing, except if treatment is due to congenital defect or accidental Injury.
37. For non-therapeutic (elective) abortions.
38. For massotherapy or massage therapy by a massotherapist.

Section VIII

Description of Dental Benefits

If a Covered Person incurs Covered dental services for the treatment of a covered disease or Injury to the teeth, the Plan will pay, after satisfaction of the Deductible amount, the percentage indicated in the Schedule of Benefits of the lesser of the scheduled amount or Reasonable and Customary (R & C) amount for such Covered Services.

Maximum Amount
The overall Calendar Year maximum dental benefit is $2,500 per person.

The orthodontic lifetime maximum benefit is $1,200 per person.

Calendar Year Deductible Amount
Before the Plan will pay, the Calendar Year Deductible amount must be met. This means the first $25 per person/$75 per family in Covered Services submitted will be applied to the satisfaction of the Deductible amount.

If during the last three months of a Calendar Year a Covered Person incurs dental Services applicable to the Deductible amount, such Services shall also be applicable to the Deductible amount for the next succeeding Calendar Year.

The dental Deductible amount is waived for preventive and diagnostic services.

Coinsurance
The Plan will pay Covered Services (R & C) at the percentage indicated in the Schedule of Benefits.

Covered Services
The following services are eligible under the Plan. Covered dental services are divided into four major categories, each subject to the Deductible amount and Coinsurance indicated. The following identifies each of the four categories and indicates the specific type of treatment or services covered under each category.

PREVENTIVE AND DIAGNOSTIC SERVICES
(Payable at 100% — No Deductible)

1. Routine oral examinations (including diagnosis) twice per Calendar Year.
2. Prophylaxis (scaling and polishing) twice per Calendar Year.
3. Topical application of stannous fluoride twice per Calendar Year. (No age limitation)
4. Space maintainers including installation and fitting.
5. Emergency treatment to relieve pain.
6. Dental X-rays
   Supplementary bitewing X-rays twice per Calendar Year.
   Full mouth X-rays once in any period of thirty-six (36) consecutive months.
   Other X-rays as required in connection with the diagnosis of a specific condition requiring treatment.
7. Tests and laboratory examinations including bacteriologic cultures, pulp vitality test and diagnostic cast (study models).

BASIC RESTORATIVE SERVICES
(Payable at 80% — After Deductible)

1. Oral surgery including necessary pre-operative treatment during Hospital Confinement and customary post-operative treatment furnished in connection with oral surgery.
   - Extraction of one or more teeth, except when done in connection with or in preparation for orthodontic services.
   - Alveoplasty (surgical reparation of ridge for dentures) and tooth replantation.
   - Treatment of fractures and reduction of dislocation of the jaw, and other cutting procedures in the oral cavity, except periodontic and endodontic surgery.

2. For amalgam, silicate, acrylic, synthetic porcelain, and composite restorative materials are payable when placed within the anterior arches to restore diseased or fractured teeth.
3. General anesthesia and the administration thereof when Medically Necessary and administered in connection with oral or dental surgery.
4. Endodontic treatment including root canal therapy.
5. The injection of antibiotic drugs and application of desensitizing medication by the attending dentist or Physician.
6. The repair or recementing of crowns, inlays, onlays, bridgework or dentures, or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any period of thirty-six (36) consecutive months.
7. The treatment of periodontal and other diseases of the gums and tissues of the mouth including gingivectomy and osseous surgery.

MAJOR RESTORATIVE SERVICES
(Payable at 80% — After Deductible)

1. Inlays, onlays, gold fillings or crown restorations to restore diseased or fractured teeth, but only when the tooth, as a result of extensive caries or fracture cannot be restored to proper function with an amalgam, silicate, acrylic, synthetic porcelain or composite restoration.
2. The initial installation of removable partial or complete denture.
3. The initial installation of fixed partial denture (bridgework — including inlays and crowns as abutments).
4. Replacement of an existing removable partial or complete denture or fixed partial denture by a new removable or fixed partial denture, or the addition of teeth to an existing removable partial denture or to a fixed partial denture, but only if (1) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing removable partial denture or fixed partial denture was installed, or (2) the existing removable denture or fixed partial denture cannot be made serviceable and, if such a denture was installed at least five years prior to its replacement, or (3) the existing denture is an immediate temporary denture which cannot be

made permanent, and replacement by a permanent removable denture takes place within 12 months from the date of initial installation of the immediate temporary denture.

5. If an inserviceable removable partial denture is replaced with a fixed partial denture and a professionally satisfactory result cannot be achieved by replacement with another removable denture, the charge will be a covered dental expense, but only to the extent of the Reasonable and Customary charge which would have been made if the replacement had been accomplished by a partial removable denture and benefits will be determined as if the removable denture had in fact been installed. The appliance must be a minimum of five (5) years old.

ORTHODONTIC SERVICES

(Payable at 60% — After Deductible)

1. Orthodontic procedures and treatment consisting of surgical therapy, appliance therapy, and functional/myofunctional therapy (including related oral examinations, surgery and extractions).

   Payment will be made on a monthly basis as follow:

   Twenty percent (20%) of the total charge for the initial down payment, payable at the coinsurance percentage, with the balance divided over the remaining course of treatment.

Incurred Date

A service is incurred on:

- the date the impression is taken, in the case of dentures or fixed bridges;
- the date the preparation of the tooth is begun, in the case of crown work;
- the date the work on the tooth is begun, in the case of root canal therapy;
- the date the initial appliance is installed, in the case of orthodontic treatment; or
- the date the treatment is performed in the case of any other work.

Section IX

Exclusions and Limitations For Dental Benefits

Coverage is not provided for the following services and supplies:

1. Not specifically included as Covered Services;
2. Incurred prior to the effective date of coverage under the Plan;
3. Incurred after the termination date of coverage under the Plan;
4. In excess of the lesser of the scheduled amount or the Reasonable and Customary (R & C) amount;
5. For which benefits may be claimed under the Workers' Compensation act or similar legislation, or which are due to the treatment of an Illness or Injury arising out of or in the course of any occupation or employment for wage or profit;
6. For treatment provided or furnished by the United States Government or the government of any other country;
7. For care or treatment while a member of the armed forces of any state or country;
8. By person who ordinarily reside in the same household with the Covered Person or who are related by blood or marriage or legal adoption to the Covered Person;
9. For which the Covered Person is not legally required to pay or which would not have been made if no coverage had existed;
10. For procedures or services rendered or supplies furnished by other than a legally qualified dentist, or another Physician, acting within the scope of his license, except for Charges for procedures performed by a licensed dental hygienist acting within the scope of his license and under the supervision and direction of a legally qualified dentist or another Physician;
11. For facing on pontics or crowns posterior to the second bicuspid;

12. For sealants and for education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene, or dental plaque control;
13. For procedures, services, or supplies which do not meet accepted standards of dental practice, including procedures, services, or supplies which are experimental in nature;
14. For procedures, services or supplies furnished on account of an Injury or disease or dental defect resulting from war or any act of war, whether declared or undeclared, which war or act of war occurs while the individual is insured under this coverage.
15. For any duplicate prosthetic device or any other duplicate dental appliance within five years of the insertion or placement of the original prosthetic device or dental appliance;
16. For the replacement of a lost, missing, or stolen prosthetic device, or any other dental appliance;
17. For implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants;
18. For periodontal splinting of teeth except for provisional intracoronal stabilization of mobile teeth;
19. For precision attachments except when they represent the sole method of completing a course of treatment.
20. For drug and/or medication, including prescriptions, other than injection of antibiotics and application of desensitizing medication by attending dentist;
21. For alternative treatment in excess of what is recognized as adequate and appropriate;
22. For dental care payable under medical benefits.

Section X

Miscellaneous Provisions

Coordination of Benefits
The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense. When paying as the Secondary plan, this plan will not pay more than it would have paid had it been the Primary plan.

Definitions

1. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
   a. Plan includes: group and non-group insurance contracts, health insuring corporation ("HIC") contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
   b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage;

benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under "a" or "b" above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

2. This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
3. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan .

   When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.
4. Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable expense.

   The following are examples of expenses that are not Allowable expenses:

   a. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an

Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.

b. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

c. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

d. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

e. The amount of any benefit reduction by the Primary plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

5. Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of Emergency or referral by a panel member.

6. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order Of Benefit Determination Rules
When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
   a. Except as provided in Paragraph "b" below, a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
   b. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.
2. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
3. Each Plan determines its order of benefits using the first of the following rules that apply:
   a. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
   b. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a

dependent child is covered by more than one Plan, the order of benefits is determined as follows:

i. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
   - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
   - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

ii. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;
   c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) above shall determine the order of benefits; or
   d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
      - The Plan covering the Custodial parent;
      - The Plan covering the spouse of the Custodial parent;
      - The Plan covering the non-custodial parent; and then

- The Plan covering the spouse of the non-custodial parent.

iii. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

c. Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.

d. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.

e. Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

f. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, When paying as the Secondary plan, this plan will not pay more than it would have paid had it been the Primary plan.

Effect On The Benefits Of This Plan

1. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.
2. If a Covered Person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other Plans. The Claims Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give the Claims Administrator any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, the Claims Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. The Claims Administrator will not have to pay that amount again. The term

"payment made " includes providing benefits in the form of services, in which case " payment made " means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by the Claims Administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes
If you believe that we have not paid a claim properly, you should attempt to resolve the problem by contacting Customer Service at the telephone number or address listed on the front of your Explanation of Benefits (EOB) form and/or identification card.

Women's Health and Cancer Rights Act Notice
Your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call your Claims Administrator for more information.

Section XI

Definitions

Alcoholism
A Condition classified as a mental disorder and described in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) or the most recent version, as alcohol dependence, abuse or alcoholic psychosis.

Allowed Amount
For In-Network and Contracting Providers, the Allowed Amount is the lesser of the Negotiated Amount or Covered Charge. For Non-Contracting Providers, the Allowed Amount is the Non-Contracting Amount, which will likely be less than the Provider's Billed Charges.

Ambulatory Care Center
A public or private establishment with an organized staff of doctors and with permanent facilities equipped mainly to do surgery. It does not provide services or accommodations for patients to stay overnight, but it has the services of a doctor or a registered nurse at all times when a patient is present.

Billed Charges
The amount billed on the claim submitted by the Provider for services and supplies provided to a Covered Person.

Calendar Year
A period of one year beginning with January 1.

Charges
The Provider's list of charges for services and supplies before any adjustments for discounts, allowances, incentives or settlements. For a Contracting Hospital, charges are the master charge list uniformly applicable to all payors before any discounts, allowances, incentives or settlements.

Chiropractic Services
The actual expense incurred for spinal manipulation therapy, defined as the manual manipulation of the spine, and/or the musculoskeletal system to restore mobility to the joints and to allow vertebrae to assume their normal position. The Physician must certify, at reasonable intervals, the Medical Necessity of continued treatment.

Coinsurance
A percentage of either the Allowed Amount or Non-Contracting Amount for which you are responsible after you have met your Deductible.

Confinement
The period of time during which an individual is an Inpatient in a Hospital or other covered institution. Successive periods of Confinement which are due to the same or related causes are considered as one period of Confinement if they are not separated by a return to active work of three (3) consecutive months.

Contracting Provider
The status of a Provider that has an agreement with the Claims Administrator about payment of Covered Services; or that is designated by the Claims Administrator as Contracting.

Covered Charges
The Billed Charges for Covered Services, except that the Claims Administrator reserves the right to limit the amount of Covered Charges for Covered Services provided by a Non-Contracting Provider to the Non-Contracting Amount determined by the Claims Administrator.

Covered Person
An Employee and/or Dependent who enrolls and becomes covered under the Plan.

Covered Service
A Provider's service or supply as described in this benefit book for which the Claims Administrator will provide benefits, as listed in the Schedule of Benefits.

Custodial Care
Care that does not require the constant supervision of skilled medical personnel to assist the patient in meeting his or her activities of daily living. Custodial Care is care which can be taught to and administered by a lay person and includes but is not limited to:

- administration of medication which can be self-administered or administered by a lay person; or
- help in walking, bathing, dressing, feeding or the preparation of special diets.

Custodial Care does not include care provided for its therapeutic value in the treatment of a Condition.

Deductible
An amount, usually stated in dollars, for which you are responsible each Benefit Period before the Plan will start to provide benefits.

Drug Abuse
A Condition classified as a mental disorder and described in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) or the most recent version, as drug dependence abuse or drug psychosis.

Emergency Care Center
A public or private establishment with an organized staff of doctors and with permanent facilities equipped mainly to provide immediate Emergency Accident Care and non-acute medical care.

Emergency Medical Condition
A medical Condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing an individual's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child;
- Result in serious impairment to the individual's bodily functions; or
- Result in serious dysfunction of a bodily organ or part of the individual.

Emergency Services
A medical screening examination as required by federal law that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to Stabilize the patient.

Essential Health Benefits
Defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn

care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental or Investigational Drug, Device, Medical Treatment or Procedure

A drug, device, medical treatment or procedure is Experimental or Investigational:

- if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is provided; or
- if reliable evidence shows that the drug, device, medical treatment or procedure is not considered to be the standard of care, is the subject of ongoing phase I, II or III clinical trials, or is under study to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis; or
- if reliable evidence shows that the consensus of opinion among experts is that the drug, device, medical treatment or procedure is not the standard of care and that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence may consist of any one or more of the following:

- published reports and articles in the authoritative medical and scientific literature;
- opinions expressed by expert consultants retained by the Claims Administrator to evaluate requests for coverage;
- the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure;
- the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure;

- corporate medical policies developed by the Claims Administrator; or
- any other findings, studies, research and other relevant information published by government agencies and nationally recognized organizations.

Even if a drug, device, or portion of a medical treatment or procedure is determined to be Experimental or Investigational, the Plan will cover those Medically Necessary services associated with the Experimental or Investigational drug, device, or portion of a medical treatment or procedure that the Plan would otherwise cover had those Medically Necessary services been provided on a non-Experimental or non-Investigational basis.

The determination of whether a drug, device, medical treatment or procedure is Experimental or Investigational shall be made by the Group and the Claims Administrator in their sole discretion, and that determination shall be final and conclusive, subject to any available appeal process.

He, Him, His
Whenever the masculine pronoun is used in this document, it shall include the feminine gender unless the context clearly indicates otherwise.

Home Health Agency
A public or private agency or organization, or part of one, that mainly provides skilled nursing and other therapeutic services. It must be legally qualified in the state or locality in which it operates. It must keep critical records on all patients. The services must be supervised by a doctor or registered nurse, and they must be based on policies set by associated professionals, which include at least one doctor and one registered nurse.

Hospice
A legally constituted healthcare program which provides a coordinated set of services rendered at home or in an Outpatient or institutional setting for individuals suffering from an Illness or condition with a terminal prognosis of six (6) months or less.

Hospital
An Institution accredited by an appropriate health care accrediting organization that meets the specifications set forth in the appropriate Chapter of the Ohio Revised Code and any other regional, state or federal licensing requirements, except for the requirement that such Institution be operated within the state of Ohio.

Illness

Any sickness or disease which manifests treatable symptoms and which requires treatment by a Physician.

Incurred
Rendered to you by a Provider. All services rendered by the Institutional Provider during an Inpatient admission prior to termination of coverage are considered to be Incurred on the date of admission.

Injury
Any bodily Injury sustained while the individual is covered under the Plan, and which requires treatment by a Physician.

In-Network Provider
Any Provider that is included in a limited panel of Providers as designated by the Claims Administrator and for which the greatest benefit will be payable when one of these Providers is used.

Inpatient
A Covered Person who receives care as a registered bed patient in a Hospital or Other Facility Provider where a room and board charge is made.

Medically Necessary (or Medical Necessity)
A Covered Service and/or supply that is required to diagnose or treat a Condition and which the Claims Administrator determines is:

- appropriate with regard to the standards of good medical practice and not Experimental or Investigational;
- not primarily for your convenience or the convenience of a Provider; and
- the most appropriate supply or level of service which can be safely provided to you. When applied to the care of an Inpatient, this means that your medical symptoms or Condition require that the services cannot be safely or adequately provided to you as an Outpatient.

Medicare
Title XVIII (Health Insurance for the Aged) of the United States Social Security Act as amended by Social Security Amendment of 1965 or as later amended.

Mental Illness
A Condition classified as a mental disorder in the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) or the most recent version, excluding Drug Abuse and Alcoholism.

Miscellaneous Services
Charges made by a Hospital or other covered institution for other than Room and Board and general nursing care including, but not limited to amounts charged for necessary services, medicines, supplies or services for diagnosis or treatment of an Illness or Injury (except services of a Physician and drugs or supplies not consumed or used in the Hospital) while the Covered Person is confined as an Inpatient.

Negotiated Amount
The amount the Provider has agreed with the Claims Administrator to accept as payment in full for Covered Services, subject to the limitations set forth below.

The Negotiated Amount may include performance withholds and/or payments to Providers for quality or wellness incentives that may be earned and paid at a later date. Your Deductible and/or Coinsurance amounts may include a portion that is attributable to a quality incentive payment or bonus and will not be adjusted or changed if such payments are not made.

The Negotiated Amount for Providers does not include adjustments and/or settlement due to prompt payment discounts, guaranteed discount corridor provisions, maximum charge increase limitation violations, performance withhold adjustments or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim.

In certain circumstances, the Claims Administrator may have an agreement or arrangement with a vendor who purchases the services, supplies or products from the Provider instead of the Claims Administrator contracting directly with the Provider itself. In these circumstances, the Negotiated Amount will be based upon the agreement or arrangement the Claims Administrator has with the vendor and not upon the vendor's actual negotiated price with the Provider, subject to the further conditions and limitations set forth herein.

Non-Contracting Provider
The status of a Provider that does not have a contract with the Claims Administrator or one of its networks.

Non-Contracting Amount
Subject to applicable law, the maximum amount allowed by the Claims Administrator for Covered Services provided to Covered Persons by a Non-Contracting Provider based on various factors, including, but not limited to, market rates for that service, Negotiated Amounts for that service, and Medicare

reimbursement for that service. The Non-Contracting Amount will likely be less than the Provider's Billed Charges. If you receive services from a Non-Contracting Provider, and you are balanced billed for the difference between the Non-Contracting Amount and the Billed Charges, you may be responsible for the full amount up to the Provider's Billed Charges, even if you have met your out-of-pocket maximum.

Outpatient
The status of a Covered Person who receives services or supplies through a Hospital, other facility provider, Physician or other professional provider while not confined as an Inpatient.

Physician
A person who is licensed and legally authorized to practice medicine.

Plan
The program of health benefits coverage established by the Stark County Schools Council of Governments for its Employees or members and their eligible Dependents.

PPACA
Patient Protection and Affordable Care Act

Pre-Admission Testing
The actual charge incurred for diagnostic laboratory tests and X-ray exams required in connection with a scheduled surgery and performed on an out-patient basis. Charges will include all such tests performed within 14 days of the Hospital admission and as a result of having these tests performed, the Covered Person must not be admitted to the Hospital prior to the actual date of service.

Provider
A Hospital, other facility provider, physician or other professional provider.

Psychiatric Hospital
A facility that is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental Illness on an Inpatient basis. Such services must be provided by or under the supervision of an organized staff of Physicians. Continuous nursing services must be provided under the supervision of a registered nurse.

Reasonable and Customary Amount (R & C)
The normal and necessary Charges made for similar services by the providers of dental services with like experience, education

and training in the same geographic (zip code) area. R & C determination shall be made by the Claims Administrator based on nationally obtained and recognized survey data.

Residential Treatment Facility
A facility accredited by an appropriate health care accrediting organization that meets all of the following:

- An accredited facility that provides care on a 24 hour a day, 7 days a week, live-in basis for the evaluation and treatment of residents with psychiatric or chemical dependency disorders who do not require care in an acute or more intensive medical setting.
- The facility must provide room and board as well as providing an individual treatment plan for the chemical, psychological and social needs of each of its residents.
- The facility must meet all regional, state and federal licensing requirements.
- The residential care treatment program is supervised by a professional staff of qualified Physician(s), licensed nurses, counselors and social workers.

Room and Board
Charges made by a Hospital or other covered institution for the cost of the room, general duty nursing care, and other services routinely provided to all inpatients.

Semi-Private Charge
The charge made by a Hospital for a room containing two (2) or more beds but does not include Special Care Unit Charges.

Skilled Care
Care that requires the skill, knowledge or training of a Physician or a:

- registered nurse;
- licensed practical nurse; or
- physical therapist

performing under the supervision of a Physician. In the absence of such care, the Covered Person's health would be seriously impaired. Such care cannot be taught to or administered by a lay person.

Skilled Nursing Facility
A facility that primarily provides 24-hour Inpatient Skilled Care and related services to patients requiring convalescent and rehabilitative care. Such care must be provided by either a

registered nurse, licensed practical nurse or physical therapist performing under the supervision of a Physician.

Special Care Unit
A specific Hospital unit which provides concentrated special equipment and highly skilled personnel for the care of critically ill patients requiring immediate, constant and continuous attention. This term will include Charges for intensive care, coronary care, acute care units of a Hospital but does not include care in a surgical recovery or post-operative room. The unit must meet the required standards an appropriate health care accrediting organization for Special Care Units.

Stabilize
With respect to an Emergency Medical Condition, to provide such medical treatment of the Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the Condition is likely to result from or occur during the transfer of the individual from a facility.

Section XII

Benefit Determination for Claims

Claims Involving Urgent Care
A Claim Involving Urgent Care is a claim for Medical Care or treatment with respect to which the application of the timeframes for making non-Urgent Care determinations (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or (b) in the opinion of a Physician with knowledge of the claimant's medical Condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Determination of urgent will be made by an individual acting on behalf of the plan applying the judgment of a prudent lay person who possesses an average knowledge of health and medicine; however, any Physician with knowledge of the claimant's medical Condition can also determine that a claim involves Urgent Care.

If you file a Claim Involving Urgent Care in accordance with the claim procedures and sufficient information is received, the Claims Administrator will notify you of its benefit determination, whether adverse or not, as soon as possible but not later than 72 hours after the Claims Administrator's receipt of the claim.

If you do not follow the Claims Administrator's procedures or we do not receive sufficient information necessary to make a benefit determination, the Claims Administrator will notify you within 24 hours of receipt of the Claim Involving Urgent Care and explain the applicable procedural deficiencies, or the specific deficiencies related to information necessary to make a benefit determination. You will have 48 hours to correct the procedural deficiencies and/or provide the requested information. Once the Claims Administrator receives the requested information, we will notify you of the benefit determination, whether adverse or not, as soon as possible, taking into account all medical exigencies, but not later than 48 hours after receipt of the information.

The Claims Administrator may notify you of its benefit determination decision orally and follow with written or electronic notification not later than three (3) days after the oral notification.

Concurrent Care Claims
If the Claims Administrator has approved an ongoing course of treatment to be provided over a period of time or for a number of treatments, any reduction or termination by the Claims Administrator of such course of treatment before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination (unless the reduction or termination of benefits is due to a health plan amendment or health plan termination).

If the Claims Administrator has approved an ongoing course of treatment to be provided over a period of time or for a number of treatments, any request to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator must notify the claimant of the benefit determination, whether adverse or not, within 24 hours after its receipt of the claim, provided that any such claim is made to the Claims Administrator at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Pre-Service Claims
A Pre-Service Claim is a claim for a benefit which requires some form of preapproval or precertification by the Claims Administrator.

If you file a Pre-Service Claim in accordance with the Claims Administrator's claim procedures and sufficient information is received, the Claims Administrator will notify you of its benefit determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. The Claims Administrator may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of the Claims Administrator. The Claims Administrator will notify you of such an extension and date by which it expects to render a decision.

If an extension is needed because you did not provide the necessary information to process your claim, the Claims Administrator will notify you, in writing, within the initial 15 day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

Post-Service Claims
A Post-Service Claim is any claim that is not a Pre-Service Claim.

If you file a Post-Service Claim in accordance with the Claims Administrator's claim procedures and sufficient information is received, the Claims Administrator will notify you of its benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. The Claims Administrator may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of the Claims Administrator. The Claims Administrator will notify you of such an extension and date by which it expects to render a decision.

If an extension is needed because you did not provide the necessary information to process your claim, the Claims Administrator will notify you, in writing, within the initial 30 day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

Adverse Benefit Determination Notices
You will receive notice of a benefit determination, orally as allowed, or in writing in a culturally and linguistically appropriate manner. All notices of an Adverse Benefit Determination will include the following:

- Information sufficient to identify the claim or health care service involved, including the health care provider, the date of service, and claim amount, if applicable;
- the specific reason(s) for the Adverse Benefit Determination;
- reference to the specific plan provision(s) on which the Adverse Benefit Determination is based;

- a description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;
- a description of the Claims Administrator 's appeal procedures and applicable timeframes, including the expedited appeal process, if applicable;
- notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
- disclosure of the availability of assistance with the appeal process from the Ohio Department of Insurance;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the Adverse Benefit Determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request; and
- if the Adverse Benefit Determination was based on Medical Necessity, Experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request.

Section XIII

Filing an Internal Appeal and External Review

I. Definitions

For the purposes of this "Filing an Internal Appeal and External Review" Section, the following terms apply:

Adverse Benefit Determination – a decision by a Health Plan Issuer:

- to deny, reduce, or terminate a requested Health Care Service or payment in whole or in part, including all of the following:
  - a determination that the Health Care Service does not meet the Health Plan Issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;
  - a determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non-employer group, to participate in a plan or health insurance coverage;
  - a determination that a Health Care Service is not a Covered Benefit;
  - the imposition of an exclusion, including exclusions for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-employer group;
- To Rescind coverage on a Health Benefit Plan.

Authorized Representative – an individual who represents a Covered Person in an internal appeal process or external review process, who is any of the following: (1) a person to whom a Covered Person has given express written consent to represent that person in an internal appeal process or external review process; (2) a person authorized by law to provide substituted consent for a Covered Person; or (3) a family member or a treating health care professional, but only when the Covered Person is unable to provide consent.

Covered Person – please refer to the definition of this term in the Definitions Section earlier in this benefit book.

Covered Service – please refer to the definition of this term in the Definitions Section earlier in this benefit book.

Emergency Medical Condition – please refer to the definition of this term in the Definitions Section earlier in this benefit book.

Emergency Services – please refer to the definition of this term in the Definitions Section earlier in this benefit book.

Final Adverse Benefit Determination – an Adverse Benefit Determination that is upheld at the completion of the Claims Administrator's mandatory internal appeal process.

Health Benefit Plan – a policy, contract, certificate, or agreement offered by a Health Plan Issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of Health Care Services.

Health Care Services – services for the diagnosis, prevention, treatment, cure, or relief of a health condition, Illness, Injury, or disease.

Health Plan Issuer - an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the Superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of Health Care Services under a Health Benefit Plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. "Health plan issuer" includes a third party administrator to the extent that the benefits that such an entity is contracted to administer under a Health Benefit Plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the Superintendent.

Independent Review Organization – an entity that is accredited to conduct independent external reviews of Adverse Benefit Determinations.

Rescission or to Rescind – a cancellation or discontinuance of coverage that has a retroactive effect. “Rescission” does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Stabilize – please refer to the definition of this term in the Definitions Section earlier in this benefit book.

Superintendent – the superintendent of insurance.

Utilization Review - a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings.

II. How to File an Appeal

If you are not satisfied with an Adverse Benefit Determination, you may file an appeal.

There is no fee to file an appeal. Appeals can be filed regardless of the claim amount at issue.

To submit an appeal, you may write a letter with the following information: Card Holder's full name; patient's full name; identification number; claim number if a claim has been denied; the reason for the appeal; date of services; the Provider/facility name; and any supporting information or medical records, documents, dental X-rays or photographs you would like considered in the appeal. Send or fax the letter and records to:

Medical Mutual Member Appeals Unit MZ: 01-4B-4809 P.O. Box 94580 Cleveland, Ohio 44101-4580 FAX: (216) 687-7990	AultCare Grievance and Appeals Department P.O. Box 6029 Canton, Ohio 44706-0910 FAX: (330) 363-3066

To submit an appeal electronically, go to Medical Mutual's Web site, www.MedMutual.com, under Members' section, complete all required fields and submit, or call the Customer Service telephone number on your identification card for more information about how to file an appeal.

The request for review must come directly from the patient unless he/she is a minor or has appointed an Authorized Representative. You can choose another person to represent you during the appeal process, as long as the Claims Administrator has a signed and dated statement from you authorizing the person to act on your behalf. However, in the case of a claim involving Urgent Care (as described below), a healthcare professional with knowledge of your medical condition may act as your Authorized Representative without a signed and dated statement from you.

III. Internal Appeals Procedure

A. Mandatory Internal Appeal Level

The Plan provides all members a mandatory internal appeal level. You must complete this mandatory internal appeal level before any additional action is taken, except when exhaustion is unnecessary as described in the following sections.

Mandatory internal appeals must be filed within 180 days from your receipt of a notice of Adverse Benefit Determination. All requests for appeal may be made by submitting an electronic form, by calling Customer Service or in writing as described above in the How to File an Appeal section.

Under the appeal process, there will be a full and fair review of the claim in accordance with applicable law. The internal appeal process is a review of your appeal by an Appeals Coordinator, a Physician consultant and/or other licensed health care professional. The review of an appeal will take into account all comments, documents, medical records and other information submitted by you and the Provider relating to the appeal, without regard to whether such information was submitted or considered in the initial benefit determination.

All determinations that involve, in whole or in part, issues of Medical Necessity, whether services are Experimental and Investigational, or any other medical judgment, are based on the evaluations and opinions of health care professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment. The health care professionals who review the appeal will not have made any prior evaluations about your claim and will not be a subordinate of the professional who made the initial evaluation of your claim. These health care professionals act independently and impartially. Decisions

to hire, compensate, terminate, promote or retain these professionals are not based in any manner on the likelihood that these professionals will support a denial of benefits. Upon specific written request from you, the Claims Administrator will provide the identification of the medical or vocational expert whose advice was obtained on behalf of the Claims Administrator in connection with the Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

You may submit written comments, documents, records, testimony and other information relating to the claim that is the basis for the appeal. These documents should be submitted by you at the time you send in your request for an appeal. Upon written request, you may have reasonable access to and copies of documents, records and other information used to make the decision on your claim for benefits that is the subject of your appeal.

If, during the appeal, the Claims Administrator considers, relies upon or generates any new or additional evidence, you will be provided free of charge with copies of that evidence before a notice of Final Adverse Benefit Determination is issued. You will have an opportunity to respond before our timeframe for issuing a notice of Final Adverse Benefit Determination expires. Additionally, if the Claims Administrator decides to issue a Final Adverse Benefit Determination based on a new or additional rationale, you will be provided that rationale free of charge before the final notice of Final Adverse Benefit Determination is issued. You will have an opportunity to respond before our timeframe for issuing a notice of Final Adverse Benefit Determination expires.

You will receive continued coverage pending the outcome of the appeals process. For this purpose, The Claims Administrator may not reduce or terminate benefits for an ongoing course of treatment without providing advance notice and an opportunity for advance review. If the Claims Administrator's Adverse Benefit Determination is upheld, you may be responsible for the payment of services you receive while the appeals process was pending.

1. Types of Mandatory Internal Appeals and Timeframes

a. Appeal of Claim Involving Urgent Care

You, your Authorized Representative or your Provider may request an appeal of a claim involving Urgent Care. The appeal does not need to be submitted in writing. You, your Authorized Representative, or your Physician should call the Care Management telephone number on your identification card as soon as possible. Appeals of claims involving Urgent Care typically involve those claims for Medical Care or treatment with respect to which the application of the time periods for making non-Urgent Care determinations (1) could seriously jeopardize the life or health of a patient, or the ability of the patient to regain maximum functions, or (2) in the opinion of a Physician with knowledge of your medical Condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. The appeal must be decided as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request to appeal. The expedited appeal process does not apply to prescheduled treatments, therapies, Surgeries or other procedures that do not require immediate action.

b. Pre-Service Claim Appeal

You or your Authorized Representative may request a pre-service claim appeal. Pre-service claim appeals are those requested in advance of obtaining Medical Care for approval of a benefit, as it relates to the terms of the Plan. The pre-service claim appeal must be decided within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the receipt of the request and must be requested within 180 days of the date you received notice of an Adverse Benefit Determination.

c. Post Service Claim Appeal

You or your Authorized Representative may request a post-service claim appeal. Post-service claim appeals are those requested for payment or reimbursement of the cost for Medical Care that has already been provided. As with pre-service claims, the post-service claim appeal must be

decided within 30 days of the request and must be requested within 180 days of the date you received notice of an Adverse Benefit Determination.

2. Notices of Final Adverse Benefit Determination after Appeal:

All notices of a Final Adverse Benefit Determination after an appeal will be culturally and linguistically appropriate and will include the following:

- Information sufficient to identify the claim or health care service involved, including the health care provider, the date of service, and claim amount, if applicable;
- the specific reason(s) for the Adverse Benefit Determination;
- reference to the specific plan provision(s) on which the Adverse Benefit Determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the Adverse Benefit Determination, this will be disclosed, or you will be advised that information about the rule, guideline, protocol or similar criteria will be provided free of charge upon written request;
- if the Adverse Benefit Determination was based on a Medical Necessity or Experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the plan to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request;
- a discussion of the decision;
- a description of applicable appeal procedures; and
- disclosure of the availability of assistance with the appeal process from the Ohio Department of Insurance.

B. What Happens After the Mandatory Internal Appeal Level
If your claim is denied at the mandatory internal appeal level, you may be eligible for either the External Review Process by an Independent Review Organization for Adverse Benefit Determinations involving medical judgment or the External Review Process by the Ohio Department of Insurance for contractual issues that do not involve medical judgment. You may request an External Review directly after receiving an Adverse Benefit Determination at the mandatory internal appeal level. The External Review Process described below.

IV. External Review Process

A. Contact Information for Filing an External Review

Medical Mutual	AultCare
Member Appeals Unit	Grievance and Appeals
MZ: 01-4B-4809	Department
P.O. Box 94580	P.O. Box 6029
Cleveland, Ohio 44101-4580	Canton, OH 44706-0910
FAX: (216) 687-7990	FAX: (330) 363-3066

B. Understanding the External Review Process

Under Chapter 3922 of the Ohio Revised Code all Health Plan Issuers must provide a process that allows a person covered under a Health Benefit Plan or a person applying for Health Benefit Plan coverage to request an independent external review of an Adverse Benefit Determination. This is a summary of that external review process. An Adverse Benefit Determination is a decision by the Plan to deny a requested Health Care Service or payment because services are not covered, are excluded, or limited under the Plan, or the Covered Person is not eligible to receive the benefit.

The Adverse Benefit Determination may involve an issue of Medical Necessity, appropriateness, health care setting, or level of care or effectiveness. An Adverse Benefit Determination can also be a decision to deny Health Benefit Plan coverage or to Rescind coverage.

C. Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. The Covered Person does not pay for the external review. There is no minimum cost of Health Care Services

denied in order to qualify for an external review. However, the Covered Person must generally exhaust the Claims Administrator's mandatory internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the Adverse Benefit Determination.

1. External Review by an IRO
   A Covered Person is entitled to an external review by an IRO in the following instances:
   - The Adverse Benefit Determination involves a medical judgment or is based on any medical information.
   - The Adverse Benefit Determination indicates the requested service is experimental or investigational, the requested Health Care Service is not explicitly excluded in the Covered Person's Health Benefit Plan, and the treating Physician certifies at least one of the following:
     - Standard Health Care Services have not been effective in improving the condition of the Covered Person.
     - Standard Health Care Services are not medically appropriate for the Covered Person.
     - No available standard Health Care Service covered by the Claims Administrator is more beneficial than the requested Health Care Service.

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

- The Covered Person's treating Physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal, and the Covered Person has filed a request for an expedited internal appeal.
- The Covered Person's treating Physician certifies that the Final Adverse Benefit Determination involves a medical condition that could seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function if treatment is delayed until after the timeframe of a standard external review.

- The Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or Health Care Service for which the Covered Person received Emergency Services, but has not yet been discharged from a facility.
- An expedited internal appeal is already in progress for an Adverse Benefit Determination of experimental or investigational treatment and the Covered Person's treating Physician certifies in writing that the recommended Health Care Service or treatment would be significantly less effective if not promptly initiated.

NOTE: An expedited external review is not available for retrospective Final Adverse Benefit Determinations (meaning the Health Care Service has already been provided to the Covered Person).

2. External Review by the Ohio Department of Insurance
   A Covered Person is entitled to an external review by the Department in either of the following instances:
   - The Adverse Benefit Determination is based on a contractual issue that does not involve a medical judgment or medical information.
   - The Adverse Benefit Determination for an Emergency Medical Condition indicates that medical condition did not meet the definition of emergency AND the Claims Administrator's decision has already been upheld through an external review by an IRO.

D. Request for External Review

Regardless of whether the external review case is to be reviewed by an IRO or the Department of Insurance, the Covered Person, or an Authorized Representative, must request an external review through the Claims Administrator within 180 days from your receipt of the notice of Adverse Benefit Determination after the mandatory internal appeal level.

All requests must be in writing, including by electronic means, except for a request for an expedited external review. Expedited external reviews may be requested orally. The Covered Person will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete and eligible the Claims Administrator will initiate the external review and notify the Covered Person in

writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the Covered Person that, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. The Claims Administrator will also forward all documents and information used to make the Adverse Benefit Determination to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete, the Claims Administrator will inform the Covered Person in writing and specify what information is needed to make the request complete. If the Claims Administrator determines that the Adverse Benefit Determination is not eligible for external review, the Claims Administrator must notify the Covered Person in writing and provide the Covered Person with the reason for the denial and inform the Covered Person that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by the Claims Administrator and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the Health Benefit Plan and all applicable provisions of the law.

E. IRO Assignment

When the Claims Administrator initiates an external review by an IRO, the Ohio Department of Insurance web based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of Health Care Service. An IRO that has a conflict of interest with the Claims Administrator, the Covered Person, the health care provider or the health care facility will not be selected to conduct the review.

F. Reconsideration by the Claims Administrator

If you submit information to the Independent Review Organization or the Ohio Department of Insurance to consider, the Independent Review Organization or Ohio Department of

Insurance will forward a copy of the information to the Claims Administrator. Upon receipt of the information, the Claims Administrator may reconsider its Adverse Benefit Determination and provide coverage for the Health Care Service in question. Reconsideration by the Claims Administrator will not delay or terminate an external review. If the Claims Administrator reverses an Adverse Benefit Determination, the Claims Administrator will notify you in writing and the Independent Review Organization will terminate the external review.

G. IRO Review and Decision

The IRO must consider all documents and information considered by the Claims Administrator in making the Adverse Benefit Determination, any information submitted by the Covered Person and other information such as; the Covered Person's medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the Health Benefit Plan, the most appropriate practice guidelines, clinical review criteria used by the Health Plan Issuer or its utilization review organization, and the opinions of the IRO's clinical reviewers.

The IRO will provide a written notice of its decision within 30 days of receipt by the Claims Administrator of a request for a standard review or within 72 hours of receipt by the Claims Administrator of a request for an expedited review. This notice will be sent to the Covered Person, the Claims Administrator and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review
- The date the Independent Review Organization was assigned by the Ohio Department of Insurance to conduct the external review
- The dates over which the external review was conducted
- The date on which the Independent Review Organization's decision was made
- The rationale for its decision
- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision

NOTE: Written decisions of an IRO concerning an Adverse Benefit Determination that involves a health care treatment or

service that is stated to be experimental or investigational also includes the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

H. Binding Nature of External Review Decision

An external review decision is binding on the Claims Administrator except to the extent the Claims Administrator has other remedies available under state law. The decision is also binding on the Covered Person except to the extent the Covered Person has other remedies available under applicable state or federal law.

A Covered Person may not file a subsequent request for an external review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to the Claims Administrator.

I. If You Have Questions About Your Rights or Need Assistance

You may contact the Claims Administrator at the customer service telephone number listed on your identification card. You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300
Columbus, Ohio 43215-4186
Telephone: 800-686-1526 / 614-644-2673
Fax: 614-644-3744
TDD: 614-644-3745
Contact ODI Consumer Affairs:
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp
File a Consumer Complaint:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

Section XIV

How to Use Your Benefits

If You Need Hospital Care
Present your health benefit Plan identification card when you enter the Hospital. You may not need to fill out claim forms or report any Hospital Charges to the Claims Administrator. The Hospital may instead bill the Claims Administrator directly and all covered services will be paid for you.

If You Need Physician Care
Show the Physician your health benefit identification card, and if requested, provide him with a claim form (which you can obtain from your employer or Claims Administrator) and ask him to bill the Claims Administrator for all of his services to you which are payable under this Plan — whether at his office, your home or in the Hospital — indicating diagnosis, date of service, and fees.

When to File a Claim
If a claim for Covered Services has not been filed on you or your Dependents behalf, you should file a claim as soon as you receive Charges for services covered. Claim forms may be obtained from your Personnel Office, by calling your Claims Administrator or visiting their Internet site.

All claims relating to payment for a benefit covered by the Plan must be filed within the twelve-month (12) period following the date the benefit is received. A claim shall not be considered filed unless and until all required information relating to the service or benefit for which the claim is filed has been provided to the Claims Administrator.

How to File a Claim for Other Health Services
Sometimes the provider of healthcare does not bill the Claims Administrator directly, but bills you for such services.

Make sure that your bill from the provider of service contains all of the following information:

a. patient's name;
b. description of each service rendered;
c. date(s) of each service rendered;
e. diagnosis (if more than one diagnosis, indicate which diagnosis refers to each specific service rendered); and
f. name, address and tax identification number of the provider of service.

Make a photocopy of the billing you receive from the provider of health service for your records and send the billing (if paid by you, make sure the bill so indicates this) with a completed claim form to your Claims Administrator:

Medical Mutual Services P.O. Box 6018 Cleveland, Ohio 44101-1018	or	AultCare P.O. Box 6910 Canton, Ohio 44706-0910

1. A separate claim form must be submitted for each family member for whom a claim is being made. The Plan maintains separate payment and Deductible records on you and each of your Dependents. It is necessary to submit another form with billings for subsequent service. If you have made payment to the provider, be sure the bill is marked paid or is accompanied by a paid receipt.
2. Please review the claim form carefully and follow the instructions it contains. It is not always necessary to complete every section. You need only complete those sections applicable to the claim being filed. For example, if no accident is involved, you need not complete the accident section. If the claim is on you, it is not necessary to complete the Dependent section, etc.

Method of Payment

All payments will be made directly to you unless you specifically request otherwise.

Other Group Coverage

Since this Plan contains a coordination of benefits provision, it is important that you advise the Claims Administrator of any other group health plan covering you or your Dependents. You should complete the appropriate section of your claim form in full.

NOTE: When another plan covers the claimant, send exact duplicates of all bills being submitted with a claim to each carrier involved to assist them in coordinating benefits without a lengthy delay. To help you to understand what coordination of benefits is and how it affects you, refer to "Coordination of Benefits Provision".

Incomplete Claim Forms
Your Claims Administrator has simplified procedures for handling your health and welfare benefits by providing you with a claim form which contains the information necessary to process your claim. When a claim form is submitted without completion of all of these items, it is necessary for the Claims Administrator to request the information. This can cause unnecessary delays in providing you with your eligible benefits.

Late Submission of Claim
Important: Claims submitted more than 12 months from date of service may be denied. You can assist your Claims Administrator by submitting your claims promptly and by following the claim filing instructions.

Right of Subrogation and Reimbursement
The Plan shall be subrogated to the extent of any payments under this Plan of health coverage to all of the Plan Member's right of recovery regardless of the entity or individual from whom the recovery may be due. The Plan will have the right, at its discretion and Plan Administrator's sole instigation, to take legal action on behalf of the insured or on behalf of the Plan itself. Accepting benefits under this Plan for those incurred medical or dental Expenses automatically assigns to the Plan any rights the Covered Person may have to recover payments from any third party or insurer. As a condition to the Plan making payments for any medical or dental charges, the Plan Member must assign to the Plan his or her rights to any recovery arising out of or related to any act or omission that caused or contributed to the Injury or Illness for which such benefits are to be paid. Any amounts so recovered, however designated, shall be apportioned as follows: this Plan shall be fully reimbursed to the extent of its payments under this plan of health coverage. This Plan shall have priority over the Plan Member to the funds recovered and this Plan shall have priority over the Plan Member to any full or partial

recovery. If any balance then remains from such recovery, it shall be applied to reimburse the Plan Member and any other policy providing benefits to the Plan Member's as their interest may appear.

Reimbursement

If the Plan Member recovers damages from any party or through any coverage named above, he must hold in trust for the Plan the proceeds of the recovery, and must reimburse the Plan to the extent of payment made. The Plan is entitled to be completely compensated for any and all funds expended as a result of the Plan Member's Illness or Injury regardless if the Plan Member is fully or only partially compensated. The Plan takes priority over the Plan Member for both full and partial recovery.

The Plan maintains both a contractual right of reimbursement and a separate right of subrogation to any funds recovered by you. You acknowledge that the Plan's subrogation and reimbursement rights shall be considered the first priority claim against any third party or your own automobile or liability carrier, to be paid before any other claims which may exist are paid, including claims by you for general damages or attorney fees or other costs.

Claims Administrators:

MEDICAL MUTUAL SERVICES

Traditional
PPO
Dental
Vision

Medical/Vision Customer Service	1-800-228-6472
Precertification	1-800-338-4114
Dental Customer Service	1-800-833-7027

www.MedMutual.com

PPO

Customer Service	1-800-344-8858 1-330-363-6360
Precertification	1-800-344-8858 1-330-363-6397

www.Aultcare.com