# COSHOCTON COUNTY COMMISSIONERS
# Non-Grandfathered
# Employee Health & Welfare Plan

**EFFECTIVE DATE**
October 1, 2012

**REVISED DATE**
January 1, 2018

**FOR COVERAGE INQUIRIES OR**
**TO CONTACT THE CLAIMS ADMINISTRATOR:**

**MUTUAL HEALTH SERVICES**
P.O. Box 5700
Cleveland, Ohio 44101
Phone: (330) 666-0337 or
1-800-367-3762 National Toll Free

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## INTRODUCTION

This booklet (otherwise known as the "Summary Plan Description" or "SPD") describes the health care benefits provided by Coshocton County Commissioners for Eligible Employees and their covered Dependents. We encourage you to take the time to become familiar with this document and how best to utilize the benefits available to you.

You will find terms starting with capital letters throughout this booklet. To help you understand your benefits, most of these terms are defined in the Definitions section at the end of the booklet. As used in this booklet, the terms "you" and "your" refer to Employees eligible to participate in the Plan.

This Plan is a self-funded benefit plan. Coshocton County Commissioners has retained the services of a professional Claims Administrator to perform the day-to-day claims administration of the Plan, but the ultimate risk of loss belongs to Coshocton County Commissioners. Coshocton County Commissioners, as Plan Administrator, has the final, sole discretion to interpret the Plan, decide any questions of eligibility, and determine any benefits which are payable under the Plan.

While Coshocton County Commissioners expects in good faith to continue this Plan indefinitely, it reserves the right to amend, suspend, or terminate the Plan in whole or in part, at any time, with or without advance notice. Any amendment or modification to the Plan must be made in writing, properly adopted, and signed by an authorized representative of Coshocton County Commissioners.

## ELIGIBILITY

Upon enrollment in the Plan you, your Spouse, and your eligible Dependents shall become Participants eligible for the benefits provided by this Plan, subject to the limitations contained in the applicable Plan provisions.

**Employee and Dependent Coverage:** Benefits are offered on a "stand-alone" basis. This means that the Employee may elect coverage for himself and his Dependents under one or more of the following benefits: Medical and Prescription Drug benefits; and/or Dental Benefits. Coverage may be waived for one or all of the benefits offered, however, a Dependent will only be covered for a particular benefit if the Employee is also covered for that benefit.

This Plan is considered a limited-scope dental plan under 29 C.F.R. §2590.732(c) (3). Although dental may be offered to you at the same time as your other benefits, it may be offered under a separate policy and may not be an integral part of the group health plan. If it is offered as a separate benefit, you have the right to decline election for the dental benefit. If you elect to receive coverage for dental, you may be required to pay additional premiums or contributions for that coverage. It is the Plan Administrator's good faith interpretation of the current law that the limited-scope benefits provided under this Plan are not subject to the restriction of annual and lifetime limits under the Patient Protection and Affordable Care Act. Therefore, the benefits offered under this Plan will be subject to benefit limits as expressly stated in the Plan. In the event that the Plan Administrator's interpretation is inconsistent with any rules promulgated by the Department of Health and Human Services or other governmental authorities in the future, the Plan Administrator will notify you accordingly.

## EMPLOYEE ELIGIBILITY

An Employee eligible for coverage under the Plan shall include only an Employee who is in an eligible Class and meets the following conditions:

- is employed by the Employer on a regular basis and who is scheduled to work a minimum of thirty (30) hours per week. Such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Employee to travel, and for which he receives regular earnings from the Employer and
- has met the required waiting period.

Should you wish to participate, you must complete an enrollment form and make any required contribution. Coshocton County Commissioners must receive the enrollment form within 30 days from the day you are eligible to enroll.

## DEPENDENT ELIGIBILITY

You may enroll yourself alone or you and your eligible Dependent(s). An eligible Dependent for medical, prescription and dental benefits includes:

- the Employee's legal Spouse, except an Employee's Spouse who is employed and is eligible for group coverage under this Plan, can only be covered if the Spouse accepts the minimum of individual coverage offered by their employer.

- Under federal law, the Employee's **married or unmarried** child who:

    a) is a natural child; legally adopted child; or stepchild;

    b) is eligible from birth to the end of the calendar month in which the child attains age 26; and

    c) may have their own employer coverage available.

Please note that the federal law does not require the child to live with or be financially dependent upon the parent.

Coverage for adopted children begins on the earlier of: the date of the actual adoption; or the date of placement for the purpose of adoption and is continuing unless the placement is disrupted prior to legal adoption of the child.

Coverage for children who have been placed under the Employee's legal custody or guardianship will begin on the date the Employee files for legal custody or guardianship unless legal custody or guardianship is not granted to the Employee.

## COVERAGE FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

Coverage may be continued beyond age 26 for your unmarried Dependent children who reside* with you if they are Totally Disabled by reason of a mental or physical handicap which commenced prior to reaching the limiting age, continue to be Totally Disabled and are principally dependent upon you or your Spouse for support. However, notification of the child's condition must be given within 90 days of the child's normal termination date. A non-permanent Total Disability where medical improvement is possible is not considered to be a "handicap" for

the purpose of this provision. This includes Alcoholism and Drug Abuse and non-permanent mental impairments.

You may be required to supply proof, upon request by Coshocton County Commissioners or the Claims Administrator, that a child satisfies these eligibility criteria.

* In this scenario *reside* includes either natural parent regardless of divorce.

In the event the child is no longer mentally or physically handicapped, then such extension of coverage will terminate within thirty (30) days of the date the child is declared no longer mentally or physically handicapped by a Physician.

**Persons specifically excluded from the definition of a Dependent:**

1. a Spouse on active military duty; or

2. any person eligible for coverage under this Plan as an individual Employee except that:
   a) when both legal Spouses are covered as Employees under this Plan, only one may cover Dependent children and either Spouse may elect to be covered as a dependent Spouse for coverage;
   b) when the person is also an eligible Dependent under this Plan, the person may be covered as an individual Employee or an eligible Dependent, but not as both; or

3. any person who is covered as a Dependent by more than one Employee of the same Employer may be eligible as a Dependent under only one Employee.

An Employee's Dependent child will not lose eligibility for coverage under the Plan as a result of the child becoming eligible for coverage as an Employee under the Plan. However, such individual must choose between coverage under the Plan as either an Employee or a Dependent, not both.

If a person is eligible to be covered under the Plan as an Employee and as an eligible dependent child and has elected to be covered as a Dependent, that person will, upon reaching the limiting age for a Dependent, be automatically covered as an Employee. The Waiting Period will be waived.

The Dependent benefits provided under the Plan for a Covered Employee shall be in accordance with the Dependent Eligibility, Effective Date and Termination Provisions included herein and his coverage classification (if any) under the Plan.

**OMNIBUS BUDGET RECONCILIATION ACT (OBRA)**

In compliance with the Omnibus Budget Reconciliation Act (OBRA) of 1993, the following provisions apply to dependent coverage:

- Adopted children are eligible for coverage immediately upon placement with the family.

- If an eligible Employee who is covered under this Plan is divorced, the children of that Employee are eligible Dependents for the Plan, regardless of other Dependent qualifications, if the eligible Employee is court ordered to provide coverage. If the eligible Employee or legal Spouse has obtained a Qualified Medical Child Support Order (QMCSO), coverage will also be provided. The Dependent may not be terminated from

coverage as long as the Employee is eligible for coverage and the court order is still in effect.

**ILLEGAL ALIEN**

Eligible Dependent shall not include any Illegal Alien. For purposes of this Plan, Illegal Alien shall mean a person who (1) is not a citizen of the United States, (2) is not lawfully admitted to the United States for permanent residence, and (3) is not authorized for employment within the United States by the United States Immigration and Naturalization Service or the Attorney General of the United States.

**QUALIFIED MEDICAL CHILD SUPPORT ORDERS**

If you are required by a "Qualified Medical Child Support Order", as defined in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), to provide coverage for your children, you can enroll these children as timely enrollees as required by OBRA 93. If you are not already enrolled in the Plan, you must also enroll at the same time.

When the Plan Administrator receives an order by a court or other authorized state agency for an Employee to provide coverage for his or her child(ren), the Plan Administrator will review the order to determine whether it is a "Qualified Medical Child Support Order", entitled to enforcement by the Plan. The Plan's procedures for reviewing these orders are available, without charge, upon written request to the Plan Administrator.

**ENROLLMENT IN THE PLAN**

An Employee contribution towards the cost of the Plan is required by Coshocton County Commissioners for participation in the Plan. You are required to complete an enrollment form and return such form to the Commissioner's office within 30 days from the date you are eligible to enroll. You must furnish such information regarding your age, family status and other relevant matters as may be required.

You must enroll within 30 days of becoming eligible. If you enroll after the initial 30-day enrollment period, you must follow the open enrollment or special enrollment provisions.

If you enroll yourself and your Dependents when first eligible, coverage will commence on the 31st day following the 30-day Waiting Period as described below.

**NOTE:** Newborn children: If the Plan Participant has previously enrolled in Dependent coverage and continues to cover his or her eligible Dependents, newborns will be eligible under this plan on the date of the new child's birth. However, no claims will be paid until a completed enrollment form is received by the Claims Administrator.

Plan Participants who have <u>not</u> previously enrolled for Dependent coverage will be required to complete and submit an enrollment form for the Newborn within 30 days of the child's birth for the child to be considered for coverage.

**WAITING PERIOD**

The Waiting Period is the length of time immediately before your coverage can become effective during which you must be an eligible Employee.

With respect to such an eligible person who becomes employed by the Employer on or after the Effective Date of this Plan, the Waiting Period is: 30 Calendar Days, coverage is effective on the 31st day.

With respect to such eligible person employed by the Employer prior to the Effective Date of this Plan who has not completed the prior plan's waiting period, the Waiting Period is: 30 Calendar Days, coverage is effective on the 31st day, with credit given for days satisfied prior to this Plan's Effective Date.

With respect to such eligible person employed by the Employer prior to the Effective Date of this Plan, who has completed the Waiting Period under the previous Plan, the Waiting Period is: None.

**OPEN ENROLLMENT**

Open enrollment will occur during the month of December with coverage becoming effective on January 1st. Open enrollment is available to Employees who initially did not enroll in the health care plan and for Employees and/or Dependents that did not enroll at the time that a special enrollment occurred. Selected coverage will remain in effect for a year unless there is a change in family status or loss of other coverage. Coverage waiting periods are waived during open enrollment for eligible Employees and eligible Dependents. An eligible Employee who fails to make an election during open enrollment will automatically retain his present coverage.

**LATE ENROLLMENT**

If an eligible Employee does not make written application for coverage during the Initial Enrollment period or a Special Enrollment period, that Employee must wait until the Open Enrollment Period to make written application for coverage.

**SPECIAL ENROLLMENT RIGHTS**

You or your eligible Dependent who has declined the coverage provided by this Plan may enroll for coverage under this Plan 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 Plan 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 coverage, but only if the Plan 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 legal separation or divorce

    b. Cessation of Dependent status (such as attaining the maximum age to be eligible as a dependent child under the Plan)

    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 Plan 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 Plan 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.

**VERIFICATION OF DEPENDENT STATUS**

The Claims Administrator may require documentation proving Dependent status, including, but not limited to, birth certificates, spousal marriage records, or initiation of legal proceedings severing spousal or parental rights.

**VERIFICATION OF INCAPACITATED DEPENDENT STATUS**

The Claims Administrator may require, at reasonable intervals, subsequent proof that such Dependent child continues to be an incapacitated Dependent. The Claims Administrator reserves the right to have such incapacitated Dependent examined by a Physician of the Plan's choice, at the Plan's expense, to determine that the incapacitated Dependent is or continues to be Totally Disabled. Coverage under the Plan will cease when such Dependent child ceases to be an incapacitated Dependent, or when such Dependent child ceases to meet the requirements to be considered a Dependent under the Plan. Once this has occurred, the child cannot be re-enrolled in the Plan.

## PREFERRED PROVIDER ORGANIZATION (PPO)

A Preferred Provider Organization (PPO) is a group of designated Hospitals, Physicians, and Other Providers who have agreed to work with an organization to help control health care costs by negotiating reduced fees. The PPO helps employers contain the skyrocketing cost of providing health benefits by encouraging Covered Persons to be cost-minded and become "Partners in Health Care".

In the following situations, services rendered by a Non-PPO Network Provider will be considered at the PPO level:

- Certain ancillary services performed by a Non-PPO Network Provider that may be beyond the Covered Person's control to designate a PPO Network Provider including, but not limited to, Hospital-based Physicians, anesthesia, pathology, lab reading and interpretation;
- If a Covered Person experiences an Emergency Medical Condition;
- If a Covered Person has no choice of a PPO Network Provider in the specialty that the Covered Person is seeking within the PPO service area;
- If a Covered Person does not live within a 50-mile radius of a PPO Network Provider;
- Eligible dependent children who reside outside of the PPO service area.

However, in these instances, the individual may be responsible for charges in excess of the Allowed Amount. Please call the Claims Administrator if you believe any of these provisions apply to you.

You can find out what Providers are included in your Plan's PPO Network(s) by reviewing the Provider directory. You'll need to search by the name of the PPO Network associated with your Plan, which is shown below. You can view and print a copy of this directory by visiting the PPO Network's website, which can be found as a link through **www.mutualhealthservices.com.** You can also request a printed copy, free of charge, by calling the telephone number for that PPO Network shown on your identification card.

**Primary Service Area:**

**Medical Mutual SuperMed PPO**

**Out of the Primary Service Area:**

**First Health**

## SCHEDULE OF BENEFITS- CORE PLAN
## COMPREHENSIVE MAJOR MEDICAL BENEFITS

**Precertification Review:** Precertification review is required for all inpatient Hospital Confinements. For elective stays, certification is required at least 24 hours prior to admission. For emergency admissions, certification is required within 48 hours following admission.

| **CORE PLAN** | | **Network** | **Non-Network** |
|---|---|---|---|
| **General Information** | | **All benefits will be based upon Allowed Amount** | |
| Product | | **Core Plan** | |
| Dependent Age | | 26 | |
| Dependent Removal | | End of Month | |
| Overall Benefit Period Maximum | | Unlimited | |
| 3 Month Deductible Carryover Credit | | Yes | |
| **How Claims are Paid** | | | |
| Benefit Period | | January 1st through December 31st | |
| Coinsurance | | 80% | 60% |
| Benefit Period Deductible - Single | | $1,000 | $2,000 |
| Benefit Period Deductible - Family | | $2,000 | $4,000 |
| Type of Deductible Accumulation | | Separate - Deductible incurred for a non-network provider will only apply to the non-network Deductible limits. Deductible incurred for a network provider will only apply to the network limits. | |
| Coinsurance Out-of-Pocket Limits –Single (Excludes Deductible) | | $2,500 | $5,000 |
| Coinsurance Out-of-Pocket Limits –Family (Excludes Deductible) | | $5,000 | $10,000 |
| Type of Coinsurance Out-of-Pocket Accumulation | | Separate - Coinsurance incurred for a non-network provider will only apply to the non-network coinsurance limits. Coinsurance incurred for a network provider will only apply to the network limits. | |
| Out-of-Pocket Maximum per Calendar Year (including any applicable Copayments, Deductible and Coinsurance) - Single | | $3,500 | $7,000 |
| Out-of-Pocket Maximum per Calendar Year (including any applicable Copayments, Deductible and Coinsurance) - Family | | $7,000 | $14,000 |
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| **Emergency Room** | | | |
| Emergency-Medical/Accident-Emergency Room | | $150 Copay, then 100% (Copay is waived if admitted) | |
| Non-Emergency-Emergency Room | | $150 Copay, then Deductible, then 80% (Copay is waived if admitted) | $200 Copay, then Deductible, then 60% (Copay is waived if admitted) |
| **Inpatient Services** | | | |
| Institutional Services | | 80% after Deductible | 60% after Deductible |
| Professional Services | | 80% after Deductible | 60% after Deductible |
| Skilled Nursing Facility (SNF) | (120 days per benefit period) | 80% after Deductible | 60% after Deductible |
| **Mental Health, Alcohol and Drug Abuse** | | | |
| Inpatient Alcoholism Services | | Benefits paid based on corresponding medical benefits | |
| Inpatient Drug Abuse Services | | Benefits paid based on corresponding medical benefits | |
| Inpatient Mental Health Services | | Benefits paid based on corresponding medical benefits | |
| Outpatient Alcoholism Services | | Benefits paid based on corresponding medical benefits | |
| Outpatient Drug Abuse Services | | Benefits paid based on corresponding medical benefits | |
| Outpatient Mental Health Services | | Benefits paid based on corresponding medical benefits | |
| **Office Visits(Illness/Injury)** | | | |
| Medically Necessary Office Visits Consultations- PCP | | $20 Copay, then 100% | 60% after Deductible |
| Medically Necessary Office Visits Consultations-Specialist | | $35 Copay, then 100% | 60% after Deductible |
| Urgent Care Provider Office Visits | | $75 Copay, then 100% | $100 Copay, then 100% |
| **Outpatient Services** | | | |
| Allergy Testing | | 80% after Deductible | 60% after Deductible |
| Allergy Treatment | | 80% after Deductible | 60% after Deductible |
| Diagnostic Lab, X-ray and Medical Tests | | 80% after Deductible | 60% after Deductible |
| Home Health Care | (40 visits per benefit period) | 80% after Deductible | 60% after Deductible |
| Surgical Services-Surgery | | 80% after Deductible | 60% after Deductible |
| Second Surgical Opinion ( and third if necessary) | | 100% | 100% |

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| **Outpatient Therapy** | | | |
| Cardiac Rehabilitation | | 80% after Deductible | 60% after Deductible |
| Chemotherapy | | 80% after Deductible | 60% after Deductible |
| Chiropractic | | $35 Copay, then 100% | 60% after Deductible |
| Licensed Massotherapist | (12 visits per benefit period) | $35 Copay, then 100% | 60% after Deductible |
| Occupational Therapy | | 80% after Deductible | 60% after Deductible |
| Physical Therapy | | 80% after Deductible | 60% after Deductible |
| Speech Therapy | | 80% after Deductible | 60% after Deductible |
| **Preventive/Routine/Well Child Care** | | | |
| Health Care Reform Preventive Benefits | | 100% | 100% |
| Health Care Reform Preventive Benefits for Women | | 100% | 100% |
| **Preventive/Routine Exams and Immunizations** | | | |
| Exam Associated with Pap Test | | 100% | 100% |
| Hearing Exam | (age 21 and over, 1 every 2 benefit periods) | 100% | 100% |
| Immunizations | (Standard Immunizations) | 100% | 100% |
| Physical Exam | (age 21 and over) | 100% | 100% |
| Vision Exam | (age 21 and over, 1 every 2 benefit periods) | 100% | 100% |
| **Preventive/Routine Tests** | | | |
| Mammogram | (all ages, 1 per benefit period) | 100% | 100% |
| Pap Test | (all ages, 1 per benefit period) | 100% | 100% |
| Standard Tests | Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, EKG, Urinalysis (all ages, 1 each per benefit period) | 100% | 100% |
| **Other Preventive/Routine Tests** | | | |
| 1) | PSA Tests (all ages) | 100% | 100% |
| 2) | Colon Cancer Screenings (all ages) | 100% | 100% |
| 3) | Bone Density Tests (all ages) | 100% | 60% after Deductible |

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| **Well Child Care** | | | |
| Age Limit | | 21 | |
| Exams | | 100% | 60% after Deductible |
| Immunizations | Well Child Immunizations | 100% | 60% after Deductible |
| Labs | | 100% | 60% after Deductible |
| **Additional Services** | | | |
| Acupuncture | | Not Covered | Not Covered |
| Ambulance | | 80% after Deductible | 80% after Deductible |
| **Additional Services** | | | |
| Durable Medical Equipment | | 80% after Deductible | 60% after Deductible |
| Hospice | | 80% after Deductible | 60% after Deductible |
| Organ Transplant | | 80% after Deductible | 60% after Deductible |
| Private Duty Nursing | (only when ordered by a Physician) | 80% after Deductible | 60% after Deductible |
| **Other Additional Services** | | | |
| 1) | Smoking Cessation Services | 100% | Not Covered |
| Gender Dysphoria Treatment | | Benefits are paid based on the services rendered | |

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| **PRESCRIPTION DRUG PLAN**<br>**General Information** | | |
| Days' Supply - Retail | | 30 |
| Days' Supply - Home Delivery | | 90 |
| **Retail Copayments** | | |
| Generic Copayment | | $15 |
| Formulary Copayment | | $25 or 30% (whichever is greater) |
| Non-Formulary Copayment | | $50 or 30% (whichever is greater) |
| **Other Retail Copayments** | | |
| Specialty Drugs | | 15% up to a $300 maximum |
| **Home Delivery Copayments** | | |
| Generic Copayment | | $15 |
| Formulary Copayment | | $50 |
| Non-Formulary Copayment | | $100 |
| **Other Home Delivery Copayments** | | |
| Specialty Drugs | | 15% up to a $300 maximum |
| **Out-of-Pocket Maximum for the Prescription Drug Plan** | | |
| Out-of-Pocket Maximum per Calendar Year- Single | | $3,100 |
| Out-of-Pocket Maximum per Calendar Year- Family | | $6,200 |

**SCHEDULE OF BENEFITS- BUY-UP PLAN**
**COMPREHENSIVE MAJOR MEDICAL BENEFITS**

| **BUY-UP PLAN** | | **Network** | **Non-Network** |
|---|---|---|---|
| Product | | **Buy-Up Plan** | |
| Dependent Age | | 26 | |
| Dependent Removal | | End of Month | |
| Overall Benefit Period Maximum | | Unlimited | |
| 3 Month Deductible Carryover Credit | | Yes | |
| **How Claims are Paid** | **All benefits will be based upon Allowed Amount** | | |
| Benefit Period | | January 1st through December 31st | |
| Coinsurance | | 85% | 70% |
| Benefit Period Deductible - Single | | $500 | $1,000 |
| Benefit Period Deductible - Family | | $1,000 | $2,000 |
| Type of Deductible Accumulation | | Separate - Deductible incurred for a non-network provider will only apply to the non-network Deductible limits. Deductible incurred for a network provider will only apply to the network limits. | |
| Coinsurance Out-of-Pocket Limits (Excludes Deductible) - Single | | $1,500 | $3,000 |
| Coinsurance Out-of-Pocket Limits (Excludes Deductible) - Family | | $3,000 | $6,000 |
| Type of Coinsurance Out-of-Pocket Accumulation | | Separate - Coinsurance incurred for a non-network provider will only apply to the non-network coinsurance limits. Coinsurance incurred for a network provider will only apply to the network limits. | |
| Out-of-Pocket Maximum per Calendar Year (including any applicable Copayments, Deductible and Coinsurance) - Single | | $2,000 | $4,000 |
| Out-of-Pocket Maximum per Calendar Year (including any applicable Copayments, Deductible and Coinsurance) - Family | | $4,000 | $8,000 |
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| **Emergency Room** | | | |
| Emergency Room - Medical/Accident | | $150 Copay, then 100% (Copay is waived if admitted) | |
| Non-Emergency - Emergency Room | | $150 Copay, then Deductible, then 85% (Copay is waived if admitted) | $200 Copay, then Deductible, then 70% (Copay is waived if admitted) |
| **Inpatient Services** | | | |
| Institutional Services | | 85% after Deductible | 70% after Deductible |
| Professional Services | | 85% after Deductible | 70% after Deductible |
| Skilled Nursing Facility (SNF) | (120 days per benefit period) | 85% after Deductible | 70% after Deductible |
| **Mental Health, Alcohol and Drug Abuse** | | | |
| Inpatient Alcoholism Services | | Benefits paid based on corresponding medical benefits | |
| Inpatient Drug Abuse Services | | Benefits paid based on corresponding medical benefits | |
| Inpatient Mental Health Services | | Benefits paid based on corresponding medical benefits | |
| Outpatient Alcoholism Services | | Benefits paid based on corresponding medical benefits | |
| Outpatient Drug Abuse Services | | Benefits paid based on corresponding medical benefits | |
| Outpatient Mental Health Services | | Benefits paid based on corresponding medical benefits | |
| **Office Visits (Illness/Injury)** | | | |
| Medically Necessary Office Visits/Consultations - PCP | | $20 Copay, then 100% | 70% after Deductible |
| Medically Necessary Office Visits/Consultations - Specialist | | $35 Copay, then 100% | 70% after Deductible |
| Urgent Care Provider Office Visits | | $75 Copay, then 100% | $100 Copay, then 100% |
| **Outpatient Services** | | | |
| Allergy Testing | | 85% after Deductible | 70% after Deductible |
| Allergy Treatment | | 85% after Deductible | 70% after Deductible |
| Diagnostic Lab, X-ray and Medical Tests | | 85% after Deductible | 70% after Deductible |
| Home Health Care | (40 visits per benefit period) | 85% after Deductible | 70% after Deductible |
| Surgical Services-Surgery | | 85% after Deductible | 70% after Deductible |
| Second Surgical Opinion (and third if necessary) | | 100% | 100% |

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|---|---|---|---|
| **Outpatient Therapy** | | | |
| Cardiac Rehabilitation | | 85% after Deductible | 70% after Deductible |
| Chemotherapy | | 85% after Deductible | 70% after Deductible |
| Chiropractic | | $35 Copay, then 100% | 70% after Deductible |
| Licensed Massotherapist | (12 visits per benefit period) | $35 Copay, then 100% | 70% after Deductible |
| Occupational Therapy | | 85% after Deductible | 70% after Deductible |
| Physical Therapy | | 85% after Deductible | 70% after Deductible |
| Speech Therapy | | 85% after Deductible | 70% after Deductible |
| **Preventive/Routine/Well Child Care** | | | |
| Health Care Reform Preventive Benefits | | 100% | 100% |
| Health Care Reform Preventive Benefits for Women | | 100% | 100% |
| **Preventive/Routine Exams and Immunizations** | | | |
| Exam Associated with Pap Test | | 100% | 100% |
| Family Planning Exam | (age 21 and over) | 100% | 100% |
| Hearing Exam | (age 21 and over, 1 every 2 benefit periods) | 100% | 100% |
| Immunizations | (Standard Immunizations) | 100% | 100% |
| Physical Exam | (age 21 and over) | 100% | 100% |
| Vision Exam | (age 21 and over, 1 every 2 benefit periods) | 100% | 100% |
| **Preventive/Routine Tests** | | | |
| Mammogram | (all ages, 1 per benefit period) | 100% | 100% |
| Pap Test | (all ages, 1 per benefit period) | 100% | 100% |
| Standard Tests | Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, EKG, Urinalysis (all ages, 1 each per benefit period) | 100% | 100% |
| **Other Preventive/Routine Tests** | | | |
| 1) | PSA Tests (all ages) | 100% | 100% |
| 2) | Colon Cancer Screenings (all ages) | 100% | 100% |
| 3) | Bone Density Tests (all ages) | 100% | 70% after Deductible |

| | | | |
|---|---|---|---|
| **Well Child Care** | | | |
| Age Limit | | 21 | |
| Maximum | | Unlimited | |
| Exams | | 100% | 70% after Deductible |
| Immunizations | (Well Child Immunizations) | 100% | 70% after Deductible |
| Labs | | 100% | 70% after Deductible |
| **Additional Services** | | | |
| Acupuncture | | Not Covered | Not Covered |
| Ambulance | | 85% after Deductible | 85% after Deductible |
| Durable Medical Equipment | | 85% after Deductible | 70% after Deductible |
| Hospice | | 85% after Deductible | 70% after Deductible |
| Organ Transplant | | 85% after Deductible | 70% after Deductible |
| **Additional Services** | | | |
| Private Duty Nursing | (only when ordered by a Physician) | 85% after Deductible | 70% after Deductible |
| 1) | Smoking Cessation Services | 100% | Not Covered |
| Gender Dysphoria Treatment | | Benefits are paid based on the services rendered | |

| | | |
|---|---|---|
| **PRESCRIPTION DRUG PLAN**<br>**General Information** | | |
| Days' Supply - Retail | | 30 |
| Days' Supply - Home Delivery | | 90 |
| **Retail Copayments** | | |
| Generic Copayment | | $15 |
| Formulary Copayment | | $25 or 30% (whichever is greater) |
| Non-Formulary Copayment | | $50 or 30% (whichever is greater) |
| **Other Retail Copayments** | | |
| Specialty Drugs | | 15% up to a $300 maximum |
| **Home Delivery Copayments** | | |
| Generic Copayment | | $15 |
| Formulary Copayment | | $50 |
| Non-Formulary Copayment | | $100 |
| **Other Home Delivery Copayments** | | |
| Specialty Drugs | | 15% up to a $300 maximum |
| **Out-of-Pocket Maximum for the Prescription Drug Plan** | | |
| Out-of-Pocket Maximum per Calendar Year- Single | | $4,600 |
| Out-of-Pocket Maximum per Calendar Year- Family | | $9,200 |

**SCHEDULE OF BENEFITS- H.S.A. PLAN**
**COMPREHENSIVE MAJOR MEDICAL BENEFITS**

| **H.S.A. PLAN** | | **Network** | **Non-Network** |
|---|---|---|---|
| **General Information** | | **All benefits will be based upon Allowed Amount** | |
| Product | | **H.S.A. Plan** | |
| Dependent Age | | 26 | |
| Dependent Removal | | End of Month | |
| Overall Benefit Period Maximum | | Unlimited | |
| **How Claims are Paid** | | | |
| Benefit Period | | January 1st through December 31st | |
| Coinsurance | | 100% | 60% |
| Benefit Period Deductible - Single | | $2,700 | $5,000 |
| Benefit Period Deductible - Family | | $5,400 | $10,000 |
| Type of Deductible Accumulation | | Separate - Deductible incurred for a non-network provider will only apply to the non-network Deductible limits. Deductible incurred for a network provider will only apply to the network limits. | |
| Coinsurance Out-of-Pocket Limits (Excludes Deductible) - Single | | $0 | $5,000 |
| Coinsurance Out-of-Pocket Limits (Excludes Deductible) - Family | | $0 | $10,000 |
| Type of Coinsurance Out-of-Pocket Accumulation | | Separate- Coinsurance incurred for a non-network provider will only apply to the non-network coinsurance limits. Coinsurance incurred for a network provider will only apply to the network limits. | |
| Out-of-Pocket Maximum per Calendar Year (including any applicable Copayments, Deductible and Coinsurance) - Single | | $2,700 | $10,000 |
| Out-of-Pocket Maximum per Calendar Year (including any applicable Copayments, Deductible and Coinsurance) - Family | | $5,400 | $20,000 |
| **Emergency Room** | | | |
| Emergency-Medical/Accident-Emergency Room | | 100% after Deductible | |
| Non-Emergency-Emergency Room | | 100% after Deductible | 60% after Deductible |
| | | | |

| | | | |
|---|---|---|---|
| **Inpatient Services** | | | |
| Institutional Services | | 100% after Deductible | 60% after Deductible |
| Professional Services | | 100% after Deductible | 60% after Deductible |
| Skilled Nursing Facility (SNF) | (120 days per benefit period) | 100% after Deductible | 60% after Deductible |
| **Mental Health, Alcohol and Drug Abuse** | | | |
| Inpatient Alcoholism Services | | Benefits paid based on corresponding medical benefits | |
| Inpatient Drug Abuse Services | | Benefits paid based on corresponding medical benefits | |
| Inpatient Mental Health Services | | Benefits paid based on corresponding medical benefits | |
| Outpatient Alcoholism Services | | Benefits paid based on corresponding medical benefits | |
| Outpatient Drug Abuse Services | | Benefits paid based on corresponding medical benefits | |
| Outpatient Mental Health Services | | Benefits paid based on corresponding medical benefits | |
| **Office Visits(illness/injury)** | | | |
| Medically Necessary Office Visits/ Consultations- PCP | | 100% after Deductible | 60% after Deductible |
| Medically Necessary Office Visits/ Consultations- Specialist | | 100% after Deductible | 60% after Deductible |
| Urgent Care Provider Office Visits | | 100% after Deductible | 60% after Deductible |
| **Outpatient Services** | | | |
| Allergy Testing | | 100% after Deductible | 60% after Deductible |
| Allergy Treatment | | 100% after Deductible | 60% after Deductible |
| Diagnostic Lab, X-ray and Medical Tests | | 100% after Deductible | 60% after Deductible |
| Home Health Care | (40 visits per benefit period) | 100% after Deductible | 60% after Deductible |
| Surgical Services - Surgery | | 100% after Deductible | 60% after Deductible |
| Second Surgical Opinion (and third if necessary) | | 100% | 100% |
| **Outpatient Therapy** | | | |
| Cardiac Rehabilitation | | 100% after Deductible | 60% after Deductible |
| Chemotherapy | | 100% after Deductible | 60% after Deductible |
| Chiropractic | | 100% after Deductible | 60% after Deductible |
| Licensed Massotherapist | (12 visits per benefit period) | 100% after Deductible | 60% after Deductible |
| Occupational Therapy | | 100% after Deductible | 60% after Deductible |
| Physical Therapy | | 100% after Deductible | 60% after Deductible |
| Speech Therapy | | 100% after Deductible | 60% after Deductible |

| | | | |
|---|---|---|---|
| **Preventive/Routine/Well Child Care** | | | |
| Health Care Reform Preventive Benefits | | 100% | 100% |
| Health Care Reform Preventive Benefits for Women | | 100% | 100% |
| **Preventive/Routine Exams and Immunizations** | | | |
| Exam Associated with Pap Test | | 100% | 100% |
| Hearing Exam | (age 21 and over, 1 every 2 benefit periods) | 100% | 100% |
| Immunizations | (Standard Immunizations) | 100% | 100% |
| Physical Exam | (age 21 and over) | 100% | 100% |
| Vision Exam | (age 21 and over, 1 every 2 benefit periods) | 100% | 100% |
| **Preventive/Routine Tests** | | | |
| Mammogram | (all ages, 1 per benefit period) | 100% | 100% |
| Pap Test | (all ages, 1 per benefit period) | 100% | 100% |
| Standard Tests | Chest X-ray, Complete Blood Count, Comprehensive Metabolic Panel, EKG, Urinalysis (all ages, 1 each per benefit period) | 100% | 100% |
| **Other Preventive/Routine Tests** | | | |
| 1) | PSA Tests (all ages) | 100% | 100% |
| 2) | Colon Cancer Screenings (all ages) | 100% | 100% |
| 3) | Bone Density Tests (all ages) | 100% after Deductible | 60% after Deductible |
| **Well Child Care** | | | |
| Age Limit | | 21 | |
| Exams | | 100% | 60% after Deductible |
| Immunizations | (Well Child Immunizations) | 100% | 60% after Deductible |
| Labs | | 100% | 60% after Deductible |
| **Additional Services** | | | |
| Acupuncture | | Not Covered | Not Covered |
| Ambulance | | 100% after Deductible | 100% after Deductible |

| | | | |
|---|---|---|---|
| **Additional Services** | | | |
| Durable Medical Equipment | | 100% after Deductible | 60% after Deductible |
| Hospice | | 100% after Deductible | 60% after Deductible |
| Organ Transplant | | 100% after Deductible | 60% after Deductible |
| Private Duty Nursing | (only when ordered by a Physician) | 100% after Deductible | 60% after Deductible |
| **Other Additional Services** | | | |
| 1) | Smoking Cessation Services | 100% after Deductible | Not Covered |
| Gender Dysphoria Treatment | | Benefits are paid based on the services rendered | |

| | | |
|---|---|---|
| **PRESCRIPTION DRUG PLAN** | | |
| **General Information** | | |
| Days' Supply - Retail | | 30 |
| Days' Supply - Home Delivery | | 90 |
| **How Claims are Paid** | | |
| Benefit Period Deductible-Single/Family | | See Medical |
| Coinsurance Out-of-Pocket Limits-Single/Family | | See Medical |
| **Major Medical Drug Copays** | | |
| Retail - Generic Copayment | $15 after Deductible is met. | |
| Retail - Formulary Copayment | $25 or 30% (whichever is greater) after Deductible is met. | |
| Retail - Non-Formulary Copayment | $50 or 30% (whichever is greater) after Deductible is met. | |
| Retail – Specialty Drug Copayment | 15%, after Deductible is met, up to a $300 maximum | |
| Home Delivery-Generic Copayment | $15 after Deductible is met. | |
| Home Delivery-Formulary Copayment | $50 after Deductible is met. | |
| Home Delivery – Non-Formulary Copayment | $100 after Deductible is met. | |
| Home Delivery – Specialty Drug Copayment | 15%, after Deductible is met, up to a $300 maximum | |
| **Out-of-Pocket Maximum for the Prescription Drug Copayments** | | |
| Out-of-Pocket Maximum for Copayments per Calendar Year-Single | $3,850 | |
| Out-of-Pocket Maximum for Copayments per Calendar Year-Family | $7,800 | |

## SCHEDULE OF DENTAL BENEFITS

Covered dental expenses will include expenses incurred for dental services listed in this Dental Schedule of Benefits. The Plan may agree to accept, as covered dental expenses, expenses for services not listed. To be considered, services should be identified in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature and/or by description and submitted to the Plan.

The Plan will determine the maximum covered expense for services that it accepts. The maximum covered expense so determined will be consistent with the maximums listed.

For the purpose of this Plan, any Class I or II dental service provided for in this schedule will be considered a Class IV dental service when performed for or in connection with orthodontic treatment.

### MAXIMUM BENEFIT

Maximum Calendar Year Benefit per Person for Class I, II, and III Services Combined .....$1,500

Maximum Lifetime Benefit per Person for Orthodontia
(for Covered Dependents up to age 19) .....$1,000

### DEDUCTIBLE AMOUNTS

**Preventive Services (Class I)** ..... None

**Basic Services (Class II) and Major Services (Class III):**
Each Person, Each Calendar Year.....$25
Maximum per Family per Calendar Year.....$50

**Orthodontia Care (Class IV) per Lifetime (each Person)** .....$50

### COINSURANCE

Subject to Dental Allowed Amount

**Preventive Services & Emergency Treatment**.....100%

**Basic Services**.....80%

**Major Services**.....80%

**Orthodontia Care** (Six months waiting period, for Covered Dependents up to age 19).....50%

## PRECERTIFICATION OF BENEFITS

The precertification program is administered by the Managed Care division of Medical Mutual. This program is designed to ensure medical necessity, to reduce unnecessary hospital admissions, and to ensure that health care services are delivered in the most cost-efficient manner, while keeping quality, as well as cost, in mind. This program also provides a means of getting answers to your health care questions and considering alternatives to a hospital stay.

Inpatient admissions and certain outpatient tests, procedures and equipment require precertification, also known as prior approval. Contracting hospitals and providers in Ohio will assure that any required prior approval is obtained for you. For Non-contracting hospitals and providers, as well as for hospitals and providers outside Ohio, you are responsible for obtaining prior approval. Failure to pre-certify may subject you to significant monetary penalties, up to and including all billed charges.

Examples of services that may require precertification (prior approval) are:

- All hospital admissions
- Reconstructive surgeries
- Durable medical equipment and devices over $500
- MRI's and PET scans
- Home health care
- Injectable Drugs over $500
- Chemotherapy (regardless of where it is performed)
- Hospice
- Skilled Nursing Facility
- Septo-rhinoplasty, tenotomy or reconstructive surgery

For a complete and current listing, please contact the Customer Care Center at the phone number shown on your identification card. Be sure to check this listing before services are received, as the information is subject to change.

### Emergency Admissions

An emergency or urgent admission refers to a situation that requires immediate Hospitalization. In such cases, the patient or his or her authorized representative must call Medical Mutual within 48 business hours of admission and provide them with the pertinent information concerning the admission, to avoid the patient being responsible for all billed charges for that emergency admission.

**Medical-Surgical**
**(800) 338-4114**

**Behavioral Health**
**(800) 258-3186**

## COMPREHENSIVE MAJOR MEDICAL BENEFITS

### BENEFITS PAYABLE

If you or a Dependent incur covered expenses after the effective date of your major medical coverage, payment will be made, at the appropriate Coinsurance level, for expenses Incurred during a Calendar Year which exceed the Deductible (and any applicable Copay amounts) as listed in the Schedule of Benefits. These percentages apply until the Covered Person reaches the Out-of-Pocket Maximum, then eligible expenses will be payable at 100% of the Allowed Amount, unless otherwise specified.

### DEDUCTIBLE

The Deductible will be applied only once during a Calendar Year.

#### Deductible Carryover for the Core Plan and Buy-Up Plan only

If, during the last 3 months of the Calendar Year, a Covered Person incurs expenses which are applied toward the Deductible amount, these expenses will also be applied to the Deductible amount for the succeeding Calendar Year. Please note this provision does not apply to the H.S.A. Plan.

#### Common Accident Deductible

If two or more Covered Persons of a family are injured in the same accident, only one Deductible will be applied toward those eligible expenses, which directly resulted from injuries Incurred by family members in the same accident.

### LIFETIME DOLLAR LIMITS

The Essential Health Benefits that may be provided by your Plan are not subject to a lifetime dollar limit. Plan benefits that are not defined as Essential Health Benefits may have a lifetime dollar limit.

### OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum applies each Calendar Year. Once a Covered Person has met the Out-of-Pocket Maximum, benefits for that Covered Person's eligible expenses will be payable at 100% of the Allowed Amount for the remainder of the Calendar Year. The Out-of-Pocket Maximum does not include penalties for pre-certification non-compliance or charges exceeding the Allowed Amount.

### METHOD OF PAYMENT

Your Benefit Plan bases its payment for Covered Services upon the Allowed Amount. These Covered Services will be paid at a rate that is equal to or lower than the Allowed Amount.

## COVERED SERVICES

The following are Covered Services, payable as outlined in the Schedule of Benefits, and subject to the other terms, conditions and limitations described in this booklet.

### HOSPITAL SERVICES

When you or your Dependent is admitted as a bed patient or as an outpatient to any state approved Hospital, the following services will be covered as needed and to the extent available for:

**Inpatient Hospital Services** - bed, board, and general nursing services:

- A room with two or more beds;
- A private room. The private room allowance is the Hospital's average semi-private room rate. Charges for a private room will be an eligible expense if the Hospital has no Semi-Private rooms, the Covered Person has a communicable disease or the private room is Medically Necessary for treatment of the Covered Person's condition;
- A bed in a special care unit approved by the Plan. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients; and
- Miscellaneous Hospital expenses for a physical Injury or Illness received by a Covered Person while the Covered Person is Confined in a Hospital.

**Ancillary Services - Inpatient and Outpatient; include but are not limited to:**

- Operating, delivery and treatment rooms and equipment;
- Prescribed drugs;
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or Other Provider;
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic services; and
- Therapy services.

**Blood and Blood Plasma**

Whole blood, blood plasma, and blood products when not replaced by donation are eligible. This includes the processing and administration of services.

**Outpatient Hospital Services**

- **Diagnostic**: Lab and x-ray services.
- **Emergency Accident Care**: Services and supplies to treat injuries caused by an accident within 72 hours of the accident;
- **Emergency Medical Services:** for treatment of a medical Condition;
- **Operating room and supplies**;
- **Preadmission Testing**: Outpatient tests and studies performed within 10 days prior to a scheduled Hospital admission. Benefits are payable as shown in the Schedule of Benefits;
- **Surgery**: Surgical services and supplies.

## MEDICAL-SURGICAL BENEFITS

In general, the Plan will pay for eligible charges for services that include the following:

### ALCOHOLISM & DRUG ABUSE BENEFITS

#### Inpatient Benefits

The charges for inpatient services are payable as listed in the Schedule of Benefits.

Benefits are provided for inpatient and partial Hospitalization Alcoholism and Drug Abuse care only at a licensed facility. Inpatient services must be pre-certified before admission.

Benefits include inpatient services provided in a Residential Treatment Facility, as well as a Hospital. Services received in a Hospital or Residential Treatment Facility must be pre-certified prior to admission.

#### Outpatient Benefits

The charges for outpatient services are payable as listed in the Schedule of Benefits.

Benefits are provided for outpatient care by a licensed Psychologist, Psychiatrist, or Licensed Social Worker. Coverage will include services provided in a certified Day Treatment Program.

Full parity is applied to all existing Alcohol and/or Drug Abuse benefits to allow for all Alcohol and/or Drug Abuse diagnoses and services to be covered as equal to those benefits for Medical and Surgical services.

If this Plan offers prescription drug services, the coverage shall include prescription drug services for the treatment of Alcoholism and Drug Abuse or addiction conditions on the same terms and conditions as other physical diseases and disorders.

### ALLERGY

Expenses for allergy testing, extract and injections when rendered by a Physician or other provider, as shown in the Schedule of Benefits.

### AMBULANCE SERVICE

Transportation by a vehicle designed, equipped and used only to transport the sick and injured:

- From the Covered Person's home, scene of accident or medical emergency to a Hospital;
- Between Hospitals;
- Between Hospital and Skilled Nursing Facility;
- From a Hospital or Skilled Nursing Facility to the Covered Person's home.

Trips must be to the closest facility that can provide Covered Services appropriate for the Covered Person's Condition. If none and it is documented that the first facility does not have the required services and/or facilities to treat the Covered person, coverage is available for trips to the closest such facility outside the Covered Person's local area. Air ambulance service is covered under the Plan when Medically Necessary.

Transportation services provided by an ambulette or wheelchair van and charges made for convenience are not Covered Services.

**ANESTHESIA**

This Plan covers anesthesia for any Covered Service when administered by a Physician or Other Provider who is not the surgeon or the assistant at surgery. Some anesthesiologists are not considered in-network providers. Many anesthesiologists are independent contractors and not Hospital employees.

**BIO-FEEDBACK**

Charges for bio-feedback.

**CLINICAL TRIALS**

Benefits are provided for Routine Patient Costs administered to a Covered Person participating in any stage of an Approved Clinical Trial, 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 be eligible to participate in an Approved Clinical Trial, according to the trial protocol with respect to treatment of cancer or other Life-threatening Conditions.

If the clinical trial is not available from a PPO 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 Group Contract 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 Cost. 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;
- A service, item, or drug that is provided at no charge or that is eligible for reimbursement by an entity other than the Plan, 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.

**CONCURRENT MEDICAL CARE**

The Plan covers care for a medical Condition by a Physician who is not the Covered Person's surgeon while in the Hospital for surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of the Covered Person's Condition requires the skills of separate Physicians is also covered.

**CONSULTATION**

A personal bedside examination by another Physician when requested by the Covered Person's attending Physician. Staff consultations required by Hospital rules are excluded.

**DENTAL SERVICES**

**For Accidental Injury**

Dental services rendered by a Physician, oral surgeon or dentist for an accidental Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident. Injury as a result of chewing or biting is not considered an accidental Injury.

The above exclusion for Injuries as a result of biting or chewing shall not apply if such Injury was the result of domestic violence or if an underlying medical Condition caused the biting or chewing-related Injury. For example, a Covered Person with epilepsy involuntarily clamps down on his teeth and breaks one during a seizure.

The underlying Illness must cause the chewing or biting accident that results in the Injury to the jaws, sound natural teeth, mouth or face. If a Covered Person has an underlying Illness that causes the teeth to be more susceptible to Injury, dental services related to such Injury will not be covered as an Injury sustained in an accident.

Services include all related charges for: 1) repair to sound natural teeth due to accidental Injury in order to restore them to their condition prior to the accident; 2) extraction of full & partial bony impacted teeth. All oral surgeons are to be paid at the Network level of benefits. Charges for Hospital expenses in connection with dental services, but only if it is deemed Medically Necessary for the Covered Person to be treated in or confined in a Hospital, due to a medical condition which could jeopardize the individual's life if the services were not rendered in a Hospital.

**Oral Surgery**

Oral surgical services, including related x-rays and anesthesia, but limited to the following procedures:

- Surgical removal of impacted, (non-erupted) teeth;
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;
- Surgical procedures to correct injuries to the jaw, cheeks, lips, tongue, roof, and floor of the mouth;
- Excision of extosis (bony outgrowth) of the jaws and hard palate;
- Frenotomy (incision of the membrane connecting the tongue to the floor of the mouth);
- Incision of drainage of cellulitis (tissue inflammation) of the mouth;
- Incision of accessory sinuses, salivary glands, or ducts.

**DIAGNOSTIC SERVICES**

The following services when performed for diagnosis of a Condition, disease, or Injury and the Physician's interpretation of these exams are covered under your Plan:

- Radiology, ultrasound and nuclear medicine;
- Laboratory and Pathology Services;
- Diagnostic Medical Examinations such as CT scans, EKG's and EEG's, MRI’s;
- Cardiographic, Encephalographic and Radioisotope Tests;
- Pneumoencephalograms, Basal Metabolism Tests;
- Allergy Testing.

Diagnostic services may be provided either in or out of a Hospital.

**DOMESTIC VIOLENCE**

Charges for Injuries as a result of an act of domestic violence. Final medical payment may be subject to subrogation. Please refer to the subrogation provision.

**EMERGENCY SERVICES**

In the event of an emergency, go to the nearest Hospital for immediate care or dial 9-1-1 for emergency assistance. An Emergency Medical Condition is any medical Condition that is severe enough to cause a prudent layperson with an average knowledge of health and medicine to believe that absence of immediate medical attention could result in any of the following:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part.

Emergency Services will be covered according to your Schedule of Benefits without regard to the day, time, or location that the emergency services are rendered.

“Stabilize” means, to provide such medical treatment of an Emergency Medical 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.

Your Plan covers Emergency Services for an Emergency Medical condition treated in any hospital emergency department.

Your Plan will not require prior authorization or impose any other administrative requirements or benefit limitations that are more restrictive if you receive Emergency Services from an out of network provider. However, an out of network provider of Emergency Services may send you a bill for any charges remaining after your Plan has paid (this is called "balance billing").

Except where your Plan provides a better benefit, your Plan will apply the same Copayments and coinsurance for out of network Emergency Services as it generally requires for in network Emergency Services. A Deductible may be imposed for out of network Emergency Services, only as part of the Deductible that generally applies to out of network benefits. Similarly, any out-of-pocket maximum that generally applies to out of network benefits will apply to out of network Emergency Services.

Your Plan will calculate the amount to be paid for out of network Emergency Services in three different ways and pay the greatest of the three amounts: 1) the amount your Plan pays to in network providers for the Emergency Services furnished (this calculation is not required if your Plan does not have negotiated per service amounts with in network providers for the services furnished); 2) the amount that would be paid using the same method your Plan generally uses to determine payment for out of network services but substituting in network Copayments and coinsurance amounts; and (3) the amount that would be paid under Medicare for the services provided. All three of these amounts are calculated before application of any network Copayments or coinsurance.

**GENDER DYSPHORIA TREATMENT**

The Plan will cover Medically Necessary services for the treatment of gender dysphoria, subject to accepted medical clinical guidelines and the relevant corporate medical policy of Claims Administrator or, if applicable, the Plan's utilization review organization.

**GENETIC TESTING**

The plan will cover BRCA1 and BRCA2 testing when Medically Necessary.

**HOME HEALTH CARE SERVICES**

This section applies only if charges for home care services are not covered elsewhere in the Plan and are Medically Necessary. A licensed or Medicare-certified home health agency or certified rehabilitation agency must provide or coordinate the services. A Covered Person should make sure the agency meets this requirement before services are provided. The Plan will pay benefits for charges for the following services:

- Part-time or intermittent home nursing care by or under the supervision of a registered nurse;

- Part-time or intermittent home health aide services when part of the home care plan. The services must consist solely of care for the patient. A registered nurse or medical social worker must supervise them;

- Physical or occupational therapy or speech-language pathology or respiratory care;

- Medical supplies, drugs, and medications prescribed by a Physician; laboratory services by or on behalf of a Hospital is needed under the home care plan. These items are covered to the extent they would be if the Covered Person had been Hospitalized;

- Nutrition counseling provided or supervised by a registered dietician;

- Evaluation of the need for a home care plan by a registered nurse, Physician extender, or medical social worker. The Covered Person's attending Physician must request or approve this evaluation.

- Home care is not covered unless the Covered Person's attending Physician certifies that (a) Hospitalization or Confinement in a licensed Skilled Nursing Facility would be needed if the Covered Person didn't have home care; and (b) members of the Covered Person's immediate family, or others living with the Covered Person couldn't give the Covered Person the care and treatment he/she needs without undue hardship.

- If the Covered Person was hospitalized just before home care started, the Covered Person's primary Physician during his/her Hospital stay must also approve the home care plan.

- Each visit by a person providing services under a home care plan, evaluating the Covered Person's need or developing a plan counts as one visit. Each period of up to four straight hours of home health aide services in a 24-hour period counts as one home care visit.

**Specifically excluded from coverage under this benefit are:**

1. Services and supplies not included in the Home Health Care Plan;
2. Services of a person who ordinarily resides in the home of the Covered Person, or is a relative of the Covered Person;
3. Services of any social worker;
4. Transportation services.

**HOSPICE BENEFITS**

Hospice services consist of health care services provided to a Covered Person who is a patient with a reduced life expectancy due to advanced Illness. Hospice services must be provided through a Hospice Facility or a Hospice program sponsored by a Hospital or Home Health Care Agency which is centrally administered, medically directed and is a Nurse coordinated program that a) provides an organized system of home care; b) uses a Hospice Team, and; c) is available 24-hours-a-day, 7-days-a-week. Hospice services may be received by the Covered Person in a private residence.

Benefits for Hospice services are available when the prognosis of life expectancy is six months or less. Benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy. The following services and supplies are eligible:

- Professional services of a registered or licensed practical nurse;
- Treatment by physical means, occupational therapy, and speech therapy;
- Medical and surgical supplies;
- Prescription drugs; (these prescription drugs must be required in order to relieve the symptoms of a Condition, or to provide supportive care);

- Oxygen and its administration;
- Medical social services, such as the counseling of patients;
- Home health aide visits;
- Acute inpatient Hospice services;
- Respite care;
- Dietary guidance; counseling and training needed for a proper dietary program;
- Durable Medical Equipment;
- Pre-death counseling and bereavement counseling for the terminally ill individual and his covered Family during the individual's Illness and until six (6) months after the Covered person's death;
- Medical social services such as: assessment of the social and emotional factors related to the Covered Person's terminal Illness, need for care, response to treatment, and adjustment to care; and action to obtain casework services to assist in resolving problems in these areas; and
- Pastoral counseling, other than counseling provided by a licensed pastoral counselor to a member of his congregation in the course of duties to which he has been called as a pastor or minister.

A treatment plan must be developed and submitted to the Plan by the Covered Person's Physician and the Provider of the Hospice services. The treatment plan must be approved by the Plan.

**Non-covered Hospice services include, but are not limited to:**

- Volunteer services;
- Homemaker services;
- Food or home delivered meals;
- Custodial Care, rest care or care which is provided solely for someone's convenience.
- Pre-death counseling and bereavement counseling which is not provided by or through the hospice program of care; or
- Services provided by homemakers, caretakers and the like; or
- Funeral services and arrangements; or
- Curative treatment or services; or
- Services and supplies that are not for the palliation or management of terminal Illness.

**HUMAN ORGAN AND TISSUE TRANSPLANTS**

Prior approval must be obtained for benefits to be provided for Human Organ and Tissue Transplant Services, except for a cornea or kidney transplant. To obtain approval, contact the Claims Administrator as soon as your Physician suggests that your condition may require a transplant.

The Plan will pay for services and supplies in connection with non-experimental organ and tissue transplant procedures, subject to the following conditions:

1. If the recipient is covered under this Plan, eligible medical expenses incurred by the recipient will be considered for benefits. Expenses which are related to the donation and are incurred by the donor, who is not ordinarily covered under this Plan according to the Plan's eligibility requirements, will be considered Eligible Expenses to the extent that such expenses are not payable by the donor's coverage. In no event will benefits be payable in excess of the benefit available to the recipient.

2. If both the donor and the recipient are covered under this Plan, eligible medical expenses incurred by each Covered Person will be treated separately for each Covered Person.

3. If the recipient is not covered under this Plan, the donor's expenses are not covered.

4. The Allowed Amount of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ, will be considered a covered charge.

However, in reference to item number 2 and 3 above, if the Plan's expenses for the transplant are covered by a separate transplant contract with the Hospital in which the transplant occurs, and such contract contains a global case fee which includes the cost of the donor's eligible expenses, then all eligible benefits will be payable for the donor under this Plan (will not be coordinated with the donor's plan).

**Tissue Transplants**

Benefits are payable for Tissue Transplants and all related charges which are described as Covered Services.

Benefits are payable as shown in the Schedule of Benefits for the following transplants:
- Cornea transplants;
- Allogenic and autologous bone marrow transplants for certain diagnoses.

In order for a tissue transplant to be considered eligible, it must not be considered Experimental and/or Investigative. The procedure must be a nationally acceptable protocol for the diagnosis requiring the transplant. Coverage may be provided for transplants that are still undergoing clinical trials if FDA approved and medical necessity is determined by a peer review organization.

**Human Organ Transplants**

Benefits are payable for Human Organ Transplants and all related charges which are described as Covered Services including the acquisition, preparation, transportation, and storage of the human organ.

Benefits are payable as shown in the Schedule of Benefits for the following transplants:
- Heart transplants;
- Heart/Lung transplants;
- Liver transplants;
- Lung transplants;
- Pancreas transplants;
- Kidney transplants.

Additional transplant procedures may be eligible for coverage. If you require an organ transplant not specified above, contact the Claims Administrator for prior approval.

**Exclusions**

The following are not covered under this section. The Plan provides no benefits for:

- Lodging expenses, including meals;
- Expenses related to the recipient's transportation, except for Medically Necessary professionally licensed ambulance services as stated in this Plan;
- The purchase price of any bone marrow, organ, or tissue that is sold rather than donated;
- Treatment, services, and supplies not ordered by a Physician or surgeon;
- Transplants involving non-human or artificial organ or tissues;
- Human-to-human bone marrow, organ, or tissue transplants other than those specifically covered under this section;
- Treatment, services, and supplies not covered by the Plan.

**INPATIENT HOSPITAL MEDICAL CARE**

The Plan covers Physician's visits to a registered bed-patient in a Hospital.

**MASTECTOMY**

In compliance with the Women's Health and Cancer Rights Act of 1998, the following benefits are available to a Covered Person who elects breast reconstruction in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance, however, coverage is not provided for removal of a healthy breast for preventative or reconstructive purposes;
- Coverage for prostheses and physical complications of all stages of mastectomy including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

Such coverage will be subject to annual Deductibles and Coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the Plan or coverage.

**MATERNITY (Statement of Rights under the Newborns' and Mothers' Health Protection Act)**

Maternity is provided for all eligible Employees and all eligible Dependents when covered under a family contract. Coverage will be paid as shown in the Schedule of Benefits.

Under Federal law, group health plans and health insurance issuers offering group health coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending provider (e.g., your Physician, nurse, midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan may not, under Federal law, require that a Physician or other Health Care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. Therefore, if your Plan contains a precertification requirement, you or your Provider must still pre-certify the stay to avoid any additional out-of-pocket expenses; however, your stay will automatically be pre-certified for 48 or 96 hours as required by this Federal law.

**Pregnancy Benefits**

Benefits for Pregnancy are treated as any other Illness under the Plan. An initial Routine Maternity ultrasound is covered, however subsequent ultrasounds are not covered unless Medically Necessary.

**Birthing Center**

Treatment in a licensed Birthing Center, which meets all of the following criteria, is also eligible:

- It is primarily engaged in providing birthing services for low risk pregnancies;
- It is operated under the supervision of a Physician;
- It has at least one licensed registered nurse certified as a nurse midwife in attendance at all times;
- It has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

**Child Birthing Center/ Newborn Exam**

Charges made by a Child Birthing Center including room and board, miscellaneous, lab work, professional fees, delivery, facility use, supplies, prenatal and postpartum care and exams.

Inpatient visits to examine a newborn, including circumcision.

Routine nursery care for a newborn child is covered as any other Illness, provided the child is enrolled for coverage under this Plan within the time periods by the Plan. This benefit is to cover Hospital or Child Birthing Center charges incurred at the time of birth and circumcision. Routine charges for a well-baby after the earlier of a) the mother's release from the Hospital or Child Birthing Center; or b) 5 days are not covered.

**Fertility Studies**

Expenses in connection with fertility studies or sterility studies necessary to diagnose the condition.

**Surgical Sterilizations**

Regardless of Medical Necessity, surgical sterilization procedures for either a covered Employee or an Employee's covered Spouse are provided under the Plan. Reversal of sterilization is not a Covered Service.

**MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES**

The Plan will allow a maximum of 150% markup on invoice and may require a copy of the Provider’s invoice prior to payment.

**Medical and Surgical Supplies**

Syringes, needles, oxygen, casts, surgical dressings, sutures, trusses, braces (other than dental braces), crutches, splints and other similar items which serve only a medical purpose. These supplies prescribed by your Physician: catheters, colostomy bags, rings and belts, flotation pads, needles and syringes, and initial contact lenses or eyeglasses after cataract surgery will also be eligible for coverage. Medicines or insulin (including glucometers) are covered when not eligible under the Prescription Drug benefit.

Covered services do not include items usually stocked in the home for general use like adhesive bandages, thermometers, and petroleum jelly.

**Durable Medical Equipment**

Rental of, or at the Plan's option, purchase of (whichever is less) Durable Medical Equipment such as, but not limited to: wheel chairs; Hospital-type beds; and artificial respiration equipment. When the equipment is purchased, benefits are payable for subsequent repairs necessary to restore the equipment to a serviceable condition. Routine periodic maintenance and replacement of batteries are not covered. The equipment must be prescribed by the Physician. Benefits are payable only if the Plan approves the equipment as being appropriate for a Covered Person's medical condition.

**Note:** The Plan will allow for only the standard equipment necessary, additional options and upgrades are not eligible.

**Orthotic Devices**

The initial purchase, fitting, repair and replacement of orthotic appliances such as braces, splints, or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition, an injury or illness. Replacements will only be covered if Medically Necessary and not as the result of loss, theft, or damage. Dental braces and corrective shoes are not covered.

A rigid or semi-rigid supportive device which limits or stops motion of a weak or diseased body part, such as: casts, splints; strapping; orthopedic braces; and crutches.

Orthotic must be custom molded and prescribed by a Physician and not used only to improve comfort or appearance.

These do not include special shoes unless the device is a permanent part of an orthopedic brace.

**Prosthetic Appliances**

Purchase, fitting, needed adjustment and necessary repairs of prosthetic devices and supplies that:

- replace all or part of a missing body organ and its adjoining tissues; or
- replace all or part of the function of a permanently useless or malfunctioning body organ.
- breast prosthesis to include special bras (limited to 2 bras per Calendar Year).

This benefit will also include replacements for children who, due to growth, must obtain a new prosthetic appliance.

Replacements will only be covered if Medically Necessary and not as the result of loss, theft, or damage. Dental braces and corrective shoes are not covered.

**MENTAL HEALTH BENEFITS**

Benefits are provided as listed in the Schedule of Benefits for inpatient and partial Hospitalization, and Day Treatment Psychiatric Care only at a licensed facility. Inpatient services must be pre-certified before admission.

Benefits include inpatient services provided in a Residential Treatment Facility, as well as a Hospital. Services received in a Hospital or Residential Treatment Facility must be pre-certified prior to admission.

Benefits are provided for outpatient psychiatric care by a Licensed Psychologist, Psychiatrist, or Licensed Social Worker, including services provided in a Day Treatment Program as listed in the Schedule of Benefits

Full parity is applied to all existing Mental Illness benefits to allow for all Mental Illness diagnoses and services to be covered as equal to those benefits for medical and surgical services.

If this Plan offers prescription drug services, the coverage shall include prescription drug services for the treatment of Mental Illness on the same terms and conditions as other physical diseases and disorders.

**OUTPATIENT MEDICAL CARE**

Office visits and consultations to examine, diagnose, and treat an eligible Condition.

**PRESCRIPTION DRUG**

Charges for drugs requiring the written prescription of a licensed Physician which are not eligible expenses under the Prescription Drug Benefit and which must be filled by a licensed pharmacist are covered at the Network level of benefits.

**PRIVATE DUTY NURSING SERVICES**

Services of a practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.) for private duty nursing services are covered only when ordered by a Physician. Nursing services do not include care that is primarily non-medical or custodial in nature such as bathing, exercising and feeding.

Benefits are not provided for a nurse who usually lives in your home nor is a member of your immediate family.

**Inpatient Services**

Services that are of such nature or degree of complexity that the Provider's regular nursing staff cannot provide them or due to the Hospital’s Intensive Care Unit being full. Prior approval is required.

## SKILLED NURSING FACILITY/REHABILITATION FACILITY BENEFITS

Benefits are available for Covered Services in a Skilled Nursing Facility / Rehabilitation Facility as listed in the Schedule of Benefits. No coverage is provided for services for Custodial Care; or, care for senile deterioration, mental deficiency, or mental retardation (except in accordance with Federal Mental Health Parity requirements).

Confinement in the facility:

- must begin within 14 days after the Covered Person has been Confined in a Hospital for at least 3 consecutive days which room and board charges were paid; and
- is for treatment of the Illness causing the Hospital Confinement; and
- is one for which a Physician visits the Covered Person at least once every 30 days; and
- is not for routine Custodial Care.

If the Covered Person leaves a Skilled Nursing Facility and is readmitted within 14 days, that person does not have to have a new 3-day stay in the Hospital to be covered.

A Convalescent Period will end when the Covered Person has been free of confinement, in any and all institutions providing Hospital or nursing care, for a period of fourteen (14) consecutive days. A new convalescent period shall not begin until a previous convalescent period has ended.

"Convalescent Period" is a period of time beginning with the date of confinement by a Covered Person to a Skilled Nursing Facility. A "Confinement Period" begins within fourteen (14) days after a three (3) day Hospital stay. Both the Hospital and convalescent confinement must have been for the care and treatment of the same Illness or Injury.

## SURGICAL SERVICES

The Plan covers you for surgical services performed by a Physician both in and out of a Hospital. As well as covering most operative and cutting procedures, surgery includes treatment of burns, fractures, and dislocations. It includes surgical pathology examinations, cast, and suture removal.

Regardless of Medical Necessity, the Plan covers surgery to restore bodily function or correct deformity. Benefits are only for problems caused by disease, Injury, birth or growth defects, or previous treatments.

### Surgical Assistance

An assistant Physician to assist your surgeon while performing covered surgery when a house staff member, intern, or resident cannot be present. Allowable charges cannot exceed 20% of the surgeon’s Allowed Amount.

### Multiple Surgical Procedures

If two or more surgical procedures are performed through the same body opening during the course of the same operative period, the total benefit shall be computed as follows: 100% for the procedure with the greatest benefit, plus 50% for each additional procedure. In no event shall any additional allowance be made for any incidental procedures performed during the operative session.

If two or more surgical procedures are performed through more than one body opening during the course of the same operative period, the total benefit shall be computed as follows: 100%

for the procedure with the greatest benefit, plus 75% for each additional procedure. In no event shall any additional allowance be made for any incidental procedures performed during the operative session.

**Note:** Where a PPO discount applies, the percentages will be based on the discounted charges.

**Second Surgical Opinion**

A voluntary second surgical opinion is recommended for some elective (non-emergency) procedures. The intent of this is to provide patients with additional information before a decision is made in an attempt to promote the delivery of high quality health care and eliminate unnecessary surgery.

The second surgical opinion must be provided by a surgeon other than the first surgeon who recommended the surgery.

**NOTE:** A third opinion will be covered if the first two conflict.

**THERAPY SERVICES**

Eligible Hospital and Physician therapy services or supplies used to promote recovery from an Illness or Injury include:

**Cardiac Rehabilitation**

Phase I and II will be covered benefits; **Phase III is not covered.**

> **Phase I** begins approximately 2-4 days following a heart attack, or 24 hours post-Surgery. Patients are assisted through range of motion exercises, which gradually progress to walking or stair climbing by the time of discharge.
>
> **Phase II** is an outpatient, Hospital-based program, usually of 2-3 months duration. Patients engage in a monitored program of exercise therapy, health education and individualized or group support sessions.
>
> **Phase III** is an outpatient exercise program held at various community fitness facilities. Patients engage in conditioning activities supervised by a Registered Nurse and an exercise physiologist.

**Chemotherapy**

The treatment of malignant disease by chemical or biological antineoplastic agents.

**Dialysis Treatments**

The treatment of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. Charges for treatment of kidney disorders by hemodialysis or peritoneal dialysis are covered.

**Hyperbaric and Pulmonary Therapy**

Introduction of high-density solutions into the lungs for treatment purposes. Treatment must be provided by a Hospital.

**Occupational Therapy**

The treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role by a licensed occupational therapist.

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time. No benefits are provided for diversional, recreational, and vocational therapies (such as hobbies, arts and crafts). Therapy must be ordered by a Physician, result from an Injury or Illness, be provided on a regular basis and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

**Massotherapist**

Charges made by a licensed massotherapist, only if prescribed by a medical doctor, payable as shown in the Schedule of Benefits.

**Radiation Therapy**

The treatment of disease by X-ray, radium, or radioactive isotopes.

**Respiratory Therapy**

Treatment by the introduction of dry or moist gases into the lungs, and other respiratory therapy related services. Expenses for respiratory therapy by a licensed therapist for which measurable improvement is expected within a reasonable period of time.

**Speech Therapy**

Fees of a legally qualified Physician or qualified speech therapist for restorative or rehabilitative speech therapy for speech loss or impairment due to a covered Illness or Injury other than a functional nervous disorder, or due to Surgery performed on account of a covered Illness or Injury. If the speech loss is due to congenital anomaly, surgery to correct the anomaly must be performed prior to the therapy.

**Spinal Treatment/Chiropractic (non-surgical)**

Charges for services, including related x-rays, to detect and/or correct (by manual or mechanical manipulation) structural imbalance, distortion or subluxation in the human body for the removal of nerve interference, when the nerve interference is the result of or related to such problems in the vertebral column, musculoskeletal, or allied modalities. Charges made by a chiropractor for benefits that exceed the maximum specified in the Schedule of Benefits and/or is determined to be for maintenance, palliation, or excessive care may not be considered a covered expense.

**Therapy by Physical Means**

Treatment given to relieve pain, restore maximum function and prevent disability following disease, Injury or loss of body part. Services include hydrotherapy; heat or similar modalities; physical agents; hyperbaric therapy; biomechanical, neurophysiological principles and devices.

Treatment must be Medically Necessary and non-maintenance to be eligible as a Therapy Benefit.

**URGENT CARE/WALK-IN CARE**

Urgent Care/Walk-in Care will be covered as described in the Schedule of Benefits.

**WELLNESS BENEFITS**

Expenses for Physician office calls, x-rays, lab work and related tests, immunizations, routine cancer screenings, routine mammograms, routine prostate exam and routine gynecological exam/pap smear, in connection with routine physicals as shown in the Schedule of Benefits.

Expenses for Physician office charges, x-rays, lab work and related tests, and immunizations, in connection with routine "well child care" physicals as shown in the Schedule of Benefits.

**Routine Physicals**

Routine office exams including related tests and x-rays, immunizations, routine gynecological exam/pap smear, routine mammogram, routine prostate exam, routine eye exam and routine hearing exam are covered under the Plan as shown in the Schedule of Benefits.

Charges will only be paid as a routine or preventive expense when there is no diagnosis of Illness or Injury connected to the service provided.

**Preventive Health Benefits**

Your Plan includes coverage for preventive services. Depending upon your age, services may include:

- Behavioral counseling to promote a healthy diet;
- Various immunizations;
- Mammograms;
- Pap smears;
- Screenings such as diabetes, bone density, chlamydia, cholesterol, colorectal cancer and hepatitis B;
- Well baby and well child visits through age 21
- Periodic physical exams

Eligible services have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations. You will be notified, at least sixty (60) days in advance, if any item or service is removed from the list of eligible services. Eligible services will be updated annually to include any new recommendations or guidelines.

**Women's Preventive Services**

These services will be provided in accordance with the age and frequency 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.

**Additional Preventive Services**

If not shown above as a Covered Service, the following services will also be covered without regard to any Deductible, Copayment 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 phone number on the back of 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/center/regulations/prevention.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.

**Direct Access to Obstetricians and Gynecologists**

You do not need prior authorization from us or any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment Plan, or procedures for making referrals.

**Selection of a Primary Care Provider**

You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

**WIG**

Expenses for a wig or artificial hairpiece but only if necessitated by Medically Necessary treatment.

## GENERAL LIMITATIONS AND EXCLUSIONS

The following are not covered by the Benefit Plan:

1. **Abdominal surgery.** Regardless of Medical Necessity, services and/or supplies for abdominal surgery and/or reconstructive surgery which is related but not limited to gastric related bypass surgery, or stomach stapling type surgery will not be eligible. This includes surgical intervention for infections, chaffing, pain, diabetes, etc.;

2. **Abortions.** Charges for elective abortions;

3. **Absence of coverage**. Charges which would not have been made had coverage not existed;

4. **Absent.** Services and/or supplies furnished during periods when the patient is temporarily absent from the Hospital;

5. **Acupuncture / Acupressure;** "Oriental Pain Control" or acupuncture unless performed by a Physician or under the supervision of a Physician;

6. **Anesthesia.** Expenses for anesthesia services when provided for surgical services not covered by the Plan; and the administration of local anesthesia for dental services;

7. **Blood.** Whole blood or plasma when donated or otherwise replaced by or on behalf of the patient;

8. **Chelation therapy.** The use of chemical solutions in an attempt to prevent or reverse cardiovascular problems. By binding tightly to calcium and other minerals, chelating agents are thought to remove such substances from atherosclerotic plaques.

9. **Civil insurrection or riot.** Treatment or services resulting from participating in a civil insurrection or riot;

10. **Close Relative.** Service provided by a “close relative,” meaning Spouse, or Covered Person’s or Spouse’s parent, brother, sister or child, or the Spouse of the Covered Person’s parent, brother, sister or child;

11. **Completion** of claim forms**,** or missed appointments;

12. **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan;

13. **Contraceptive devices or medication.** For all male contraceptives and female over-the-counter birth control without a prescription.

14. **Cosmetic services.** Services rendered for cosmetic purposes, unless made necessary by accidental Injury except when due to a) a congenital anomaly of a covered newborn or for a covered child if the procedure was delayed due to medical necessity; or b) the surgical removal of all or part of the breast tissue solely because of an Illness or Injury to the breast to include surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complication at all stages of the mastectomy, including lymph edemas; or c) for reconstructive surgery as necessary for

the prompt treatment of a diseased condition; This includes, but is not limited to stomach stapling, breast augmentation and face lifting;

15. **Court ordered.** Charges for health care ordered by the court;

16. **Custodial Care.** Services or supplies provided mainly as a rest cure, domiciliary or convalescent care, or Custodial Care or charges made by a Hospital for a confinement primarily for physiotherapy or hydrotherapy;

17. **Dental procedures.** Dental services or dental supplies of any kind except those specifically shown as an eligible medical expense under this Plan, including charges for Temporomandibular Joint Syndrome (TMJ);

18. **Diagnostic Hospital Admission.** Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting;

19. **Educational or vocational testing.** Services for educational or vocational testing or training, except for diabetic management training or as required by PPACA;

20. **Excess charges.** Charges that exceed the Allowed Amount, if applicable;

21. **Exercise programs**. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy, as specified by this Plan. This exclusion includes exercise equipment;

22. **Experimental or Investigative services**, procedures, treatment, prescription drugs and supplies, or substances, which have not been recognized as accepted standards of medical protocol;

23. **Eye care.** Radial keratotomy or other eye surgery to correct sight, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to a) aphakic patients and soft lenses or sclera shells intended for use as corneal bandages, and initial cataract lenses after cataract surgery; b) an accidental Injury or c) the first pair of lenses prescribed as a therapeutic treatment of keratoconus;

24. **Felony.** Services and/or supplies for treatment of an accident or Illness that resulted while committing a felony, unless due to a medical condition (physical or mental), this does not include services and/or supplies incurred by a victim of domestic violence;

25. **Foot care.** Expenses or treatment for foot care for flat foot conditions, the treatment of subluxation of the foot, care or removal of corns, care of bunions (except capsular or bone surgery), care or removal of calluses, care or removal of toe nails (except surgery for ingrown nails), treatment for fallen arches, weak feet and chronic foot strain. Charges for the cutting or removal of corns, calluses or toenails will be covered when an underlying medical condition such as diabetes or hardening of the arteries has been diagnosed;

26. **Functional Nervous Disorder.** Any expenses for charges made by a counselor, psychologist, or psychiatrist for the treatment of functional nervous disorders (such as learning disorders, autism, mental retardation, or senility) beyond the period necessary to diagnose the Condition; except as required by PPACA;

27. **Genetic counseling or testing**. Counseling or testing concerning inherited (genetic) disorders except as stated specifically by the Plan and as required by PPACA; This exclusion includes tests to determine the sex of an unborn child;

28. **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid, to Medicare or when otherwise prohibited by law;

29. **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, except as specified by the Plan as covered;

30. **Hazardous Activities**. Treatment for injuries sustained while hang gliding, bungee jumping, parachuting or injuries sustained while racing any sort of motorized vehicle in an organized race;

31. **Hearing Care.** Expenses for hearing aids, batteries or repairs except for the initial purchase of a hearing aid if the loss of hearing is a result of a surgical procedure;

32. **Hospital Employees.** Professional services billed by a Physician or nurse who is an Employee of a Hospital or Skilled Nursing Facility and who is paid by the Hospital or facility for the service;

33. **Housekeeping, shopping, or meal preparation services** (except as provided through an approved Home Health Care Program, as described in Covered Services in this booklet);

34. **Hypnosis;**

35. **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence not caused by organic disease;

36. **Infertility.** Expenses related to the treatment of infertility, procedures to restore or enhance fertility, artificial insemination, in vitro fertilization, pregnancy of a surrogate mother or expenses in connection with fertility studies or sterility studies beyond the period necessary to diagnose the Condition;

37. **Marital counseling**. Treatment, services and supplies for marriage counseling, health education, holistic medicine or other programs with an objective to provide complete personal fulfillment; Any expenses related to counseling for "Transient Situational Adjustments" (such as marital problems, family problems, behavioral problems, or social problems) unless such counseling is necessary for the treatment of a diagnosed Mental Illness;

38. **Medicare Part B.** For which benefits would have been payable under Part B of Medicare if a Covered Person had enrolled in Part B coverage. For the purposes of the calculation of benefits, if the Covered Person is eligible for, but has not enrolled in, Medicare Part B, Mutual Health Services will calculate benefits as if he or she had enrolled. This provision only applies where Medicare is the primary payer under the law;

39. **Milieu Therapy.** Confinement in an institution primarily to change or control one's environment;

40. **No charge.** Services for which there is no charge received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group;

41. **No fault.** To the extent expenses are in any way reimbursable through "No-Fault" automobile insurance;

42. **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of the admission;

43. **Not Medically Necessary**. Any services or supplies which are not Medically Necessary, except as expressly included herein;

44. **No obligation to pay.** Charges Incurred for which the Covered Person has no legal obligation to pay;

45. **No Physician recommendation.** Any expenses Incurred for any service or treatment which is not provided or recommended by a Physician;

46. **Not specified as covered.** Services, treatment and supplies which are not specified as covered under the Plan;

47. **Notice of Claim**. Treatment, services and supplies for which proof of claim is not provided to the Plan in accordance with the When to File a Claim section;

48. **Nuclear accident**;

49. **Nursing services.** Services that are primarily non-medical or custodial in nature;

50. **Nutritional supplements.** Including those prescribed by a Physician; Except as required by PPACA;

51. **Obesity.** Care and treatment of obesity, weight loss or dietary control, whether or not it is a part of the treatment plan for another Illness. This exclusion includes any bariatric surgery and complications as a result of, which includes but is not limited to:

    - Gastric Bypass surgery (including Laparoscopic gastric bypass);
    - Gastroplasty;
    - Gastric banding

52. **Outside United States** - Elective procedures performed outside the United States, unless pre-authorization from the Plan for outside the United States coverage has been obtained prior to treatment; Services or supplies purchased outside the United States unless the covered participant is a resident of the United States and the charges are incurred while traveling on business or for pleasure;

53. **Payment prohibited by law** to the extent that payment under this Plan by any law to which you or your Dependent is subject at the time expenses are Incurred;

54. **Personal comfort items.** Personal comfort items or other equipment such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, hot tubs, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, first-aid supplies and non-Hospital adjustable beds;

55. **Prescription Drugs.** Expenses for prescription drugs or substances which are eligible expenses under the Prescription Drug Benefit.

56. **Reimbursable through any public program.** To the extent those expenses are in any way reimbursable through any public program, except as otherwise required by law;

57. **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by PPACA;

58. **Self-inflicted injuries, or threatened suicide**, whether sane or insane, unless due to a medical Condition. The Plan will not exclude coverage for self-inflicted injuries or injuries from attempted suicide if the injuries are otherwise covered by the Plan and if the injuries are the result of a medical Condition such as depression;

59. **Services before or after coverage.** Care, treatment or supplies for which a charge was Incurred before a person was covered under this Plan or after coverage ceased under this Plan;

60. **Services rendered or billed** for by a school or halfway house or by a member of its staff;

61. **Sleep disorders.** Care and treatment for sleep disorders, unless deemed Medically Necessary;

62. **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization;

63. **Telephone or internet consultations**. Expenses for mailing, telephone consultations, sales tax, preparing reports, preparing itemized bills, completing claim forms or telephone consultations;

64. **Therapy.** Any expenses for occupational, speech or orthopedic therapy or training unless related to a covered Illness or Injury;

65. **Transportation services provided by an ambulette or wheelchair van and ambulance charges made for convenience**;

66. **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as defined by the Plan;

67. **Violation of law.** An Injury or Illness resulting from the voluntary use of prescription drugs, nonprescription drugs, or alcohol which the use of same constitutes or contributes to the violation of any state or federal law. It will be determined by the Plan that violation of a state or federal law has occurred if:

a) the individual is convicted or found guilty of the applicable charges; or
b) there is sufficient evidence that a state or federal law has been violated and no charges were brought against the individual. Sufficient evidence is defined as, but not limited to: (1) blood alcohol levels which exceed established state or federal minimums, (2) the possession of illegal nonprescription drugs, or (3) prescription/legend drugs used or taken without a written prescription;

68. **Vitamins.** Expenses for vitamins or nutrition supplements; except as required by PPACA;

69. **War.** Disease or Injury caused by, resulting from, or related to, participation in a war, or act of war, whether declared or undeclared;

70. **Weight Loss Programs.** Weight loss programs whether or not they are under medical or Physician supervision. Weight loss programs for medical reasons are also excluded. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, etc.) or fasting programs.

71. **Without Cost**. Care received without cost under the laws of the United States or any other country or government entity;

72. **Work related**. Expenses Incurred as a result of accidental bodily Injury or sickness arising out of or in the course of any occupation or employment for wage or profit, or for which the Covered Person may be entitled to benefits under any Workers Compensation or occupational disease policy, whether or not any such policy is actually in force. However, this exclusion only applies to persons who can elect, or could have elected for them, coverage under a worker's compensation act, policy or similar law.

## PRESCRIPTION DRUG BENEFITS

The Prescription Drug Benefits provided by this Plan help to meet the cost of legend drugs. A legend drug is a compound or substance that requires, under federal law, a written prescription by a licensed Physician of medicine or osteopathy, dentist or podiatrist who is legally licensed to prescribe medications. It is a drug or medication that cannot be sold over the counter without a written prescription.

**CAREMARK** 1-888-202-1654

### COVERED PRESCRIPTION DRUGS

Benefits include up to a 30-day supply of most legend drugs and compound prescriptions containing at least one legend drug.

The amount of drugs, including insulin, which is to be dispensed per prescription or refill, will be in quantities prescribed up to a 30-day supply.

When a Physician writes a prescription for both disposable syringes and needles and a one-month supply of insulin, the Covered Person must present the prescription to a pharmacist. If the Physician prescribes a three-month supply of insulin, coverage is provided for up to 100 disposable syringes and needles.

Prescriptions or refills can be prescribed over the telephone. Prescriptions can be refilled for the number specified by the Physician and are good for one year from the date of the prescription order.

The Plan also provides benefits for certain preventive drugs required by PPACA when a written prescription from your Physician is received. These PPACA-required drugs are covered at a zero Copayment, but specific ages and quantity limits may apply. Please call Caremark at 1-888-202-1654 for more information.

### HOW THE PLAN WORKS

When the Physician writes a prescription for a covered drug item for you or for a Dependent, present the prescription and your identification card to a participating Pharmacy.

You will be charged the corresponding Copay for each prescription filled or refilled. The prescription card company pays any cost beyond that to the Pharmacy.

If you have a prescription filled at a Non-Participating Pharmacy or if you do not have your card with you at the time the prescription is filled, pay the pharmacist, then complete a reimbursement form and send that to the prescription card company listed on your identification card with the itemized Pharmacy receipt. Reimbursement forms are available by contacting the claims office.

If you have any questions regarding your prescription coverage, you may call Mutual Health Services at 1-800-367-3762 or Caremark at 1-888-202-1654.

**MAIL ORDER DRUG PROGRAM**

You will be able to save time and money by ordering your maintenance drugs through the Mail-Order Drug Program. Maintenance drugs can be purchased through your Mail-Order Drug Program.

To order your prescriptions, send the initial order form and attach the original prescription from your Physician. The prescription will come directly to your home.

In order to take advantage of this program, you must order at least a 30-day supply but can receive up to a 90-day supply of your maintenance drugs.

**EXCLUSIONS AND LIMITATIONS**

This prescription drug program does not provide benefits for the following:

1. Drugs that are not approved by the U.S. Food and Drug Administration (FDA);

2. Drugs obtained without a Physician's prescription;

3. Drugs for which the provider's Allowed Amount is less than the Copay amount of the Plan;

4. Covered drugs for which benefits are paid elsewhere under the Plan; including but not limited to drugs used in connection with covered transplants under the transplant section;

5. Drugs not requiring a prescription under federal law;

6. For male contraceptives and over-the-counter birth control without a prescription;

7. Fertility drugs/agents;

8. Charges for growth hormones, unless prior approval is obtained by the Plan;

9. Charges for Retin-A or similar products for those over age 21;

10. Drugs which sole purpose are to promote or stimulate hair growth;

11. Any charge for therapeutic devices or appliances, regardless of their intended use (except for disposable insulin syringes); support garments; medical supplies and equipment; other non-medical items regardless of their intended use;

12. Any charge for administration of drugs or insulin;

13. The charge for more than a 30-day supply of retail/ 90-day supply of mail order legend drugs;

14. The charge for any prescription order refill in excess of the number specified by a doctor or any refill dispensed after one year from the date of the original prescription order;

15. Allergy serums, biological sera, blood or plasma, laterite;

16. Dietary/nutritional supplements and injectable vitamins except prenatal vitamins used while receiving maternity benefits and those required by PPACA;

17. Cosmetic products, health and beauty aids;

18. Drugs labeled “Caution: limited by Federal law to investigational use” or experimental drugs, even though a charge is made;

19. Drugs taken or given while at a Hospital, convalescent care facility, or similar institution;

20. Fluoride preparations; except as required by PPACA;

21. Weight control/Anti-Obesity Drugs;

22. Vaccines and toxoids except as required by PPACA;

23. Impotency agents/Drugs (Viagra, MUSE, etc.) and injectable drugs; except as determined to treat a medical Illness. Prior approval must be obtained by the Plan;

24. The charge for any medication for which you or your eligible Dependent is entitled to receive reimbursement under any Worker's Compensation law, or for which entitlement to benefits is available without charge from any municipal, state or federal program of any sort, whether contributory or not;

25. Drugs which do not have the required governmental approval when you receive them or are considered Experimental, investigative, or of a research nature; and

26. Drugs and medicines not covered under the Plan. Please see the General Limitations and Exclusions section.

**PLEASE NOTE:** If your Medical coverage terminates or if your eligible Dependent’s Medical coverage terminates, coverage under this program also terminates. If you continue to use your prescription drug card, you will be held responsible for payment of any charges Incurred on or after such termination date.

## DENTAL BENEFITS

### DEDUCTIBLE

The Calendar Year Deductible, as shown in the Schedule of Benefits, is the amount of Eligible Basic and/or Major Expenses which must be incurred by each Covered Person (if applicable) before any benefits are payable, unless stated otherwise in the Schedule of Dental Benefits.

If more than one Covered Person in a family incurs expenses during a Calendar Year and the accumulated expenses payable by those individuals exceed the Family Deductible shown in the Schedule of Benefits, the Deductible will be considered to be satisfied for all other Family members for the remainder of that Calendar Year.

The Calendar Year Deductible does not apply to eligible Preventive Care Services or Orthodontia Services. However, Orthodontia has a separate Lifetime Deductible as shown in the Schedule of Dental Benefit for each person.

The Plan Administrator reserves the right to allocate the Deductible amount to any eligible charges and to apportion the benefits to the Covered Person and any assignee. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

### DENTAL DEDUCTIBLE CARRYOVER

Eligible dental expenses applied during the months of October, November and December will be used to reduce the amount of the Deductible for the following Calendar Year.

### COINSURANCE

Unless otherwise shown, the Plan will pay the applicable percentage rate as shown in the Schedule of Benefits for Eligible Expenses which exceed the Calendar Year Deductible, if applicable, up to the maximums shown in the Schedule of Benefits.

### CALENDAR YEAR MAXIMUM

The maximum payable for all Eligible Expenses for each Covered Person shall not exceed in the aggregate the Calendar Year Maximum amount shown in the Schedule of Benefits.

### ALTERNATE SERVICES

If two or more services are considered to be acceptable to correct the same dental condition, the Plan will determine service on which payment will be based and the expenses that will be included as Covered Expenses. Benefits payable may be based on the covered expenses for the least expensive service which will produce a professional satisfactory result as determined by the Plan Administrator using guidelines established by the American Dental Association.

### PREDETERMINATION OF BENEFITS

Whenever recommended dental treatment is expected to exceed $200, the Covered Person is encouraged to submit a dental treatment plan to the Third Party Administrator and/or Plan Administrator for review prior to treatment. The dental treatment plan should consist of:

1. A list of the services to be performed, using the American Dental Association nomenclature and codes;
2. A written description of the proposed treatment from the treating Dentist;
3. Supporting pre-treatment x-rays showing the Covered Person's dental needs;
4. Itemized cost of the proposed treatment; and
5. Any other appropriate diagnostic materials requested by the Third Party Administrator.

A predetermination of benefits is not a guarantee of benefits payable. You will be advised if any services are limited or not covered. If you elect a more costly treatment than is determined by the Plan Administrator to be satisfactory for treatment of the condition, payment will be limited to the lesser of the Dental Allowed Amount of the least costly treatment (subject to any applicable Deductible, Coinsurance and/or Calendar Year Maximum).

When there has not been a predetermination of benefits, the Plan will determine the expenses that will be included as covered expenses at the time the claim is received.

**INCURRED DATE OF DENTAL SERVICES**

A Dental Services is considered incurred on the date the service, supply, or treatment is started except that service for a prosthetic device will be deemed to start when the prosthetic device is ordered. The term “ordered” means:

1. For fixed bridgework, restorative crowns, inlays or onlays; the date that the first impressions are taken and/or abutment teeth fully prepared;
2. For dentures, the date that the first impressions are taken.

Payment will be made when services are complete.

**ELIGIBLE DENTAL EXPENSES**

Eligible expenses will include only those expense incurred for such charges when the dental service is performed by or under the direction of a Dentist; is essential for the necessary care of the teeth; and starts and is completed while the person is covered under this Plan.

Any portion of charges for a dental service that exceeds the maximum shown in the Schedule of Dental Benefits is not included.

**ELIGIBLE PREVENTIVE CARE EXPENSES:**

Eligible Preventive Care expenses include the following services:

1. Routine oral examinations limited to one (1) per person in any six (6) consecutive months.

2. Routine prophylaxis (cleaning), scaling, polishing, and examination, limited to one in any six (6) consecutive months.

3. Topical application of fluoride, limited to one in any six (6) consecutive month period, for Covered Persons under age eighteen (18). Prophylaxis in connection with fluoride treatment is a separate dental service. Allowance includes examination and prophylaxis.

4. X-Rays:

a. Full mouth series of at least 14 films, including bitewings if needed limited to once in any thirty-six (36) consecutive months;
b. Bitewing x-rays, limited to four (4) films in any six (6) consecutive months;
c. Intraoral periapical or occlusal x-rays-single films;
d. Extraoral x-rays, superior or inferior maxillary film;
e. Panoramic film, maxilla and mandible, limited to one examination in any six (6) consecutive months.

5. Problem focused exam. Emergency care and palliative treatment for relief of dental pain. Expense incurred is payable as a separate benefit only if no other service was rendered during the same visit. (Any x-ray taken in connection with such treatment is a separate dental service).

6. Space Maintainers for children under age 16, for the initial appliance only. Allowance includes all adjustments to the space maintainers within the first six months after installation.

7. Fixed and removable appliances to inhibit thumbsucking and other harmful habits, limited to Dependent children under the age of sixteen (16) and limited to the initial appliance only. Allowance includes all adjustments in the first six (6) months after installation.

**ELIGIBLE BASIC SERVICES**

Eligible Basic Expenses include the following services:

1. Diagnostic consultation with a dentist other than the one providing treatment, limited to one consultation for each dental specialty in any twelve (12) consecutive months. Benefits are payable for this service only if no other service is rendered during the visit.

2. Diagnostic casts.

3. Biopsy and examination of oral tissue.

4. Restorative dentistry; multiple restorations on one surface will be considered one restoration:
   a. Fillings of amalgam;
   b. Synthetic restorations; fillings of silicate, acrylic, plastic, or composite resin;
   c. Crowns; acrylic or plastic without metal; or stainless steel;
   d. Pin retention, exclusion of restorative material;
   e. Recementation; inlay or onlay, crown and bridge.

5. Endodontic services (treatment of disease within a tooth, including root canal). Allowance include routine x-rays and cultures, but excludes final restoration:
   a. Pulp capping, direct;
   b. Root canal therapy of non-vital (nerve-dead) teeth. Traditional therapy, Medicated past therapy, N2 Sargenti;
   c. Vital pulpotomy;
   d. Apicoectomy (removal of part of the tooth root), as a separate procedure or in conjunction with other endodontic procedures;
   e. Apexification;
   f. Remineralization (Calcium Hydroxide), as a separate procedure.

6. Periodontic services (treatment of diseases of the gums and tissues of the mouth). Allowance includes the treatment plan, local anesthetics and post-surgical care:
   a. Gingivectomy or gingivoplasty, per quadrant;
   b. Gingivectomy per tooth (fewer than six (6) teeth);
   c. Sub-gingival curettage and root planing, per quadrant, limited to a maximum of four quadrants in any twelve (12) consecutive months;
   d. Pedicle or free soft tissue grafts including donor sites;
   e. Osseous surgery including flap entry and closure, per quadrant;
   f. Osseous grafts including flap entry, closure and donor sites;
   g. Muco-gingival surgery;
   h. Occlusal adjustment not involving restorations and done in conjunction with periodontic surgery, per quadrant, limited to a maximum of four (4) quadrants in any twelve (12) consecutive months.

7. Oral Surgery – allowance includes routine x-rays, the treatment plan, local anesthetics and post-surgical care:
   a. Simple extraction, one or more teeth;
   b. Surgical removal of erupted teeth, involving tissue flap and bone removal;
   c. Surgical removal of impacted teeth;
   d. Alveolectomy, per quadrant;
   e. Stomatoplasty with ridge extension, per arch;
   f. Excision of pericoronal gingiva, per tooth;
   g. Removal of cyst or tumor;
   h. Incision and drainage of an abscess;
   i. Closure of salivary fistula;
   j. Dilation of salivary duct;
   k. Sequestrectomy for osteomyelitis or bone abcess, superficial;
   l. Maxillary sinusotomy for removal of tooth fragment or foreign body;

8. Prosthodontic Services – specialized techniques and characterization are not covered:
   a. Denture repairs, acrylic – repairing dentures, no teeth damaged; repairing dentures and replacing one or more broken teeth; and/or replacing one or more broken teeth, no other damage;
   b. Denture repairs, metal – allowance based on the extent and nature of damage and on the type of materials involved;
   c. Denture duplication, jump case limited to once per denture in any thirty-six (36) consecutive months;
   d. Denture reline, limited to once per denture in any twelve (12) consecutive months. Office reline, cold cure, laboratory reline;
   e. Denture adjustments, limited to adjustments by a dentist other than the one providing the denture and adjustments more than six (6) months after initial installation;
   f. Tissue conditioning, limited to a maximum of two (2) treatments per arch in any twelve (12) consecutive months;
   g. Adding teeth to partial dentures to replace external natural teeth;
   h. Repairs to crowns and bridges. Allowance based on the extent and nature of damage and the type of material involved.

9. General anesthesia in conjunction with surgical procedures only;

10. Injectable antibiotics needed solely for treatment of a dental condition.

**ELIGIBLE MAJOR SERVICES**

All services will be paid on the date of completion. Eligible Major Expenses include the following services:

1. Restorative services (crowns, inlays and onlays). Cast restorations and crowns are covered only when needed because of decay or injury, and only when the tooth cannot be restored with a routine filling material:
   a. Inlays;
   b. Onlays, in addition to inlay allowance;
   c. Crowns and abutments;
      - Acrylic with metal;
      - Precious (full or ¾-cast), semi-precious, or non-precious (full cast) metal, other than stainless steel;
      - Porcelain or porcelain fused to metal;
      - Cast post and core, in addition to crown (not a thimble coping);
      - Steel post and composite or amalgam core, in addition to crown;
      - Cast dowel pin (one piece cast with crown). Allowance based on type of crown.

2. Prosthodontic Services – specialized techniques and characterizations are not covered.
   a. Fixed bridges – each abutment and each pontic makes up a unit in a bridge;
   b. Bridge abutments – see inlays and crowns under Major Services;
   c. Bridge pontics;
   d. Cast metal, sanitary;
   e. Plastic or porcelain with metal;
   f. Slotted facing;
   g. Slotted pontic;
   h. Simple stress breakers, per unit;
   i. Removable bridges, unilateral partial, one piece chrome casting, clasp attachment, including pontics.

3. Dentures – includes all adjustments done by the dentist furnishing the denture in the first six months after installation.
   a. Full dentures, complete or immediate, upper or lower;
   b. Partial dentures, including base, all clasps, rests and teeth;
      - Upper, with two chrome clasps with rests, acrylic base;
      - Upper, with chrome palatal bar and clasps, acrylic base;
      - Lower, with two chrome clasps with rests, acrylic base;
      - Lower, with chrome lingual bar and clasps, acrylic base;
      - Stay plate, upper or lower (anterior teeth only).

**ORTHODONTIA EXPENSES**

Benefits for orthodontic services are paid up to the maximum shown in the Schedule of Dental Benefits, for dependent children who are less than nineteen (19) years old when the active appliance is first placed.

The Lifetime Deductible, as shown in the Schedule of Dental Benefits, is the amount of eligible Orthodontia Expenses which must be incurred by each Covered Person (if applicable) before any benefits are payable. These charges must be incurred while the eligible dependent is covered under this Plan. Charges used to meet this Deductible cannot be used to meet the Deductible which applies to other services.

Once the Lifetime Deductible is met, eligible services will be payable. Using the treatment plan, the total benefit payable will be calculated, then divided into equal payments which will distributed over the lesser of two years or the proposed length of treatment.

The initial payment will be made when the active appliance is first placed. Further payments will be made at the end of each subsequent three (3) month period. However, treatment must continue and the patient must remain a covered person under this Plan.

The following are covered expenses for Orthodontic services:

- Any Class I, II or III service furnished in connection with orthodontic treatment;
- Surgical exposure of impacted or un-erupted teeth in connection with orthodontic treatment, including routine x-rays, local anesthestics and post-surgical care;
- Active appliances (all types), including diagnostic services, the treatment plan, the fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.

Although diagnostic procedures are included as part of orthodontic coverage, the course of orthodontic treatment begins when the first orthodontic band or appliance is inserted and ends when the last band or appliance is taken off.

**DENTAL EXCLUSIONS AND LIMITATIONS**

No benefits are payable for the following under the Dental Plan.

1. Any service that is considered cosmetic dentistry, including, but not limited to, characterizing and personalizing prothetic devices and making facing on prosthetic devices for any teeth in back of the second bicuspid;

2. Porcelain or acrylic veneers of crowns or pontics on or replacing teeth other than the ten upper and lower anterior teeth;

3. Preventive control programs including, but not limited to: oral hygiene instructions, plaque control, fissure sealants, or dietary planning;

4. Fees for services rendered by someone other than a licensed Dentist or auxiliary personnel under the Dentist's direct supervision, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed Dental Hygienist. The treatment must be rendered under the direct supervision and guidance of the Dentist in accordance with generally accepted dental standards;

5. Any services or supplies provided for Inpatient or Outpatient Hospital care; for a surgical treatment facility;

6. Any services or supplies that are in any way paid or entitled to payment by or through a public program, other than Medicaid;

7. Any service which is deemed Experimental in nature, based on standards of the American Dental Association;

8. Treatment which does not meet accepted standards of dental practice, based on standards of the American Dental Association;

9. Replacement of a bridge or denture or addition of teeth to a partial bridge or denture, unless a) such replacement or addition is required to replace one or more teeth extracted after installation; b) the bridge or denture cannot be made usable and it was installed at least five (5) years prior to its replacement; c) the denture is an immediate temporary denture which cannot be made permanent and which is replaced within twelve (12) months after it was installed. If an existing denture can be made usable, but the choice is made to replace the denture, only the amount which would have been required to make the denture usable will be paid.

10. Replacement of a bridge or denture that can be made useable according to dental standards;

11. Replacement of any lost, stolen, damaged, misplaced or duplicate major restoration, prosthesis or appliance, including replacement or repair of an orthodontic appliance;

12. Treatment an individual receives before coverage starts or after it ends, unless otherwise stated herein;

13. Services to replace a tooth that was missing prior to the effective date of coverage, including congenitally missing teeth, unless a prosthetic device also replaces one or more natural teeth lost or extracted after coverage under the Plan became effective;

14. Services or supplies for which there is no legal obligation to pay, or charges which would not be made but for the availability of benefits under this Plan;

15. Any charge for any condition, disability or expense resulting from or sustained as a result of war or act of war, declared or undeclared;

16. Dental service or supplies received through a dental or medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar person or group;

17. Eligible dental benefits or services or prepaid treatment program sponsored or covered by this Employer’s Medical Plan;

18. Expenses incurred in connection with any intentionally self-inflicted Injury or Illness;

19. Any expense which exceeds the Dental Allowed Amount for the care rendered;

20. Any expenses for preparing dental reports or itemized bills;

21. Any expense for professional services performed by a person who ordinarily resides in the Covered Person's household or who is related to the Covered Person, such as a spouse, parent, child, brother, or sister, whether such relationship is by blood or exists in law;

22. Any expenses which would entitle the Covered Person to any benefit under Worker's Compensation Act or similar legislation or which is due to Injury or Illness arising out of or in the course of any occupation or employment for wage or profit;

23. Any expense for care or treatment provided or furnished by the United States Government or in any other Hospital operated by a government of any country if in-service related;

24. Expenses for surgical implants of any type including prosthetic device attached to it;

25. Expenses for procedures or appliances (except full dentures), whose main purpose is to change the vertical dimension, stabilize periodontal involved teeth or restore occlusion, (i.e. occlusal guards, athletic guards, splinting occlusal adjustments), except to the extent that this Plan covers orthodontic treatment, splint or stabile teeth for periodontic reasons, replace tooth structure lost as a result of abrasion or attrition and to treat disturbances of the Temporomandibular Joint;

26. Expenses for topical sealants or precision attachments;

27. No payment will be made for expenses incurred for a Covered Person to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a) “no-fault” insurance law; or b) an uninsured motorist insurance law. The Plan will take into account any adjustment option chosen under such part by the Covered Person or their covered dependent.

## GENERAL INFORMATION

## CLAIMS PROCEDURES

### Types of Claims

How you file a claim for benefits depends on the type of claim it is. There are several categories of claims for benefits:

**Pre-Service Care Claim** - A Pre-Service Care Claim is a claim for a benefit under the Plan which the terms of the Plan require approval of the benefit in advance of obtaining medical care. There are two special kinds of pre-service claims:

> **Claim Involving Urgent Care** – A Claim Involving Urgent Care is any Pre-Service Care 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 your life or health or your ability to regain maximum function or (b) 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. This type of claim generally includes those situations commonly treated as emergencies. Determination of ***urgent*** will be made by an individual acting on behalf of the plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine; however, any Physician with knowledge of your medical condition can determine that a claim involves urgent care.
>
> **Concurrent Care Claim** - A Concurrent Care Claim is a claim for an extension of the duration or number of treatments provided through a previously approved pre-service claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought. Additionally, if the Plan or its designee reduces or terminates a course of treatment before the end of the course previously approved (unless the reduction or termination of benefits is due to a health plan amendment or health plan termination), then the reduction or termination is considered an adverse benefit determination. The Plan or its designee will notify you, in advance, of the reduction or termination so that you may appeal and obtain an answer on the appeal before the benefit is reduced or terminated.

**Post-Service Care Claim** - A Post-Service Care Claim is a claim for payment or reimbursement after services have been rendered. It is any claim that is not a Pre-Service Care Claim.

### Who Must File

You may initiate pre-service claims yourself if you are able or your treating Physician may file the claim for you. You are responsible for filing post-service claims yourself, although the Plan or its designee may accept billings directly from providers on your behalf, if they contain all of the information necessary to process the claim.

**Appointing an Authorized Representative.** If you or your Dependent wish to have someone act on your behalf for purposes of filing claims, making inquiries and filing appeals, you must furnish the Plan or its designee with a signed and dated written statement designating your authorized representative. You can appoint any individual as your authorized representative. A Health Care Provider with knowledge of your medical condition can act as your authorized representative for purposes of a Claim Involving Urgent Care as defined above without a written designation as authorized representative. Once you appoint an authorized representative in

writing, all subsequent communications regarding your claim will be provided to your authorized representative.

**Time Limit for Filing a Claim**

You must file claims within 12 months of receiving Covered Services. Your claim must have the data the Plan needs to determine benefits. Should you receive a request for additional information, this must be provided within the initial 12 months.

**Where to File a Claim**

Claims should be filed as indicated on your Identification Card.

**What to File**

The Plan Administrator and the Claims Administrator furnish claim forms. When filing claims, you should attach an itemized bill from the Health Care Provider. The Claims Administrator may require you to complete a claim form for a claim. Please make sure that the claim contains the following information:

- Employee's Name and Social Security Number or Alternate ID Number
- Patient's Name
- Name of Company/Employer

**Method of Claims Delivery**

Pre-Service Care Claims may be initiated by telephone. The Plan may require you to provide follow-up paperwork in support of your claim.

Other claims may be submitted by U.S. Mail, by hand delivery, by facsimile (FAX), or as a HIPAA compliant electronically filed claim.

**Timing of Claims Determinations**

**Claims Involving Urgent Care**. If you file a Claim Involving Urgent Care in accordance with the claims procedures and sufficient information is received, you will be notified of the Plan's or its designee's benefit determination, whether adverse or not, as soon as is feasible, but not later than 72 hours after receipt of the claim. If you do not follow the claims procedures or the claim does not include sufficient information for the Plan or its designee to make a benefit determination, you will be notified within 24 hours after receipt of the claim of the applicable procedural deficiencies, or the specific deficiencies related to additional information necessary to make a benefit determination. You will have at least 48 hours to correct the procedural deficiencies and/or provide the requested information. The Plan or its designee must inform 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 additional information. The Plan or its designee 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 your claim is one involving concurrent care, the Plan or its designee will notify you of its decision, whether adverse or not, within 24 hours after receiving the claim, if the claim was for urgent care and was received by the Plan or its designee at least 24 hours before the expiration of the previously approved time period for treatment or number of

treatments. You will be given time to provide any additional information required to reach a decision. If your concurrent care claim does not involve urgent care or is filed less than 24 hours before the expiration of the previously approved time period for treatment or number of treatments, the Plan or its designee will respond according to the type of claim involved (i.e., urgent, other pre-service or post-service).

**Other Pre-Service Care Claims.** If you file a Pre-Service Care Claim in accordance with the claim procedures and sufficient information is received, the Plan or its designee 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 the date it receives the claim. This 15-day period may be extended by the Plan or its designee for an additional 15 days if the extension is necessary due to matters beyond the Plan's or its designee's control. The Plan or its designee 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 all of the necessary information to process your claim, the Plan or its designee will notify you, in writing, within the initial 15 day response period and will specifically describe the missing information. You will then have at least 45 days to provide any additional information requested of you by the Plan or its designee. If you do not provide the requested information, your claim may be denied.

**Post-Service Care Claims.** If you file a Post-Service Care Claim in accordance with the claims procedures and sufficient information is received, the Plan or its designee 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 30 day time period can be extended for up to an additional 15 days, if the Plan or its designee determines that an extension is necessary due to matters beyond the Plan's or its designee's control and the Plan or its designee notifies you within the initial 30 day time period of the circumstances requiring an extension of the time period, and the date by which the Plan or its designee expects to render a decision.

If more information is necessary to decide a Post-Service Care Claim, the Plan or its designee will deny the claim and notify you of the specific information necessary to complete the claim.

**Notice of Claims Denial (Adverse Benefit Determination)**

If, for any reason, your claim is denied, in whole or in part, you will be provided with a written notice of adverse benefit determination, in a culturally and linguistically appropriate manner, containing the following information:

1. Information sufficient to identify the claim or health care service involved, including the date of service, healthcare provider, and claim amount (if applicable);
2. The specific reason(s) for the adverse benefit determination, including the denial code and its corresponding meaning;
3. Reference to the specific plan provision(s) on which the adverse benefit determination was based;
4. If the adverse benefit determination relied upon any internal rules, guidelines or protocols, a statement that you may request a copy of the rule, guideline or protocol, which will be provided free of charge;
5. If the adverse benefit determination was based in whole or in part on Medical Necessity, Experimental/Investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the

determination which applies the terms of the plan to the patient's medical circumstances, which will be provided free of charge;

6. Notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
7. Disclosure of the availability of assistance with the appeal process from the Ohio Department of Insurance if your Plan is regulated by the Ohio Department of Insurance;
8. A description of additional material or information, if any, that is required to perfect the claim and an explanation of why the information is necessary; and
9. A description of the Plan's or its designee's appeal procedures and applicable time limits, including the expedited appeal process, if applicable.

**FILING A COMPLAINT**

If you have a complaint, please call or write to the Customer Care Center at the telephone number or address listed on your Explanation of Benefits (EOB) form and/or identification card. To expedite the processing of an inquiry, the Employee should have the following information available:

- name of patient
- identification number
- claim number(s) (if applicable)
- date(s) of service

If your complaint is regarding a claim, a Customer Care Specialist will review the claim for correctness in processing. If the claim was processed according to terms of the Plan, the Customer Care Specialist will telephone the Employee with the response. If attempts to telephone the Employee are unsuccessful, a letter will be sent explaining how the claim was processed. If an adjustment to the claim is required, the Employee will receive a check, Explanation of Benefits or letter explaining the revised decision.

If you are not satisfied with the results, and your complaint is regarding an adverse benefit determination, you may continue to pursue the matter through the appeal process.

Additionally, the Customer Care Specialist will notify you of how to file an appeal.

**APPEALS PROCEDURES**

**Definitions**

For the purposes of this "APPEALS PROCEDURES" Section, the following terms are defined as follows:

**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 nonemployer group, to participate in a plan or health insurance coverage;
  - a determination that a Health Care Service is not a Covered Service;
  - 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 Service –** please refer to the definition of this term in the Definitions Section in this SPD.

**Covered Person –** please refer to the definition of this term in the Definitions Section of this SPD.

**Emergency Medical Condition –** a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the covered person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

**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 an Emergency Medical Condition;
- Such further medical examination and treatment that are required by federal law to stabilize an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

**Final Adverse Benefit Determination –** an Adverse Benefit Determination that is upheld at the completion of the Plan's 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 –** the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a Covered Person's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the Covered Person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
    - Serious impairment to bodily functions;
    - Serious dysfunction of any bodily organ or part.
- In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

**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.

**How and When to File a Claims Appeal**

If you dispute an Adverse Benefit Determination, you may file an appeal within 180 days of receipt of the notice of Adverse Benefit Determination. This appeal must be in writing (unless the claim involves urgent care, in which case the appeal may be made orally). Your request for review must contain the following information:

1. Your name and address;
2. Your reasons for making the appeal; and
3. The facts supporting your appeal.

You can submit your appeal by calling 1-800-367-3762. You may also submit your appeal in writing by sending your request to:

Member Appeals
PO Box 5700
Cleveland, Ohio 44101
1-800-367-3762

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

**First Level Mandatory Internal Appeal**

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

Under the appeal process, there will be a full and fair review of the claim in accordance with applicable law for this Plan. In connection with your right to appeal the Adverse Benefit Determination, you also:

1. May review relevant documents and submit issues and comments in writing;
2. Will be given the opportunity to submit written comments, documents, records, and testimony or any other matter relevant to your claim;
3. Will, at your request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
4. Will be given a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination;
5. Will be provided free of charge with copies of any new or additional evidence that the Plan or its designee considers, relies upon or generates before a notice of Final Adverse Benefit Determination is issued, and you will have an opportunity to respond before the Plan's or its designee's time frame for issuing a notice of Final Adverse Benefit Determination expires;
6. Will be provided free of charge with any new or additional rationale upon which a Final Adverse Benefit Determination is based before the notice of Final Adverse Benefit Determination is issued, and you will have an opportunity to respond before the Plan's or its designee's timeframe for issuing a notice of Final Adverse Benefit Determination expires; and
7. May request an external review at the same time you request an internal appeal for an urgent care claim or for a concurrent care claim that is urgent.

The claim review will be subject to the following rules:

1. The claim will be reviewed by an appropriate individual, who is neither the individual who made the initial denial nor a subordinate of that individual.
2. The review will be conducted without giving deference to the initial denial.
3. If the Adverse Benefit Determination was based in whole or in part on a medical judgment (including any determinations of Medical Necessity or Experimental/Investigative treatment), the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional shall not be an individual who was consulted on the initial claim denial nor the subordinate of such an individual. Health care professionals who conduct the appeal 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 Plan or its designee will provide the identification of the medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.
4. You will receive continued coverage pending the outcome of the appeals process. For this purpose, the Plan or its designee may not reduce or terminate benefits for an

ongoing course of treatment without providing advance notice and an opportunity for advance review. If the Plan's Adverse Benefit Determination is upheld, you may be responsible for the payment of services you receive while the appeals process was pending.

**Timetable for Deciding Appeals**

The Plan must issue a decision on your appeal according to the following timetable:

**Urgent Care Claims** – as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receiving your request for a review.

**Pre-Service Claims** – within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receiving your request for a review.

**Post-Service Claims** - not later than 30 days after receiving your request for a review.

Decisions will be issued on concurrent claim appeals within the time frame appropriate for the type of concurrent care claim (i.e., urgent, other pre-service or post-service).

**Notice of Final Adverse Benefit Determination after Appeal**

If the appeal has been either partially or completely denied, you will be provided with a written notice of Final Adverse Benefit Determination in a culturally and linguistically appropriate manner containing the following information:

1. Information sufficient to identify the claim or health care service involved, including the date of service, healthcare provider, and claim amount (if applicable);
2. The specific reason(s) for the Final Adverse Benefit Determination, including the denial code and its corresponding meaning;
3. Reference to the specific plan provision(s) on which the Final Adverse Benefit Determination is based;
4. A statement that you may request reasonable access to and copies of all documents, records and other information relevant to your appealed claim for benefits, which shall be provided to you without charge;
5. If the Final Adverse Benefit Determination relied upon any internal rules, guidelines or protocols, a statement that you may request a copy of the rule, guideline or protocol, which will be provided to you without charge;
6. If the Final Adverse Benefit Determination was based in whole or in part on Medical Necessity, Experimental/Investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided to you without charge;
7. Notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
8. Disclosure of the availability of assistance with the appeal process from the Ohio Department of Insurance if your Plan is regulated by the Ohio Department of Insurance;
9. A discussion of the decision;
10. A description of the Plan's or its designee's applicable appeal procedures.

## What Happens After the First Level Mandatory Internal Appeal

If your claim is denied at the mandatory first level 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.

## Second Level External Review Process for Non-Federal Governmental Health Plans

### A. Contact Information for Filing an External Review

Member Appeals
PO Box 5700
Cleveland, Ohio 44101
1-800-367-3762

### 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 Plan'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 Plan 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 time frame 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 Plan'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 Plan within 180 days of the date of the notice of final adverse benefit determination issued by the Plan.

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 Plan 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 Plan 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 Plan will inform the Covered Person in writing and specify what information is needed to make the request complete. If the Plan determines that the Adverse Benefit Determination is not eligible for external review, the Plan 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 Plan 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 Plan 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 Plan, the Covered Person, the health care provider or the health care facility will not be selected to conduct the review.

**F. Reconsideration by the Plan**

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 Plan. Upon receipt of the information, the Plan may reconsider its Adverse Benefit Determination and provide coverage for the Health Care Service in question. Reconsideration by the Plan will not delay or terminate an external review. If the Plan reverses an Adverse Benefit Determination, the Plan 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 Plan 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 Plan of a request for a standard review or within 72 hours of receipt by the Plan of a request for an expedited review. This notice will be sent to the Covered Person, the Plan 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 were 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 Plan except to the extent the Plan 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 Plan.

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

You may contact the Plan at the Customer Care Center 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

## LEGAL ACTION

You may not begin any legal action until you have followed the procedures and exhausted the administrative remedies described in this section. These review procedures shall be the exclusive mechanism through which determinations of eligibility and benefits may be appealed. No action, at law or in equity, shall be brought to recover benefits within 60 days after Mutual Health Services receives written proof in accordance with this Summary Plan Description that Covered Services have been given to you. No such action may be brought later than three years after expiration of the required claim filing limit as specified.

## HEALTH CARE FRAUD

Health care fraud is a felony that can be prosecuted. Any Participant who willfully and knowingly engages in an activity intending to defraud this Plan will face disciplinary action and / or prosecution. Furthermore, any Participant who receives money from the Plan to which he is not entitled will be required to fully reimburse the Plan.

## PLAN AMENDMENTS

Plan amendments are required to be distributed to all eligible Employees within 60 days of the effective date of the amendment.

## RIGHT TO RELEASE CLAIMS AND RECEIVE NECESSARY INFORMATION

For the purpose of implementing the terms of this coverage, Mutual Health Services may, without the consent of or notice to any person, release or obtain from any insurance company or other organization or person any information, with respect to any person, which it deems necessary for determining benefits payable.

## PHYSICAL EXAMINATION

Mutual Health Services shall, upon request and at the expense of The Plan and by a Physician of its own choice, have the right and opportunity to physically examine any covered individual with respect to the surgical and medical services listed in the Summary Plan Description.

## FACILITY OF PAYMENT

When another plan makes payment that should have been made under this Plan, the Plan shall have the right to directly reimburse the other plan making payment.

## RESCISSION OF COVERAGE

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

Your coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by your employer. You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review.

## RIGHT OF RECOVERY

If the Plan makes any payment which is determined in excess of the Plan's benefits, the Plan shall have the right to recover the amount determined to be in error. The Plan shall have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

## GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

Individuals will be protected from discrimination in health plans on the basis of their genetic information. The Plan will not discriminate against individuals based upon their genetic information, which includes information about genetic tests, the genetic test of family members and the manifestation of a disease or disorder in family members. In addition, genetic information will be considered "health information" for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

## LARGE CASE MANAGEMENT

Large case management is a program which identifies potential high-risk, high-cost claims in order to direct the patient toward the most cost-effective, quality medical care available, as well as provide the patient and the patient's family with another avenue for information and options.

When a Covered Person's Condition warrants additional management (i.e. chronic Illness, catastrophic Injury, etc.), the Plan shall have the right to initiate case management and waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result without sacrifice to the quality of patient care. The case manager will first contact the patient and/or the patient's family to make an introduction and answer questions. The case manager will also contact the patient's attending Physician and other medical providers to make an introduction and to assure that all available resources are considered.

Should an alternate treatment plan be proposed, the case manager, attending Physician, patient and/or the patient's family must all agree to the alternate treatment plan. Once the agreement is established, the patient and/or the patient's family cannot refuse to cooperate with the case management firm, including signing the necessary authorization forms to obtain health information.

## COORDINATION OF BENEFITS

Individuals might be covered under two or more plans and in the event of an accidental Injury or Illness, could possibly submit claims to the different companies. The end result might be that the total claim payments from the companies exceed the individual's total medical expenses. Therefore, the following Coordination of Benefits provision applies to this coverage:

This provision is not intended to deny you benefits, but to ensure that duplicate payments are not made when you are covered by this and any "Other Plan". Under this Plan of group coverage, all benefits will be coordinated with all "Other Plans" you or your Dependent might have coverage through, so that the total amount payable under all plans will not exceed 100% of your total allowable medical expense Incurred during a Calendar Year. However, if your Dependents have coverage under any "Other Plan" and said Plan is considered a primary payor and the Dependent Spouse fails to comply with the requirements of the "Other Plan" or fails to utilize a Health Maintenance Organization (HMO) which has been selected by said Dependent Spouse under the "Other Plan" and the "Other Plan" would have been primary for the Dependent's actions, this Plan will not pay any portion of the allowable expenses Incurred by that Dependent Spouse.

For a Dependent child who fails to utilize the services of the HMO, which would otherwise be considered as the primary payor for the Dependent, this Plan will pay its pro-rata share, up to one-half of the allowable benefits determined by this Plan.

With regard to Coordination of Benefits, "Other Plan(s)" shall mean:

- Any HMO's and other group or individual practice plans;
- Governmental programs, except:
  - Coverage provided under Medicare, Medicaid (Title XIX), or the Social Security Act of 1965, as amended;
  - Any plan where, by law, its benefits are excess to those of any private insurance plan or non-governmental plan;
- Coverage under labor-management trusteed plans;
- Coverage under union welfare plans;

- Coverage under employer organization Plans or employee benefit organization Plans.

The order of benefit determination will be handled as follows:

1. The primary plan for husbands or wives is that which covers the person as an Employee or as the certificate holder.
2. For children's expenses, the primary plan is the plan of the parent whose birthday falls earlier in the Calendar Year.
3. For children's expenses when the parents are separated or divorced:
    a. Primary will be the plan of the parent who, by court decree, is responsible for providing medical coverage.
    b. Secondary will be the plan of the other natural parent. *
    c. If any plan lacks a coordination of benefits' provision, it will be the primary plan.

* If there is no court decree stating who should provide benefits, then the plan of the parent with custody will be the primary payor. If the parent with custody has remarried, then the stepparent will be the secondary plan and the plan of the natural parent without custody will pay last.

**SUBROGATION AND RIGHT OF RECOVERY**

The provisions of this section apply to all current or former Plan Participants and also to the parent(s), guardian, or other representative of a Dependent child who Incurs claims and is or has been covered by the Plan. The Plan's right to Recover (whether by Subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the Plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to Recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult Covered Person without the prior express written consent of the Plan.

The Plan's right of Subrogation or reimbursement, as set forth below, extends to all insurance coverage available to you due to an Injury, Illness, or Condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile coverage, or any first party insurance coverage).

Your health Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other Recovery funds from any insurance coverage or other source will be made until the health Plan’s Subrogation and reimbursement interest are fully satisfied.

**Subrogation**

The right of Subrogation means the Plan is entitled to pursue any claims that you may have in order to Recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be Subrogated to (stand in the place of) all of your rights of Recovery with respect to any claim or potential claim against any party, due to an Injury,

Illness, or Condition to the full extent of benefits provided, or to be provided, by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its Subrogation claim, with or without your consent. The Plan is not required to pay you part of any Recovery it may obtain, even if it files suit in your name.

**Reimbursement**

If you receive any payment as a result of an Injury, Illness, or Condition, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that Injury, Illness, or Condition, up to and including the full amount of your Recovery. Benefit payments made under the Plan are conditioned upon your obligation to reimburse the Plan in full from any Recovery you receive for your Injury, Illness or Condition.

**Constructive Trust**

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider); you agree that if you receive any payment as a result of an Injury, Illness, or Condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other Recovery funds from any insurance coverage or other source will be made until the health Plan’s Subrogation and reimbursement interest are fully satisfied.

**Lien Rights**

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the Illness, Injury, or Condition upon any Recovery whether by settlement, judgment or otherwise, related to treatment for any Illness, Injury, or Condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

**Assignment**

In order to secure the Plan's Recovery rights, you agree to assign to the Plan any benefits, or claims, or rights of Recovery you have under any automobile policy or other coverage, to the full extent of the Plan's Subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

**First-Priority Claim**

By accepting benefits from the Plan, you acknowledge that the Plan's Recovery rights are a first priority claim and are to be repaid to the Plan before you receive any Recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a Recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

**Applicability to All Settlements and Judgments**

The terms of this entire Subrogation and right of Recovery provision shall apply and the Plan is entitled to full Recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to Recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

**Cooperation**

You agree to cooperate fully with the Plan's efforts to Recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to Recover damages or obtain compensation due to your Injury, Illness or Condition. You and your agents agree to provide the Plan or its representatives notice of any Recovery you or your agents obtain prior to receipt of such Recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other Recovery funds obtained. You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal Injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its Subrogation rights or failure to reimburse the Plan from any settlement or Recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the Plan's Subrogation or Recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or Recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other Recovery prior to fully satisfying the health Plan's Subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the Injury, Illness or Condition to identify potential sources of Recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its Subrogation and reimbursement rights.

**Future Benefits**

If you fail to cooperate with and reimburse the Plan, the health Plan reserves the right to deny any future benefit payments on any other claim made by you until the Plan is reimbursed in full. However, the amount of any Covered Services excluded under this section will not exceed the amount of your Recovery.

**Interpretation**

In the event that any claim is made that any part of this Subrogation and right of Recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

**Jurisdiction**

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the Plan incurs in successful attempts to Recover amounts the Plan is entitled to under this section.

**Discretionary Authority**

The Plan shall have discretionary authority to interpret and construct the terms and conditions of the Subrogation and Reimbursement provisions and make determination or construction which is not arbitrary and capricious. The Plan's determination will be final and conclusive.

**PROVISIONS APPLICABLE TO ALL COVERAGE**

The Plan Sponsor reserves the right to terminate, suspend, withdraw, amend, or modify the Plan at any time. Any such change or termination in benefits (a) will be based solely on the decision of the Plan Sponsor; and (b) may apply to active Employees or present and future retirees as either separate groups or as one group.

Any representations or statements which disagree with the provisions of the Plan as stated herein, which are made by the Plan Sponsor, Plan Administrators, Representatives or Agents, Plan Participants or providers:

1. Shall not be considered as representations or statements made by, or on behalf of the Plan; Plan Sponsor or Administrator;
2. Shall not bind Plan Administrator for benefits under the Plan.

**TERMINATION OF EMPLOYEE COVERAGE**

Your coverage under this Plan will terminate automatically without notice as of midnight on the earliest of the following dates:

1. The date the Plan terminates and/or is dissolved; or
2. The date that you die; or
3. Up to the end of the month from which the Employee begins an approved personal leave of absence without pay if he is not entitled or is no longer entitled to a leave of absence under the Family and Medical Leave Act. Such leave will run concurrently with any other approved leave of absence to which the Employee is entitled under the Plan; or
4. Up to twelve (12) weeks from the date the Employee begins an approved personal or medical leave of absence under the Family and Medical Leave Act ("FMLA"). Such leave is subject to all provisions of the "FMLA" and will run concurrently with any other approved leave of absence to which the Employee is entitled under the Plan; or

5. The date the Employee ceases to be in a class of Employees eligible for coverage (such as becoming a part-time Employee, being laid-off, or taking an unapproved personal or medical leave of absence) unless the Employee's coverage is continued for a time due to a temporary lay-off, approved personal leave of absence, or approved medical leave of absence; or
6. The date the Employee becomes a full-time member of the Armed Forces of any country. However, if a Covered Employee temporarily leaves the Employer because of military service, the applicable provisions of the Uniformed Services Employment and Re-Employment Rights Act of 1993 will apply.

**EXTENSION OF COVERAGE FOR DISABLED EMPLOYEES:** Under some conditions, coverage under the Plan may be extended beyond the normal termination of coverage date due to disability. Coverage may continue for an Employee and their Dependents for a period of 90 days.

**REINSTATEMENT OF COVERAGE:** The Waiting Period will be waived for an eligible Employee (and any of his eligible Dependents who were covered under the Plan) if the Employee's coverage terminates after the expiration of an extension of coverage due to being laid off, being granted an approved leave of absence and he is rehired within a six (6) month period immediately following the date his coverage terminated under this Plan. Expenses incurred during the time the individual (or any eligible Dependent) was not covered under the Plan will not be eligible for benefits under the Plan.

An Employee's coverage under the Plan (and that for his eligible Dependents, if previously covered) will become effective on the day he returns to work as an eligible Employee if he agrees to pay any required contribution and applies for coverage for himself (and his Dependents, if applicable) within thirty (30) days of that date.

All other "Eligibility, Effective Date and Termination" provisions as shown in the Plan will apply.

**TERMINATION OF DEPENDENT CHILD COVERAGE**

For a Dependent, as of midnight on the earliest of the following dates:

1. When the Employee’s coverage terminates; or
2. Thirty (30) exact days after the death of an Employee; or
3. When the Employee ceases to make the required contribution regarding Dependent coverage; the end of the period for which the Employee made his last required contribution; or
4. The date the child becomes eligible and chooses to be covered as an Employee; or
5. The date the child reached the limiting as described in the eligibility section; or
6. When this Plan is terminated and/or discontinued or with respect to any Dependent's benefit of the Plan, the date of termination of such benefits.

**In order for any Dependent whose coverage is terminated to be eligible for continuation of coverage under "COBRA", the Employee must notify the Plan Administrator within 60 days of the date the Dependent is no longer eligible for coverage under the Plan.**

**TERMINATION OF DEPENDENT SPOUSE COVERAGE**

For a Dependent Spouse, as of midnight on the earliest of the following dates:

1. When the Employee's coverage terminates; or
2. Thirty (30) exact days after the death of an Employee; or
3. When the Employee ceases to make the required contribution regarding Dependent coverage; the end of the period for which the Employee made his last required contribution; or
4. The date the Spouse becomes covered as an Employee; or
5. The date the Spouse is legally separated or divorced from the Employee; or
6. When this Plan is terminated and/or discontinued or with respect to any Dependent's benefit of the Plan, the date of termination of such benefits.

**In order for any Dependent whose coverage is terminated to be eligible for continuation of coverage under "COBRA", the Employee must notify the Plan Administrator within 60 days of the date the Dependent is no longer eligible for coverage under the Plan.**

**FAMILY AND MEDICAL LEAVE**

If you take an approved leave of absence in accordance with the federal Family and Medical Leave Act of 1993, coverage for you and your Dependents will be continued under the same terms and conditions as if you have continued performing services for Coshocton County Commissioners, provided you continue to pay your regular contribution towards coverage.

If you fail to make the required contribution for coverage within the 30-day grace period from the contribution due date, then your coverage will terminate as of the date the contribution was due.

If you do not return to work for Coshocton County Commissioners after the approved Family Medical Leave, or if you have given notice of intent not to return to work during the leave, or if you exhaust your FMLA entitlement, coverage may be continued under the Continuation of Coverage (COBRA) provision of this Plan, provided you elect to continue under the COBRA provision. Continuation of Coverage (COBRA) will be provided only if the following conditions have been met:

1. You were covered under this Plan on the day before the FMLA leave began or became covered during the FMLA leave;
2. You do not return to work after an approved FMLA leave; and
3. Without COBRA, you would lose coverage under this Plan.

Continuation of Coverage (COBRA) will become effective on the last day of the FMLA leave as determined below:

1. The date you fail to return to work after an approved Family or Medical Leave;
2. The date you inform Coshocton County Commissioners that you do not intend to return to work; or
3. The date you exhaust your FMLA entitlement and fail to return to work.

Coverage continued during a Family or Medical Leave will not be counted toward the maximum COBRA continuation period.

If you decline coverage during the FMLA leave period, or if you elect to continue coverage during the Family or Medical Leave and fail to pay the required contributions, you will still be eligible for COBRA continuation at the end of the FMLA leave, if you do not return to work. COBRA continuation will become effective on the last day of the FMLA leave. You need not

provide evidence of good health to elect COBRA continuation, even if there was a lapse in coverage during the FMLA leave period.

If coverage lapses for any reason during an FMLA leave and you return to work on a timely basis following an approved FMLA leave, coverage will be reinstated as if you have continued performing services during the leave, including Dependent coverage. Reinstatement will be provided without having to satisfy any waiting period, or provide evidence of good health.

**Eligible Employees:** You will be eligible for an extension of benefits under the Family and Medical Leave Act if you are covered under this Plan and have worked for the Employer for at least 12 months and 1,250 hours in the 12 months immediately preceding the start of your leave of absence. (The 12 months of service need not be consecutive. Each partial week on the payroll is counted as one week, and 52 weeks are considered as 12 months.)

Whenever possible, you must try to set up your leave schedule so as not to disrupt the Employer's operations.

During a qualified leave of absence, you will be subject to the same benefits and plan provisions as active Employees.

**Qualifying Events:** The following situations will qualify you for an extension:

- Birth or adoption of a child by the Employee or the Employee's spouse; or
- Placement in the Employee's or Employee's Spouse's care of a foster child; or
- The Serious Illness of an Employee's spouse, child or parent; or
- Your own disabling Serious Illness.

**Serious Illness:** "Serious Illness", as it applies to the Family and Medical Leave Act, means an illness, injury, impairment, or physical or mental health condition involving a period of incapacity and/or either In-Patient care or "continuing treatment by a health care provider", or requiring absences on a recurring basis or for more than three days for treatment or recovery.

**Notice to the Employer:** You must give 30 days' advance notice to the Employer of your need for a leave of absence. In cases when advance notice is not possible (i.e., a premature birth or accident), you must give notice to the Employer as soon as you can: ordinarily this should be within two business days of the date of the event.

You must give the Employer the following information at that time:

- the reason for the leave; and
- the date you will begin your leave of absence; and
- how long you expect to be on leave.

If an emergency exists where it is not possible for you to notify the Employer, your spouse or other family member may provide such notice.

If you do not give the Employer adequate notice of a leave of absence, the Employer has 30 days from the date you notify him to deny your leave of absence

**Medical Certification:** If you are seeking leave due to a Serious Illness, the Employer may require you to obtain certification from your attending Physician that you are disabled due to a serious health condition. If the Employer requests such certification you must provide it, at your own expense, within 15 calendar days of his request. The Employer may also require, at his

expense, a second opinion and, if the first two opinions disagree, a third medical opinion.

If your leave is foreseeable and you do not provide the Employer with such notification within the time limit shown above, the Employer may deny your leave of absence until you do provide certification.

The Employer may also require re-certification of medical necessity every 30 days (but not less than 30 days from the last certification) or if there is a change in your medical condition or if he receives information questioning the validity of the most recent certification.

If the leave is for your own Illness, the attending Physician must certify that you are unable to perform any work or to perform the essential functions of your own job.

If the leave is for the Illness of your spouse or other eligible family member, you must certify the care you will be providing to that family member and the family member's attending Physician must certify the need for such care.

**Intent to return to work:** While you are on leave, the Employer may require you to provide periodic reports to him regarding your status and your intent to return to work.

**Contributions:** If you are required to make a contribution for coverage as an active Employee and this is an unpaid leave of absence, you and the Employer must work out, in advance, an acceptable method of payment for your contributions during your leave. Once the method of payment has been established, the Employer must provide you, in advance, a written notice of the terms and conditions of such payments. During your leave, your contribution may not be more than what you would have paid as an active Employee.

If you do not make any agreed upon payment within 30 days after the date it is due, the Employer may terminate your coverage at the end of the 30-day "grace period".

If the Employer determines that you will not be returning to work after your leave of absence (i.e., you are not seriously ill and you did not return to work and continue to work for at least 30 calendar days), the Employer may recover the full cost of coverage from you. The "full cost of coverage" is the amount that COBRA continuees are charged less the 2% administration fee.

**Maximum length of extension:** If you work 30 or more hours per week and are eligible for an approved leave of absence under the Family and Medical Leave Act you may take up to 12 weeks of leave in any 12-month period. This 12-month period will be determined by the Employer (i.e., it may be a Calendar Year or a fixed 12-month period). The Employer must notify you 60 days in advance of any change made to the term of the 12-month leave period.

If the reason for the approved leave of absence is the birth or adoption of a child by you or your spouse or placement in your or your spouse's care of a foster child, your entitlement to the 12-week leave of absence ends 12 months after the date of birth or placement.

If maternity is the reason for the approved leave of absence, periods taken for medical disability and periods taken as a personal leave of absence both count towards the 12-week maximum extension. (For example, if you take 6 weeks of leave due to medical disability, only 6 more weeks remain for the personal leave of absence.)

If you work less than 30 hours per week or have variable hours and are eligible for an approved leave of absence under the Family and Medical Leave Act, the leave entitlement is calculated

on a prorated or proportional basis. (For example, if you are a part-time Employee and work 10 hours per week, you will be entitled to a 4-week extension. If you work variable hours, your leave will be based on the average weekly hours worked in the 12 weeks prior to the start of your leave of absence.)

If you and your spouse work for the same Employer, the combined maximum amount of leave you may both take under the following conditions is 12-work-weeks during any 12-month period:

- the birth or adoption of a child; or
- placement in your care of a foster child; or
- the serious health condition of a parent.

**Changes in coverage/benefits:** While you are on an approved leave of absence, you may make coverage changes, such as adding coverage for a newborn child, on the same basis as if you were an Active Employee and any changes made to the Plan's benefits or eligibility provisions while you are on an approved leave of absence will apply to you and your dependents on the same basis as any other Covered Person.

**Returning to work:** You will continue to be covered under the Plan on the same basis as any other Covered Person as long as you return to work for the Employer before the maximum length of time for the approved leave of absence has expired.

**Employee's Rights:** The Employer may not in any way interfere with your rights under the Family and Medical Leave Act or discriminate against you if you either file charges or provide information or testimony against the Employer for alleged violations of the Family and Medical Leave Act. The basis for this is Title VII of the Civil Rights Act of 1964.

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)**

In compliance with the requirements of the HIPAA Privacy and Security regulations, herein referred to as the "HIPAA Regulations", the following has been established as the extent to which the Plan Sponsor will receive, use, and/or disclose Protected Health Information.

**Permitted disclosure of Individuals' Protected Health Information to the Plan Sponsor**

A. The Plan (and any business associate acting on behalf of the Plan), or any health care issuer servicing the Plan will disclose Individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of the HIPAA Regulations.

B. All disclosures of the Protected Health Information of the Plan's Individuals by the Plan's business associate or health care issuer, to the Plan Sponsor will comply with the restrictions and requirements set forth in this document and in 45 C.F.R. §164.504 (the "504" provisions).

C. The Plan (and any business associate acting on behalf of the Plan), may not permit a health care issuer, to disclose Individuals' Protected Health Information to the Plan Sponsor for employment-related actions and decisions in connection with any other benefit or employee benefit plan of the Plan Sponsor.

D. The Plan Sponsor will not use or further disclose Individuals' Protected Health Information other than as described in the Plan Documents and permitted by the "504" provisions.

E. The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides Individuals' Protected Health Information received from the Plan (or from the Plan's business associate or health care issuer), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.

F. The Plan Sponsor will not use or disclose Individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

G. The Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, including any Breaches, of which the Plan Sponsor becomes aware.

**Disclosure of Individuals' Protected Health Information - <u>Disclosure by the Plan Sponsor</u>**

A. The Plan Sponsor will make the Protected Health Information of the Individual who is the subject of the Protected Health Information available to such Individual in accordance with 45 C.F.R. § 164.524.

B. The Plan Sponsor will make Individuals' Protected Health Information available for amendment and incorporate any amendments to Individuals' Protected Health Information in accordance with 45 C.F.R. § 164.526.

C. The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of Individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. § 164.528.

D. The Plan Sponsor will make its internal practices, books, and records relating to the use and disclosure of Individuals' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Regulations.

E. The Plan Sponsor will, if feasible, return or destroy all Individuals' Protected Health Information received from the Plan (or a business associate or health care issuer with respect to the Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

F. The Plan Sponsor will ensure that the required adequate separation, described later in this section, is established and maintained.

**Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan Sponsor**

A. The Plan, or a business associate or health care issuer with respect to the Plan, may disclose summary health information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions, if the Plan Sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from health plans for providing health coverage under the Plan; or
2. Modifying, amending, or terminating the Plan.

B. The Plan, or a business associate or health care issuer with respect to the Plan, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

**Required separation between the Plan and the Plan Sponsor**

A. In accordance with the "504" provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan Sponsor who may have access to Individuals' Protected Health Information received from the Plan or from a business associate or health care issuer servicing the Plan.

1. **Administrator/Clerk**

B. This list reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who may receive or at times access Individuals' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to Individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of Individuals' Protected Health Information in violation of, or noncompliance with, the provisions of this Amendment.

C**.** The Plan Sponsor will promptly report any violation or noncompliance, including any unauthorized use or disclosure of Individuals' Protected Health Information to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

**HIPAA Security Standards**

**Definitions**

A. *Electronic Protected Health Information* – The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

B. *Plan* – The term "Plan" means Coshocton County Commissioners Non-Grandfathered Employee Health & Welfare Plan.

C. *Plan Documents* – The term "Plan Documents" means the group health plan's governing documents and instruments (*i.e.,* the documents under which the group health plan was

established and is maintained), including but not limited to Coshocton County Commissioners Non-Grandfathered Employee Health & Welfare Plan Document.

D. *Plan Sponsor* – Coshocton County Commissioners.

E. *Security Incidents* – The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

**Plan Sponsor Obligations**

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

A. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

B. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f) (2) (iii) of the HIPAA Regulations is supported by reasonable and appropriate security measures;

C. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

D. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

1. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

2. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

**COBRA COVERAGE**

**SUMMARY OF RIGHTS AND OBLIGATIONS REGARDING CONTINUATION OF COVERAGE UNDER THE BENEFIT PLAN**

Federal law requires most employers sponsoring group health plans to offer Employees and their families the opportunity to elect a temporary extension of health coverage (called “continuation coverage” or “COBRA coverage”) in certain instances where coverage under the group health plan would otherwise end. You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay all of the cost of your continuation coverage.

This section is intended only to summarize, as best possible, your rights and obligations under the law. The Plan offers no greater COBRA rights than what the COBRA statute requires, and this Notice should be construed accordingly.

Both you (the Employee) and your Spouse should read this summary carefully and keep it with your records.

**Qualifying Events**

If you are an Employee of Coshocton County Commissioners and you are covered by the Plan, you have a right to elect continuation coverage if you lose coverage under the Plan because of any of the following "qualifying events":

1. Termination (for reasons other than your gross misconduct) of your employment.
2. Reduction in the hours of your employment.
3. Disability Determination

If you are the Spouse of an Employee covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following five "qualifying events":

1. The death of your Spouse.
2. A termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of employment with Coshocton County Commissioners.
3. Divorce or legal separation from your Spouse. (Also, if an Employee drops his or her Spouse from coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later event will be considered a qualifying event even though the ex-Spouse lost coverage earlier. If the ex-Spouse notifies the administrator within 60 days of divorce and can establish that the coverage was dropped earlier in anticipation of divorce, then COBRA coverage may be available for the period after the divorce or legal separation.)
4. Your Spouse becomes entitled to Medicare benefits.
5. Your Spouse becomes disabled.

In the case of a Dependent child of an Employee covered by the Plan, he or she has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following six "qualifying events":

1. The death of the Employee parent.
2. The termination of the Employee parent's employment (for reasons other than gross misconduct) or reduction in the Employee parent's hours of employment with Coshocton County Commissioners.
3. Parents' divorce or legal separation.
4. The Employee parent becomes entitled to Medicare benefits.
5. The Dependent ceases to be a "Dependent child" under the Plan.
6. Employee parent becomes disabled.

**Notices and Election Procedures**

**Your employer is responsible for notifying the plan administrator of certain qualifying events, such as termination of employment (other than gross misconduct), reduction of**

**hours, death and employee's Medicare entitlement.** You (the Employee) and/or your qualified beneficiaries will be notified of the right to elect continuation coverage automatically (i.e., without any action required by you or a family member) upon these events that resulted in a loss in coverage.

Under the COBRA statute, you (the Employee) or a family member have the responsibility to notify the Plan Administrator upon a divorce, legal separation, a child losing Dependent status, or a disability determination. This notice is required to be submitted to your Plan Administrator in writing. You must contact your Plan Administrator to obtain an "Enrollment/Change Form" to provide proper notice. The form provides information as to whom and where the Notice is to be sent. You or a family member must provide this notice within 60 days of the date of the qualifying event, or the date coverage is lost, whichever is later.

Notification of a second qualifying event must be made to the Plan Administrator within 60 days of the qualifying event, and must be in writing as described in the above paragraph.

Notification of a disability determination must be made to the Plan Administrator within 60 days of the LATER of the date of determination, date of qualifying event, or date coverage is lost as a result of the qualifying event. Notification must be in writing as described in the above paragraph, and a copy of the SSA Determination, or another correspondence from the Social Security Administration that includes all the information Mutual Health Services will need from the original determination letter to decide whether you are eligible for the extended coverage, must accompany your notice. Please note you have 30 days from the determination to notify Plan Administrator that you are no longer disabled.

If you or family members fail to provide this notice to the Plan Administrator during this 60-day notice period, any family member who loses coverage will NOT be offered the option to elect continuation coverage. Further, if you or a family member, fail to notify the Plan Administrator, and any claims are paid mistakenly for expenses Incurred after the last day of coverage, then you and your qualified beneficiaries will be required to reimburse the Plan for any claims so paid.

If the Plan Administrator is provided timely notice of a divorce, legal separation, a child's losing Dependent status, or a disability determination that has caused a loss of coverage, the Plan Administrator will notify the affected family member of the right to elect continuation coverage.

You (the Employee) or your qualified beneficiaries must elect continuation coverage within 60 days after Plan coverage ends or, if later, 60 days after the Plan Administrator sends you or your family member notice of the right to elect continuation coverage.

If you or your qualified Beneficiaries do not elect continuation coverage within this 60-day election period, you or your qualified Beneficiaries will lose the right to elect continuation coverage. Once the election is sent to the Plan Sponsor it is effective back to the date the employer sponsored coverage was lost. Please Note: No claims will be paid until the COBRA payment is received.

A covered Employee or the Spouse of the covered Employee may elect continuation coverage for all qualified beneficiaries. The covered Employee and his or her Spouse and Dependent children each also have an independent right to elect continuation coverage. Thus, a Spouse or Dependent child may elect continuation coverage even if the covered Employee does not (or is not deemed to) elect it.

You or your qualified beneficiaries can elect continuation coverage if you or the family member, at the time you or the family member elect continuation coverage, are covered under another employer-sponsored group health plan or are entitled to Medicare.

**Type of Coverage; Payments of Contributions**

Ordinarily, you or your qualified beneficiaries will be offered COBRA coverage that is the same coverage that you, he or she had on the day before the qualifying event. Therefore, a person (Employee, Spouse or Dependent child) who is not covered under the Plan on the day before the qualifying event is generally not entitled to COBRA coverage except, for example, where there is no coverage because it was eliminated in anticipation of a qualifying event such as divorce. If the coverage for similarly situated Employees or their family members is modified, COBRA coverage will be modified the same way.

The premium payments for the "initial premium months" must be paid for you (the Employee) and any qualified beneficiaries by the 45th day after electing continuation coverage. The initial premium months begin from the date you lost your employer sponsored coverage, and end on or before the 45th day after the date of the COBRA election. All other premiums are due on the 1st day of the month for which the premium is paid, subject to a 30-day grace period. A premium payment is made on the date it is post-marked or actually received; whichever is earlier.

**COBRA Premium Payment Guidelines**

COBRA premium payments can be made by personal check. After the second non-sufficient funds (NSF) personal check is received, only cashier's checks or money orders will be accepted for payment.

If a member has paid their COBRA premium through the month and then gets other insurance and wants to drop the COBRA coverage, the Plan will prorate the monthly premium only if the member on COBRA does not receive any coverage in that month. For example, if a member on COBRA pays for the full year and stops coverage on November 16th, the Plan will refund the premium for the month of December only.

Please contact the Commissioner's Office if you have any other questions.

**Maximum Coverage Periods**

**36 Months**. If you (Spouse or Dependent child) lose group health coverage because of the Employee's death, divorce, legal separation, or the Employee's becoming entitled to Medicare, or because you lose your status as a Dependent under the Plan, the maximum continuation coverage period (for Spouse and Dependent child) is 36 months from the date of the qualifying event.

If the Employee is entitled to Medicare at the time of or after the initial qualifying event, please see Item 3 under Exceptions below.

**18 Months**. If you (Employee, Spouse or Dependent child) lose group health coverage because of the Employee's termination of employment (other than for gross misconduct), reduction in hours, or disability determination the maximum continuation coverage period (for the Employee, Spouse and Dependent child) is 18 months from the date of termination or reduction in hours.

If the Employee is entitled to Medicare at the time of or after the initial qualifying event, please see Item 3 under Exceptions below.

**Exceptions.** There are three exceptions:

1. If an Employee or family member is disabled at any time during the first 60 days of continuation coverage (running from the date of termination of employment or reduction in hours), the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to Coshocton County Commissioners or the Plan Administrator both within the 18-month coverage period and within 60 days after the date of the determination.

2. If a second qualifying event that gives rise to a 36-month maximum coverage period (for example, the Employee dies or becomes divorced) occurs within an 18-month or 29-month coverage period, the maximum coverage period becomes 36 months from the date of the initial termination or reduction in hours for the Spouse or dependent child.

3. If within the 18 month period after Medicare entitlement, the Employee experiences a qualifying event (due to termination or reduction of hours worked) then the period of continuation for family members, other than the Employee, who are qualified beneficiaries, is up to 36 months from the date of Medicare entitlement.

If the Employee experiences a qualifying event on or before the date of Medicare entitlement, or after the expiration of the 18 month period after Medicare entitlement, both Employee and family members who are qualified beneficiaries are entitled to up to 18 months from the date of the qualifying event.

If the Employee's Medicare entitlement follows an initial qualifying event (due to termination or reduction of hours worked) and would have resulted in a loss of coverage had it occurred before the initial qualifying event, then other family members who are qualified beneficiaries will be allowed to elect COBRA coverage up to 36 months from the date of the initial qualifying event.

**Children Born To, or Placed for Adoption with the Covered Employee after the Qualifying Event**

If, during the period of continuation coverage, a child is born to, adopted by or placed for adoption with the covered Employee and the covered Employee has elected continuation coverage for himself or herself, the child is considered a qualified beneficiary. The covered Employee or other guardian has the right to elect continuation coverage for the child, provided the child satisfies the otherwise applicable plan eligibility requirements (for example, age). The covered Employee or a family member must notify the Plan Administrator within 30 days of the birth, adoption, or placement to enroll the child on COBRA, and COBRA coverage will last as long as it lasts for other family members of the Employee. (The 30-day period is the Plan's normal enrollment window for newborn children, adopted children or children placed for adoption). If the covered Employee or family member fails to so notify the Plan Administrator in a timely fashion, the covered Employee will NOT be offered the option to elect COBRA coverage for the child.

**Termination of COBRA before the End of Maximum Coverage Period**

Continuation coverage of the Employee, Spouse, and/or Dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs:

1. Coshocton County Commissioners no longer provides group health coverage to any of its Employees.
2. The premium for the qualified beneficiary's COBRA coverage is not timely paid.
3. After electing COBRA, you (Employee, Spouse or Dependent child) become covered under another group health plan (as an Employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the "other plan" has applicable exclusions or limitations, your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group health plan. Note that under Federal law (the Health Insurance Portability and Accountability Act of 1996), an exclusion, or limitation of the other group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group health plan.
4. After electing COBRA, you (Employee, Spouse or Dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
5. If you (Employee, Spouse or Dependent child) became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).
6. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered Employees or their Spouses or Dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of Federal law.

**Other Information**

If you (the Employee) or your qualified beneficiaries have any questions about this notice or COBRA, please contact the Plan Administrator at the address listed below. Also, please contact Coshocton County Commissioners if you wish to receive the most recent copy of the Plan's Summary Plan Description, which contains important information about Plan benefits, eligibility, exclusions, and limitations.

If your marital status changes, or a Dependent ceases to be a Dependent eligible for coverage under the Plan terms, or your or your Spouse's address changes, you must immediately notify the Plan Administrator.

Coshocton County Commissioners
401 ½ Main Street
Coshocton, Ohio 43812-1586
(740) 622-1158

**USERRA**

The following provisions are required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA):

**Continuation of Coverage Due to Military Leave**

If you are absent from work due to a leave for military service and were covered under this Plan prior to the leave, coverage for you and your Dependents may be continued for a period that is the lesser of twenty-four (24) months or a period that ends the day you fail to apply for or return to a position of employment. Coverage continued during the military service will be counted toward the maximum COBRA continuation period. The twenty-four (24) month period is measured from the date you leave work for military service.

If you are on military leave for less than thirty-one (31) days, your contribution for coverage will be the same as while you are actively at work. If your military leave extends for more than thirty-one (31) days, then you are required to pay the full cost of coverage.

**Reinstatement of Coverage Following Military Leave**

If you are reemployed following military leave, you will be covered under the same terms and conditions that would have been provided had you continued actively working.

Your coverage will be reinstated on your date of reemployment, provided the following conditions are met:

1. You have given advance written or verbal notice of the military leave to Coshocton County Commissioners (advance notice to your Employer is not required in situations of military necessity or if giving notice is otherwise impossible or unreasonable under the circumstances);
2. The cumulative length of the leave and all previous absences from employment do not exceed five (5) years;
3. Reemployment follows a release from military service under honorable conditions; and
4. You report to, or submit an application to Coshocton County Commissioners as follows:
    a. On the first business day following completion of military service for a leave of thirty (30) days or less; or
    b. Within fourteen (14) days of completion of military service for a leave of thirty-one (31) days to one hundred-eighty (180) days; or
    c. Within ninety (90) days of completion of military service for a leave of more than one hundred-eighty days.

If you are Hospitalized for, or recovering from, an Illness or Injury when your military leave expires, you have two (2) years to apply for reemployment.

If you provide written notice of intent not to return to work after military leave, you are not entitled to reemployment benefits.

If the requirements for reemployment are satisfied, coverage will continue as though employment had not been interrupted by a military leave, even if you decline continued coverage during the leave. No new waiting periods will apply to you or your Dependents. However, a waiting period and/or plan exclusion may apply for Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during military service.

**EFFECT OF MEDICARE ON THE PLAN**

If a Covered Person is eligible for Medicare and incurs covered expenses for which benefits are payable under this Plan, then the Plan Administrator will first determine if the Plan is Primary or Secondary to coverage provided by Medicare. Primary means that benefits payable under this Plan will be determined and paid without regard to Medicare. Secondary means that payments under the Plan will be reduced so that the total payable by Medicare and the Plan will not exceed 100% of the actual covered expense.

Coverage for a Covered Person will always be Primary if:

1. The Covered Person is entitled to benefits under Medicare based off his/her age, and is an active Employee or the Spouse of an active Employee of an employer with 20 or more Employees; or

2. The Covered Person is entitled to benefits under Medicare because of renal dialysis or kidney transplant. In this case, starting on the date the Covered Person becomes eligible for Medicare, coverage under this plan will be Primary only during the first 30 months of the coordination period such person is so entitled; or

3. The Covered Person is entitled to Medicare on the basis of disability, and his/her employer has 100 or more Employees.

Coverage for a Covered Person will be Secondary if:

1. The Covered Person is entitled to Medicare on the basis of age, and is an active Employee or the Spouse of an active Employee of an employer with less than 20 Employees.

2. The Covered Person has been entitled to benefits under Medicare because of renal dialysis or kidney transplant for more than 30 months (coordination period). In this case, coverage under this Plan will be Secondary only after the first 30 months of the coordination period such person is so entitled; or

3. The Covered Person is entitled to Medicare on the basis of disability, and his/her employer has less than 100 Employees.

4. The Covered Person is a retired Employee or the covered Dependent of a retired Employee.

The Plan Administrator will decide whether coverage is Primary or Secondary based on the status of the Covered Person on the date the covered expense is Incurred.

If a Covered Person is eligible for Part B benefits, but does not enroll for coverage or does not make due claim for Medicare benefits, the Plan Administrator may calculate benefits as if he/she were enrolled in part B of Medicare and full claim for benefits had been made.

## 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.

**Alcoholism Treatment Facility** - a facility which mainly provides detoxification and rehabilitation treatment for Alcoholism.

**Allowed Amount** - the negotiated amount that a PPO Network Provider, including a network Pharmacy, will accept as payment in full. In the absence of a contract between the Hospital, Physician or Other Provider and Claims Administrator or another network vendor, the Allowed Amount will be the maximum amount payable for the claim, as determined by the Claims Administrator in its discretion, and will be based upon various factors, including, but not limited to, market rates for that service, negotiated amounts with other PPO Network Providers for that service, and Medicare reimbursement rates for that service. In this case, the Allowed Amount will likely be less than the Hospital's, Physician's or Other Provider's Billed Charges. If you receive services from a Non-Participating Hospital, Physician or Other Provider, including a non-network Pharmacy, and you are balanced billed for the difference between the Allowed Amount and the Billed Charges, you may be responsible for the full amount up to the Hospital's, Physician's or Other Provider's Billed Charges, even if you have met your Out-of-Pocket Maximum.

**Ambulatory Surgical Facility** - a facility, with an organized staff of Physicians, which:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;
- provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- does not provide Inpatient accommodations; and
- is not, other than incidentally, used as an office or clinic for the private practice of a Physician or Professional Other Provider.

**Billed Charges** - charges for all services and supplies that the Covered Person has received from the Provider, whether they are Covered Services or not.

**Birthing Center** - a facility which meets all of the following tests:

- It is primarily engaged in providing birthing services for low risk pregnancies;
- It is operated under the supervision of a doctor;
- It has at least one licensed registered nurse certified as a nurse midwife in attendance at all times;
- It has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

**Calendar Year** - the period that starts with the effective date on your identification card and ends on December 31st of such year. Each following Calendar Year shall start on January 1st of any year and end on December 31st of that year.

**Child Support Performance and Incentive Act of 1998 (CSPIA) Information and Notification -** requires a group health plan, insurance company, and HMO to honor a qualified medical child support order (QMCSO) submitted to the Plan and pay benefits to:

1. Any child who is an "alternate recipient" specified therein;
2. The child's custodial parent or guardian who incurs covered expenses on the child's behalf; or
3. An official of a state or political subdivision whose name and address has been substituted for that of any alternate payee in the order. This third alternative is effective for QMCSOs issued on or after August 5, 1997.

- If the Plan receives a court order to provide coverage for a qualified employee's dependent child, the Plan Sponsor must notify the employee and determine if the child is eligible for coverage. Eligibility determinations will be made in accordance with federal child support order laws and regulations. The employee will be responsible for any required contributions.

- The coverage provided in accordance with a child support order will be effective as of the date of the child support order and subject to all provisions of the group plan. The coverage required by a child support order will cease on the earlier of the date the support order expires or the date the dependent is enrolled for similar coverage. The Plan will not deny coverage or benefits because a person is eligible for other state or federal sponsored medical benefits.

- If covered expenses for a dependent child are paid by a custodial parent or legal guardian who is not the covered employee and/or dependent, reimbursement must be made directly to the custodial parent or legal guardian rather than the covered employee and/or dependent. A custodial parent or legal guardian may also sign claim forms and assign Plan benefits.

**Claims Administrator** – an organization which has been retained by the Plan Administrator / Plan Sponsor to process healthcare claims and / or provide administrative services on behalf of the Plan. Administrator in this definition does not have the same meaning as the term "Plan Administrator" as used in the Employee Retirement Income Security Act of 1974 (ERISA).

**Coinsurance** - a dollar amount, as specified in the Schedule of Benefits, that you are required to pay toward Covered Services.

**Complications of Pregnancy** - a condition needing medical treatment before or after termination of pregnancy. The condition must be diagnosed as distinct from pregnancy or as caused by it. Examples are: acute nephritis, cardiac decompensation; miscarriage; disease of the vascular, hemopoietic, nervous or endocrine systems; and similar conditions that can't be classified as a distinct complication of pregnancy but are connected with the management of a difficult pregnancy. Also included are: Medically Necessary cesarean sections; terminated ectopic pregnancy; spontaneous termination that occurs during pregnancy in which a viable birth is impossible; hyperemesis gravidarum; and preeclampsia.

**Condition** - an Injury, ailment, disease, Illness or disorder.

**Confinement/Confined** - the period starting with a Covered Person's admission on an inpatient basis (more than 24 hours) to a Hospital or other licensed health care facility for treatment of an Illness or Injury. Confinement ends with the Covered Person's discharge from the same Hospital or other facility. If the Covered Person is transferred to another Hospital or other facility for continued treatment of the same or related Illness or Injury, it's still just one Confinement.

**Consultant** - a Physician or Professional Other Provider, as defined, who has special knowledge, training, and skill related to your Injury, Illness, or disease.

**Convalescent Facility/Skilled Nursing Facility/Rehabilitation Facility**

- A Skilled Nursing Facility, as the term is defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare, except for a Skilled Nursing Facility which is part of a Hospital, as defined; or

- An institution which fully meets all of the following:
  a. It is operated in accordance with the applicable laws of the jurisdiction in which it is located;
  b. It is under the supervision of a licensed Physician, or registered graduate nurse (R.N.) who is devoting full-time to such supervision;
  c. It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness;
  d. It maintains a daily medical record of each patient who is under the care of a duly licensed Physician;
  e. It is authorized to administer medication to patients on the order of a duly licensed Physician;
  f. It is not, other than incidentally, a home for the aged, the blind, the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill;
  g. It is not a Hospital or part of a Hospital.

**Copay/Copayment** - A cost sharing arrangement whereby a Covered Person pays a set amount to a provider for a specific service.

**Covered Person** - an eligible Employee or eligible Dependent who has been properly enrolled and is covered by the Plan.

**Covered Service** - a Provider's service or supply as described in this document for which benefits will be provided as listed in the Schedule of Benefits.

**Custodial Care** - care provided primarily for maintenance of the patient or care which is designed essentially to assist the patient in meeting his activities of daily living. This does not include care primarily provided for its therapeutic value in the treatment of an Illness, disease, bodily Injury, or condition. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medications not requiring the constant attention of trained medical personnel.

**Day Treatment Programs** - nonresidential programs for treatment of Alcoholism and Drug Abuse, which are operated by certified inpatient and outpatient Alcoholism and Drug Abuse Treatment Facilities, that provide case management, counseling, medical care, and therapies on a routine basis for a scheduled part of the day and a scheduled number of days per week; also known as partial Hospitalization.

**Deductible-** an amount, usually stated in dollars, for which you are responsible each Benefit Period before the Plan will start to provide benefits. This is the amount of expense that must be Incurred and paid by you for Covered Services before the Plan starts to provide benefits.

**Dental Allowed Amount -** the amount specified as payable for Covered Services in the Schedule of Benefits, or for Covered Services not specified in the Schedule of Benefits, the maximum amount payable, as determined by the Claims Administrator.

**Dependent** - as defined in the Eligibility section of this booklet.

**Dialysis Facility -** a facility which mainly provides dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.

**Dialysis Treatment –** the treatment of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine.

**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.

**Drug Abuse Treatment Facility -** a facility which provides detoxification and rehabilitation treatment for Drug Abuse.

**Durable Medical Equipment** - an item which can withstand repeated use and is, as determined by the Plan, (a) primarily used to serve a medical purpose with respect to an Illness or Injury; (b) generally not useful to a person in the absence of an Illness or Injury; (c) appropriate for use in a Covered Person's home; and (d) prescribed by a Physician. All requirements of this definition must be satisfied before an item can be considered to be Durable Medical Equipment.

**Eligible Employee** - as defined in the Eligibility section of this booklet.

**Emergency -** a sudden and unexpected condition requiring immediate medical attention to prevent death or serious harm to health. (Examples: heart attacks, suspected heart attacks, coma, loss of respiration, stroke, asthmatic attack, dehydration, high fevers, acute appendicitis, fractures, concussions, and broken bones.)

**Emergency Medical Care** - medical services provided by a Health Care Provider to treat a Covered Person's medical emergency. A medical emergency is the sudden and unexpected onset of one or more acute conditions calling for medical services which the Covered Person receives right after the onset of such condition(s). For example, such an emergency includes heart attack, cardiovascular accident, poisoning, loss of consciousness or loss of breathing. These and other acute conditions are medical emergencies when all of the following are met, as determined by the Plan:

1. The Covered Person requires immediate medical care; and
2. The onset of the severe symptom(s) of the acute condition(s) is sudden and unexpected. The symptom(s) must be severe enough to cause a reasonably prudent person to seek medical care right away, no matter what time of day it is; and
3. Immediate care must be obtained (if it is not, it's not a medical emergency); and

4. A Health Care Provider's diagnosis of the symptom(s) indicates the condition(s) required immediate 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 capability 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.

**Employee** - Any common law employee of Coshocton County Commissioners. The term "Employee" excludes any person who is not classified by Coshocton County Commissioners on its payroll records as an Employee for purposes of federal income tax withholding. Employees do not include individuals classified as independent contractors, even if the classification is determined to be erroneous or is retroactively revised (such as by a governmental agency or court order). If a person who was excluded from the definition of Employee is later determined to have been misclassified, the person shall continue to be treated as a non-Employee for all periods prior to the date the classification of the person should be revised for purposes of the Plan.

**Essential Health Benefits -** is 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/Investigative** - any treatments, procedures, devices, drugs or medicines for which one or more of the following is true:

1. The device drug or medicine 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 device, drug, or medicine is furnished;

2. Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is 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 means only published reports and articles in the authoritative medical and scientific literature; the written protocols used by the treating facility and the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine;

or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

Experimental or Investigative shall also mean: (a) any treatments, services or supplies that are educational or provided primarily for research; or (b) treatments, procedures, devices, drugs or medicines or other expenses relating to transplant of non-human organs.

**Health Care Provider** - any person, institution or other entity licensed by the state in which he/she or it is located to provide treatment, services or supplies covered by the Plan to a Covered Person within the lawful scope of his/her license.

**Home Health Care Agency -** a facility which:

a. provides skilled nursing and other services on a visiting basis in the Covered Person's home; and
b. is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

**Hospice** - an agency that provides counseling, medical services and may provide room and board to a terminally ill eligible individual and which meets all of the following:

- It has obtained any required state or governmental Certificate of Need approval;
- It provides service 24 hours a day, 7 days a week;
- It is under the direct supervision of a doctor;
- It has a nurse coordinator who is a registered nurse (R.N.);
- It has a social service coordinator who is licensed;
- It is an agency that has as its primary purpose the provision of Hospice services;
- It has a full-time administrator;
- It maintains written records of services provided to the patient; and
- It is licensed, if licensing is required.

**Hospice Facility-** a facility that provides supportive care for patients with a reduced life expectancy due to advanced illness as specified in the Hospice benefit in this SPD.

**Hospital** an accredited institution that meets all applicable regional, state and federal licensing requirements and that meets all of the criteria described below:

1. It is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense;
2. It is accredited by the Joint Commission on Accreditation of Hospitals;
3. It is a Hospital, a Psychiatric Hospital, or a tuberculosis Hospital as those terms are defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare;
4. It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified Physicians;
5. It continuously provides on the premises 24 hour-a-day nursing service by or under the supervision of registered graduate nurses; and
6. It is operated continuously with organized facilities for operative surgery on the premises.

A Hospital does not include, as determined by the Plan: (a) a convalescent or extended care facility unit within or affiliated with the Hospital; (b) a clinic; (c) a nursing, rest or convalescent

home or extended care facility; (d) an institution operated mainly for care of the aged or for treatment of Mental Illness or Alcoholism and Drug Abuse; (e) a health resort, spa or sanitarium; or (f) a sub-acute care center.

**Illness** - any physical or mental sickness or disease which manifests treatable symptoms and which requires treatment of a Physician. This definition will also include pregnancy.

**Incurred** - a charge is considered Incurred on the date the Covered Person receives the service or supply for which the charge is made.

**Injury** - any accidental bodily damage or hurt sustained while the Covered Person is covered under the Plan and which requires treatment by a Physician. Damage caused by chewing is not an Injury.

**Lifetime Maximum** - "Lifetime Maximum" refers to a maximum amount measured by the total period of an individual's participation in the Plan. It does not mean that an individual is entitled to coverage by the Plan for the individual's entire lifetime.

**Medically Necessary (or Medical Necessity)** – Health care services, supplies or treatment that are required to identify or treat the illness or injury which a physician has diagnosed or reasonably suspects. To be medically necessary the service, supplies or treatment must be:

- consistent with the diagnosis and treatment of the patient's condition
- consistent with professionally recognized standards of health care;
- not solely for the convenience of the patient, physician or supplier; and
- performed in the least costly setting required by the patient's medical condition.
- The fact that a physician may have prescribed, ordered, recommended, or approved the services, supplies or treatment does not necessarily mean that they satisfy the above criteria.

**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 Hospital Expense** - the regular Hospital charges (but not room and board, nursing services and ambulance services) covered under the Plan for care for an Illness or Injury requiring inpatient Hospitalization.

**Non-Covered Charges -** Billed Charges for services and supplies which are not Covered Services.

**Non-Participating -** the status of a Physician, Other Professional Provider, Hospital or Other Facility Provider that does not have a signed agreement with the Plan's PPO Network Provider regarding payment for Covered Services.

**Other Provider** - the following entities which are licensed (where required) and provide their patients with Covered Services in exchange for compensation.

Other Professional Providers include the following:

- Advanced nurse practitioner (A.N.P.);
- Ambulance services;

- Certified dietician;
- Certified nurse-midwife;
- Certified nurse practitioner;
- Certified registered nurse anesthetist (CRNA);
- Clinical nurse specialist;
- Dentist;
- Doctor of chiropractic medicine;
- Durable medical equipment or prosthetic appliance vendor;
- Laboratory (must be Medicare approved);
- Licensed independent social worker (L.I.S.W.);
- Licensed mental health and Alcoholism and Drug Abuse counselors;
- Licensed practical nurse (L.P.N.);
- Licensed professional clinical counselor;
- Licensed professional counselor;
- Licensed vocational nurse (L.V.N.);
- Mechanotherapist (licensed or certified prior to November 3, 1975);
- Midwife;
- Nurse practitioner;
- Occupational therapist;
- Ophthalmologist;
- Optometrist;
- Osteopath;
- Pharmacy;
- Physician assistant (PA);
- Physical therapist;
- Podiatrist;
- Psychologist;
- Registered nurse (R.N.);
- Registered nurse anesthetist; and
- Urgent Care Provider.

Other Provider Facilities include the following institutions:

- Alcoholism Treatment Facility;
- Ambulatory Surgical Facility;
- Birthing Center;
- Convalescent Facility/Skilled Nursing Facility/Rehabilitation Facility;
- Day/Night Psychiatric Facility;
- Dialysis Facility;
- Drug Abuse Treatment Facility;
- Home Health Care Agency;
- Hospice Facility**;**
- Psychiatric Hospital;
- Residential Treatment Facility.

**Out-of-Pocket Maximum** – a specified dollar amount of Copayment, Deductible and Coinsurance expense Incurred in a benefit period by a Covered Person for Covered Services as shown in the Schedule of Benefits.

**Participant** – an eligible Employee or Dependent who has selected and is participating in the Plan.

**Pharmacy** - an "Other Professional Provider" which is a licensed establishment where Prescription Drugs are dispensed by a pharmacist licensed under applicable state law.

**Physician** - a person who received a degree in medicine and is a medical doctor or surgeon licensed by the state in which he/she is located and provides services while he/she is acting within the lawful scope of his/her license. When the Plan is required by law to cover the services of any other licensed medical professional a Physician also includes such other licensed medical professional, for example, a chiropodist, podiatrist, dentist, or chiropractor who: (a) is acting within the lawful scope of his/her license; (b) performs a service which is covered under the Plan.

**Plan** – Coshocton County Commissioners Non-Grandfathered Employee Health & Welfare Plan.

**Plan Administrator** – Same entity as Plan Sponsor.

**Plan Documents** – the Plan's governing documents and instruments (i.e., the documents under which the Plan was established and is maintained), including but not limited to this summary of benefits.

**Plan Sponsor** – Coshocton County Commissioners.

**PPACA** – The Patient Protection and Affordable Care Act which was passed by Congress in 2010, also referred to as the Health Care Reform Act.

**PPO Network Provider** - a Physician, Other Professional Provider, contracting Hospital or contracting Other Facility Provider which is included in a limited panel of Providers as designated by the Participating Network(s) and for which the greatest benefit will be payable when one of these Providers is used.

**Pre-Admission Tests** - tests performed on you or your Dependent prior to Confinement as an inpatient, provided:

1. such tests are related to the performance of scheduled surgery;

2. such tests have been ordered by a duly qualified Physician after a Condition requiring such surgery has been diagnosed and Hospital admission for such surgery has been requested by the Physician; and

3. you or your Dependent are subsequently admitted to the Hospital, or the Confinement is canceled or postponed because a Hospital bed is unavailable or because there is a change in your or your Dependent's condition which precludes the surgery.

**Prescription Drug (Federal Legend Drug)** - any medication that by federal or state law may not be dispensed without a prescription order.

**Preventive Care** – As used in the SPD refer to Routine immunizations and other evidence-based items or services that are United States Preventive Services Task Force (USPSTF) A or

B recommendations or recommendations from other bodies such as the American Academy of Pediatrics.

**Protected Health Information (PHI)** – individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearing house and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

**Psychiatric Hospital** - a facility which is primarily engaged in providing diagnostic services and therapeutic services for the Inpatient treatment of mental Illness. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.

**Psychologist** - only a person who specializes in clinical psychology and fulfills the requirements specified in item (1) or (2) below, whichever is applicable:

1. A person who is licensed or certified as a Psychologist by the appropriate governmental authority having jurisdiction over such licensure or certification, as the case may be, in the jurisdiction where such person renders service to you or your dependent.

2. A person who is a Member or Fellow of the American Psychological Association, if there is no licensure or certification in the jurisdiction where such person renders service to you or your dependent.

**Qualified Medical Child Support Orders** - the term “Qualified Medical Child Support Order”, (QMCSO), means a Medical Child Support Order, (MCSO), which creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to receive benefits for which a Participant or beneficiary is eligible under the Plan. The term “Medical Child Support Order” means any court issued judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which provides for child support with respect to a child of a Participant under the Plan or provides for health coverage to such a child pursuant to a state domestics relations law and relates to benefits under the Plan.

The term “Alternate Recipient” means any child of a Participant who is recognized under a MCSO as having a right to enrollment under the Plan with respect to such Participant.

A person who is an Alternate Recipient under a QMCSO shall be considered a beneficiary under the Plan.

Any payment for benefits by the Plan, pursuant to a MCSO in reimbursement for expense paid by an Alternate Recipient or an Alternate Recipient’s custodial parent or legal guardian, shall be made to the Alternate Recipient or the Alternate Recipient’s custodial parent or legal guardian.

Upon receipt of the MCSO, the Plan shall immediately determine if such child is qualified. The MCSO must include the following to be considered a QMCSO:

1. The name and last known mailing address of the Participant;

2. The name and address of each Alternate Recipient;

3. A reasonable description of the type of coverage to be provided by the group health plan or the manner in which such coverage is to be determined;

4. The period for which coverage must be provided; and

5. Each Plan to which the order applies.

After determining whether the MCSO is or is not a QMCSO, the Claims Administrator shall notify all affected parties (including the Alternate Recipient) in writing. They will be given the opportunity to represent themselves or to designate a representative to receive all communications. The determination as to whether the QMCSO Participant is qualified or not, and whether coverage will be extended, will be provided in writing within 30 days of receipt of all requested documentation.

Coshocton County Commissioners shall not disenroll or eliminate coverage on such child until:

1. Satisfactory written evidence is provided that the court order or administrative order is no longer effective;
2. Satisfactory written evidence is provided that comparable coverage through another Plan will take effect no later than the disenrollment date; or
3. Coshocton County Commissioners eliminates family coverage for all Participants.

Changes made in order to provide benefits for any Dependent pursuant to a QMCSO as provided by ERISA 609 (a) (A) (I) shall be made any time, irrespective of the normal enrollment dates, as required by the Revenue Reconciliation Act of 1993.

If it is determined that the MCSO is a QMCSO, thereafter, the Alternate Recipient, for the appropriate period, shall be treated as a beneficiary under the Plan.

Benefits shall be provided in accordance with the applicable requirements of any QMCSO. However, the QMCSO shall not cause the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan.

**Recovered / Recovery** - monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the injuries or Illness whether or not said losses reflect medical or dental charges covered by this Plan.

**Refund** - repayment to this Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Illness.

**Residential Treatment Facility –** a facility that meets all of the following:

- An accredited facility that provides care on a 24 hours- 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.

**Skilled Nursing Care** - care furnished on a Physician's orders which require the skill of professional personnel such as a registered or licensed practical nurse and is provided either directly by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

1. Minimal custodial, ambulatory, or part-time care; or

2. Treatment for pulmonary tuberculosis.

**Stabilize** - to provide such medical treatment of an Emergency Medical 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.

**Subrogation** - this Plan's rights to pursue the Covered Person's claims for medical or dental charges against the other party.

**Totally Disabled (Total Disability)** - a condition resulting from disease or Injury in which, as certified by a Physician:

- Covered Person: You are unable to perform the substantial duties of any occupation or business for which you are qualified and are not in fact engaged in any occupation for wage or profit; or

- Dependent: you are substantially unable to engage in the normal activities of an individual of the same age and sex.

## GENERAL PLAN INFORMATION

| | |
|---|---|
| Plan Name: | Coshocton County Commissioners<br>Non-Grandfathered Employee Health & Welfare Plan |
| Plan Sponsor: | Coshocton County Commissioners<br>401 ½ Main Street<br>Coshocton, Ohio 43812-1586 |
| Employer Tax I.D. No.: | 31-6400064 |
| Claims Administrator: | Mutual Health Services<br>P.O. Box 5700<br>Cleveland, Ohio 44101<br>(330) 666-0337<br>1-800-367-3762 |
| Plan Number: | 501 |
| Type of Plan: | Self-Funded Employee Benefit Plan - a Group Health Plan |
| Plan Year: | January 1st – December 31st |
| Statutory Agent for Service of Legal Process: | The Plan Sponsor named above |

# Multi-Language Interpreter Services & Nondiscrimination Notice

MUTUAL HEALTH SERVICES℠

This document notifies individuals of how to seek assistance if they speak a language other than English.

**Spanish**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-367-3762.

**Chinese**

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-800-367-3762。

**German**

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-367-3762.

**Arabic**

ملحوظة:إذاكنتتتحدثاذكراللغة،فإنخدماتالمساعدةاللغويةتتوافرلك بالمجان.اتصلبرقم1-800-367-3762رقمهاتفالصموالبكم

**Pennsylvania Dutch**

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-367-3762.

**Russian**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-367-3762.

**French**

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-367-3762.

**Vietnamese**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-367-3762.

**Navajo**

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-367-3762.

**Oromo**

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-367-3762.

**Korean**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-367-3762 번으로 전화해 주십시오.

**Italian**

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-367-3762.

**Japanese**

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-800-367-3762 まで、お電話にてご連絡ください。

**Dutch**

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-367-3762.

**Ukrainian**

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-367-3762.

**Romanian**

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-367-3762.

**Tagalog**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-367-3762.

**QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MUTUAL HEALTH SERVICES' CUSTOMER CARE DEPARTMENT AT 1-800-367-3762.**

## Nondiscrimination Notice

Mutual Health Services complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Mutual Health Services does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Mutual Health Services provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Mutual Health Services provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

**If you need these services or if you believe Mutual Health Services failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.**

**Civil Rights Coordinator**
Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900

**Email:** CivilRightsCoordinator@MedMutual.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- Electronically through the Office for Civil Rights Complaint Portal available at:
  ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW Room 509F
  HHH Building
  Washington, DC 20201-0004
- By phone at:
  (800) 368-1019 (TDD: (800) 537-7697)
- Complaint forms are available at:
  hhs.gov/ocr/office/file/index.html