Final Draft

HANCOCK COUNTY SCHOOLS CONSORTIUM
MCCOMB LOCAL SCHOOLS
Dental and Vision Employee Benefit Plan

EFFECTIVE DATE
October 1, 2005

REVISED DATE
May 1, 2025

FOR COVERAGE INQUIRIES OR
TO CONTACT THE CLAIMS ADMINISTRATOR:

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P.O. Box 5700
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TABLE OF CONTENTS

INTRODUCTION 3

ELIGIBILITY 3
- EMPLOYEE ELIGIBILITY 3
- DEPENDENT ELIGIBILITY 3
- OMNIBUS BUDGET RECONCILIATION ACT (OBRA) 2
- ILLEGAL ALIEN 2
- QUALIFIED MEDICAL CHILD SUPPORT ORDERS 2
- ENROLLMENT IN THE PLAN 3
- OPEN ENROLLMENT 3
- SPECIAL ENROLLMENT RIGHTS 3
- VERIFICATION OF DEPENDENT STATUS 4
- VERIFICATION OF INCAPACITATED DEPENDENT STATUS 4

SCHEDULE OF BENEFITS 6

DENTAL BENEFITS 7
- PREDETERMINATION OF BENEFITS 7
- COVERED DENTAL EXPENSES 7
- SUMMARY OF DENTAL BENEFITS 7
- ALTERNATIVE PROCEDURES 10
- INCURRED DATES OF BENEFITS 10
- DENTAL EXCLUSIONS AND LIMITATIONS 10

VISION COVERAGE 13
- VISION EXAMINATIONS 13
- LENSES AND FRAMES 13
- CONTACT LENSES 13
- VISION COVERAGE LIMITATIONS 14
- VISION BENEFIT EXCLUSIONS 14

GENERAL INFORMATION 16
- CLAIMS PROCEDURES 16
- HEALTH CARE FRAUD 28
- PLAN AMENDMENTS 28
- RIGHT TO RELEASE CLAIMS AND RECEIVE NECESSARY INFORMATION 28
- DENTAL EXAMINATION 28
- FACILITY OF PAYMENT 28
- RIGHT OF RECOVERY 28
- COORDINATION OF BENEFITS 28
- SUBROGATION AND RIGHT OF RECOVERY 29
- PROVISIONS APPLICABLE TO ALL COVERAGE 33
- TERMINATION OF EMPLOYEE COVERAGE 34
- TERMINATION OF DEPENDENT COVERAGE 34
- FAMILY AND MEDICAL LEAVE 34
- COVERAGE DURING DISABILITY LEAVE 35
- HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) 35
- COBRA COVERAGE 38
- USERRA 44
- EFFECT OF MEDICARE ON THE PLAN 45

DEFINITIONS 47

GENERAL PLAN INFORMATION 52

INTRODUCTION

This booklet (otherwise known as the "Summary Plan Description" or "SPD") describes the dental and vision benefits provided by McComb Local Schools through the Hancock County Schools Consortium 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 you have elected.

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. McComb Local Schools through the Hancock County Schools Consortium 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 McComb Local Schools through the Hancock County Schools Consortium. McComb Local Schools through the Hancock County Schools Consortium, 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 McComb Local Schools through the Hancock County Schools Consortium 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 the Hancock County Schools Consortium and must be in accordance with the master agreement with the McComb Local Schools Education Association.

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 ELIGIBILITY

All full-time/part-time Employees who work for McComb Local Schools, are eligible for coverage per the Board policy and/or negotiated agreement. A contribution towards the cost of the Plan may be required by the Plan Sponsor for participation in the Plan. Should you wish to participate, you must complete an enrollment form. McComb Local Schools Treasurer's Office must receive the enrollment form within 31 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 includes:

1. Your lawful Spouse provided you are not legally separated;

2. Your natural children, adopted children, children placed for adoption with you, stepchildren (provided you remain married to the natural, living parent and the natural parent resides in your household) or legal wards, married or unmarried, are eligible for coverage until the end of the calendar month in which the child attains age 26. (Grandchildren are not covered under the Plan unless you have assumed legal guardianship for them).

Coverage may be continued beyond age 26 for your unmarried Dependent children who reside* with you or in an assisted living facility 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 31 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 McComb Local Schools or the Claims Administrator, that a child satisfies these eligibility criteria.

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

If both Spouses are Employees of McComb Local Schools, both may elect family dental and vision coverage and cover each other as Dependents as well as both Employees may cover the eligible Dependent children.

OMNIBUS BUDGET RECONCILIATION ACT (OBRA)

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

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

2. 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 may be required by McComb Local Schools for participation in the Plan. You are required to complete an enrollment form and return such form to McComb Local Schools Treasurer's Office within 31 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 31 days of becoming eligible. If you enroll after the initial 31-day enrollment period, you must follow the open enrollment or special enrollment provisions.

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 31 days of the child's birth for the child to be considered for coverage.

OPEN ENROLLMENT

Open enrollment will occur during the month of November with coverage becoming effective on January 1st. Open enrollment is available to Employees who initially did not enroll in the Plan and for Employees and/or Dependents that did not enroll at the time that a special enrollment occurred.

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. Termination of an Employee's or Dependent's coverage under Medicaid or under a state child health insurance plan (CHIP)
j. 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 "i" (termination of Medicaid or CHIP coverage) and "j" (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 "i" and "j" 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, 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.

SCHEDULE OF BENEFITS

DENTAL BENEFITS

Note: Dental Benefits are stand-alone, HIPAA-excepted benefits.

Calendar Year Maximum (per individual, Class I, II and III) $1,000.00

Orthodontic Lifetime Maximum ..... $1,500.00 per Participant
(Children to the age of 19)

Calendar Year Deductible (Class II and III only):
- Per individual $25.00
- Per family $50.00

Percentages Payable: All benefits will be based upon Dental Allowed Amount
- I. Preventive Services ..... 100%, not subject to Deductible
- II. Basic Services ..... 80%, subject to Deductible
- III. Major Services ..... 60%, subject to Deductible
- IV. Orthodontic Services ..... 60%, not subject to Deductible
  (Children to the age of 19)

VISION COVERAGE

Note: Vision Benefits are stand-alone, HIPAA-excepted benefits.

All benefits will be based upon Vision Allowed Amount

Vision Examinations (Limited to one exam every year) ..... $50.00, subject to $5.00 Copay
Includes refraction

Lenses (Limited to one pair every year)
- Single Vision Lenses ..... $35.00, subject to $5.00 Copay
- Bifocal Lenses ..... $50.00, subject to $5.00 Copay
- Trifocal Lenses ..... $65.00, subject to $5.00 Copay
- Lenticular Lenses ..... $100.00, subject to $5.00 Copay

Frames (Limited to one set every 2 years) ..... $75.00, subject to $5.00 Copay

Contact Lenses (Limited to one pair every year)
- Elective ..... 100% to $160.00
- Necessary ..... 100% to $180.00

Note: One pair of Contact Lenses may be purchased in lieu of the one pair of Lenses.

IMPORTANT: If you opt to receive vision care services or vision care materials that are not covered benefits under the Plan, a participating vision care provider may charge you his or her normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request.

Please be sure to review the “Vision Coverage” section of this document for a description of the vision care services and materials that are Covered Services under this Plan. You are responsible for any non-Covered Services you elect to receive.

DENTAL BENEFITS

Note: Dental Benefits are stand-alone, HIPAA-excepted benefits.

Calendar Year Maximum (per individual, Class I, II and III) $1,000.00

Orthodontic Lifetime Maximum .....$1,500.00 per Participant
(Children to the age of 19)

Calendar Year Deductible (Class II and III only):
Per individual.....$25.00
Per family $50.00

Percentages Payable: All benefits will be based upon Dental Allowed Amount
I. Preventive Services..... 100%, not subject to Deductible
II. Basic Services ..... 80%, subject to Deductible
III. Major Services..... 60%, subject to Deductible
IV. Orthodontic Services ..... 60%, not subject to Deductible
(Children to the age of 19)

PREDETERMINATION OF BENEFITS

Prior to beginning a course of treatment expected to cost $200.00 or more, a "Dental Treatment Plan" is suggested to be submitted to the Claims Administrator. A "Dental Treatment Plan" shall consist of a written report describing recommendations for necessary dental services and the cost for such services. A dental care claim form completed and signed by the Dentist shall be an acceptable "Dental Treatment Plan".

The Claims Administrator will notify the Dentist of the services that will be rendered and the benefits payable. If the predetermined work is not completed within six (6) months from the date of approval, a new predetermination will be requested.

COVERED DENTAL EXPENSES

Covered dental charges are the expenses Incurred by a Covered Person for charges made by a Dentist for any dental service if the dental service is performed by or under the direction of a Dentist, is essential for the necessary care of the teeth, is customarily used nationwide, and is deemed by the profession to be appropriate.

Dental coverage includes services provided through TeleDentistry, if those services would be covered under the Plan when delivered other than through TeleDentistry. All other terms and conditions of the Plan apply.

If the dental service is performed on the date other than the date the service was recommended or considered necessary, the dental service will be considered to begin on the date the actual performance of the service begins.

Dental expenses are payable at the applicable percentage of the Dental Allowed Amount. All charges are subject to the Calendar Year maximum and Deductible.

SUMMARY OF DENTAL BENEFITS

This summary includes a sample of the many services covered. Eligible dental expenses may include dental services not listed and a Dental Treatment Plan is recommended to determine the level of coverage, if any. The maximum covered dental expense for a dental service will be determined and will be consistent with those listed.

A temporary procedure such as a temporary filling, crown or preparatory procedure will be considered a part of the final dental service rather than a separate one.

I. PREVENTIVE SERVICES

1. Office visit during regular office hours for an oral examination (not more than 2 per year);

2. Prophylaxis (limited to 2 per year);

3. Topical application of fluoride including prophylaxis (limited to 2 per year);

4. Bitewings (not more than 2 per year);

5. Space Maintainers (for preventive measures) including all adjustments within six months after installation, limited to children under age 19;

6. Palliative Treatment;

7. Diagnostic X-ray;

8. Full Mouth X-rays (limited to one every 36 month).

II. BASIC SERVICES

1. Special consultation by a specialist for case presentation when diagnostic procedures have been performed by a general Dentist;

2. Pathology;

3. Oral Surgery including local anesthetics and routine postoperative care;

4. Extractions, including impacted (non-erupted) teeth;

5. Apicoectomy (surgical removal of the apex of the tooth root);

6. Vestibuloplasty;

7. Alveolar or Gingival Reconstructions;

8. Odontogenic Cysts and Neoplasms;

9. Anesthetics, general, only when provided in conjunction with a surgical procedure;

10. Periodontics except periodontal splinting;

11. Sealants for covered children up to age 19 (limited to one every 3 years);

12. Endodontics, including root canals;

13. Repair of prosthetics including dentures, crowns, bridges and partials;

14. Fillings made of silver amalgam, silicate or plastic;

15. Restorative Dentistry, excludes inlays, crowns and bridges (Multiple restoratives in one surface will be considered as a single restoration);

16. Repair and recementation of crowns, inlays, onlays, bridges and dentures.

III. MAJOR SERVICES

1. Restorative. Gold restorations and crowns are covered only as treatment for a decay or traumatic Injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge;

2. Inlays and Onlays;

3. Crowns;

4. Prosthodontics;

5. Bridge Abutments;

6. Pontics;

7. Removable Bridge (unilateral). One piece casting, chrome cobalt alloy clasp attachment (all types) including pontics;

8. Dentures and partials (Fees for dentures, partial dentures and relining within six months after installation. Specialized techniques and characterizations are not eligible).

IV. ORTHODONTIC SERVICES

Orthodontic services consisting of installing tooth straightening appliances and all treatments for abnormally positioned teeth, subject to the following limitation:

Benefits for orthodontic treatment are payable for a covered Dependent child who is less than age 19 on the date the treatment commences.

An "Orthodontic Treatment Plan" is a report on a form satisfactory to the Plan that among other things describes the recommended treatment, gives the estimated charge, and is accompanied by cephalometric x-rays, study models and other supporting evidence.

Eligible charges are those made for an orthodontic procedure that:

1. Is in an "Orthodontic Treatment Plan" that has been reviewed by the Plan prior to the treatment and has been returned to the Dentist showing estimated benefits.

2. Is required by an overbite of at least four millimeters, cross bite, or protrusive or retrusive relationship of at least one cusp.

The claim will be paid in installments beginning when the orthodontic appliances are first inserted, and monthly thereafter for the estimated duration of the plan, as long as the patient remains covered or for a maximum period of two years. The installments will be paid in equal amounts, except that the initial payment will be twice the subsequent monthly amounts. If the actual eligible charges for the Orthodontic Treatment Plan are less than or more than the estimated eligible charges, the last installment above will be:

1. reduced by any excess of estimated over actual; or
2. increased by an excess of actual over estimated.

ALTERNATIVE PROCEDURES

There is often more than one way customarily used by Dentists to treat a dental condition. Different materials or procedures may be used to correct the same condition.

For example, a tooth could be repaired with an amalgam filling. That same tooth could also be repaired with a more expensive cap (crown) or gold filling. The Plan will allow as eligible charges only the least expensive service and supplies which are appropriate and meet acceptable dental standards.

The patient and the Dentist may decide upon the more expensive treatment. If so, the patient must pay the charges which are greater than the covered charge for the less expensive appropriate treatment. Because the Plan has this alternative procedure provision, it is important for the patient to use The Dental Treatment Plan. This will notify the patient the amount the Plan will pay for the treatment.

INCURRED DATES OF BENEFITS

A charge is Incurred on:

1. The date the impression is taken, in the case of dentures or fixed bridges;
2. The date the preparation of the tooth is begun, in the case of crown work;
3. The date the work on the tooth is begun, in the case of root canal therapy; and
4. The date the work is done, in the case of any other work.

DENTAL EXCLUSIONS AND LIMITATIONS

Covered dental charges do NOT include charges for services and supplies:

1. Not furnished by a Dentist, unless they are performed by a licensed dental hygienist, or an expanded function dental auxiliary, under the direction of a Dentist and that meet the specifications set forth in the appropriate section of the Ohio Revised Code;

2. Rendered by more than one Dentist. If you change Dentists during a Course of Treatment or if more than one Dentist treats you for a procedure, additional benefits are provided;

3. Which do not meet the standards set by the American Dental Association;

4. For charges in excess of the Dental Allowed Amount;

5. Due to loss or theft of an appliance;

6. Which a Participant would not legally have to pay if there were no coverage;

7. Due to war, if declared or not;

8. From a health department maintained by an employer, a trustee or a similar type of entity;

9. Which are payable by a government agency, local or other;

10. For cosmetic reasons, including altering or extracting and replacing sound teeth to change appearance except when necessary as a result of accidental Injury;

11. For these items:
    - Tooth implants;
    - Athletic mouthguards;
    - Oral hygiene, dietary, plaque control and other educational programs;
    - Duplicate prosthetic appliances; and
    - Porcelain veneered crowns or pontics placed on or in place of a tooth behind the second bicuspid, to the extent the charges would be more than the charge that would have been a covered dental charge for acrylic veneered crowns or pontics;

12. For services rendered in connection with work-related sickness or Injury;

13. For congenital or developmental malformation or other services primarily to improve appearance;

14. Sealants over the age of 19;

15. Replacement of a partial or full removable denture, a removable bridge or fixed bridgework, or a crown or gold restoration within five years of installation;

16. A charge for a service not included on the list of Covered Services, unless the unlisted service is a professionally acceptable alternative to a Covered Service. The charge will be covered as if the Covered Service was rendered;

17. A charge for a service to the extent that it is more than the usual or prevailing charge made by the provider for the service in the area where it was performed;

18. Appliances, restorations or procedures needed to alter vertical dimensions or restore occlusion or for splinting or correcting attrition or abrasion (except in the case of approved orthodontic treatment);

19. A gold restoration or gold crown unless:
    - It is treatment for decay or traumatic Injury and the tooth cannot be restored with a filling material; or
    - The tooth is an abutment to a covered partial denture or fixed bridge.

20. For orthodontic treatment which began prior to the Participant's effective date;

21. Any charges for an orthodontic procedure if an active appliance for that orthodontic procedure has been installed before the first day on which the person became a Participant;

22. Sterilization supplies and other infection control procedures;

23. For completion of claim forms, or missed appointments; and

24. For the repair of a damaged space maintainer or replacement of a lost or stolen space maintainer.

VISION COVERAGE

Note: Vision Benefits are stand-alone, HIPAA-excepted benefits.

All benefits will be based upon Vision Allowed Amount

Vision Examinations (Limited to one exam every year) ..... $50.00, subject to $5.00 Copay
Includes refraction

Lenses (Limited to one pair every year)
- Single Vision Lenses ..... $35.00, subject to $5.00 Copay
- Bifocal Lenses ..... $50.00, subject to $5.00 Copay
- Trifocal Lenses ..... $65.00, subject to $5.00 Copay
- Lenticular Lenses ..... $100.00, subject to $5.00 Copay

Frames (Limited to one set every 2 years) ..... $75.00, subject to $5.00 Copay

Contact Lenses (Limited to one pair every year)
- Elective ..... 100% to $160.00
- Necessary ..... 100% to $180.00

Note: One pair of Contact Lenses may be purchased in lieu of the one pair of Lenses.

IMPORTANT: If you opt to receive vision care services or vision care materials that are not covered benefits under the Plan, a participating vision care provider may charge you his or her normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request.

Please be sure to review the "Vision Coverage" section of this document for a description of the vision care services and materials that are Covered Services under this Plan. You are responsible for any non-Covered Services you elect to receive.

VISION EXAMINATIONS

A comprehensive examination of the visual functions to determine the presence of visual problems and/or other abnormalities, including the prescription of corrective eye wear where indicated.

Vision examinations are a Covered Service payable as listed in the Vision Schedule of Benefits.

LENSES AND FRAMES

When the vision examination indicated lenses or frames or both are necessary for the proper visual health and welfare of a Covered Person, they will be supplied, together with such professional services as are necessary to the prescribing and fitting of the proper eye wear.

If a Covered Person wishes to select a more expensive lenses and/or frame than allowed under the program, the cost difference shall be the responsibility of the Covered Person.

CONTACT LENSES

Necessary - Contact lenses and the necessary ophthalmic materials are furnished when the Covered Person secures prior approval for any of the following Conditions:

1. Following cataract surgery
2. To correct visual acuity problems not correctable with spectacle lenses
3. To correct for significant anisometropia
4. Keratoconus

When the Covered Person receives prior approval for such cases, they will be fully covered in lieu of all other benefits for the Benefit Period.

Contact lenses, once furnished under the Plan, can only be replaced once in any Calendar Year.

Elective (Cosmetic) - If contact lenses are chosen for reasons other than above, they are considered cosmetic in nature. An allowance of $160.00 will be made toward their cost in lieu of all other benefits for the Benefit Period of once per Calendar Year.

VISION COVERAGE LIMITATIONS

This Plan is designed to cover visual needs rather than cosmetic desires. Thus, when a Covered Person selects any of the following cosmetic extras which are not covered under this program, the Plan will pay the basic cost of the allowed lenses or frames and the Covered Person will pay the additional costs for cosmetic extras by agreement between the Covered Person and the provider.

1. Blended or progressive multifocal lenses
2. Oversized lenses
3. Frames exceeding the Plan allowance
4. Two pair of glasses in lieu of bifocals
5. Contact lenses (in excess of the Plan allowance)
6. Tinted or coated lenses (other than pink #1 or #2)
7. Prescription sunglasses
8. Sales tax

VISION BENEFIT EXCLUSIONS

1. Diagnostic services, drugs or medications not part of a vision examination.
2. Eye examinations or materials ordered as a result of an eye examination prior to your Effective Date.
3. Safety glasses and safety goggles.
4. Tints with photosensitive or antireflective properties.
5. Illness or Injury arising out of or in the course of employment, or for a sickness covered by Worker's Compensation.
6. A frame that costs more than the Plan allowance.

7. Care received without cost under the laws of the United States or any political subdivision thereof.

8. Disease or Injury resulting from an act of war.

9. Cosmetic contact lenses in excess of the Plan allowance.

10. Orthoptics or vision training, low vision aids, or plano (non-prescription) lenses.

11. Lenses and frames furnished under this program which are lost, broken or scratched. They will not be replaced, except at the normal intervals when services are otherwise available.

12. Medical or surgical treatment of the eyes.

13. Any eye examination or corrective eye wear required by an employer as a condition of employment.

14. For services provided by a member of the immediate family. Immediate family shall be required as mother, father, grandmother, grandfather, mother-in-law, father-in-law, sister, brother, husband, wife, child or anyone who currently holds the position of parent or child, or anyone who is a relative residing in the household of the Employee.

15. For charges which would not have been made had coverage not existed.

16. For unnecessary care and treatment.

17. For experimental services, procedures, or substances which have not been recognized by established medical review mechanisms as accepted standards of medical practice.

18. For radial keratotomy or keratoplasty.

19. For lenses which are not prescribed.

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. 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

A claim must be filed for you to receive benefits. The following provision applies when you are submitting the claim yourself.

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

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.

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:

http://insurance.ohio.gov/consumer/pages/healthcoverageappealtoolkit.aspx

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.

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.

DENTAL EXAMINATION

Mutual Health Services shall, upon request and at the expense of The Plan and by a Dentist of its own choice, have the right and opportunity to physically examine any covered individual with respect to the surgical and dental 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.

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 to that Provider for this Plan and/or other plans administered by Mutual Health Services. This right does not affect any other right of recovery Mutual Health Services may have with respect to overpayments.

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 dental or vision 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 dental or vision 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:

1. Any HMO's and other group or individual practice plans;
2. 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;
3. Coverage under labor-management trusteed plans;
4. Coverage under union welfare plans;
5. 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:
   - Primary will be the plan of the parent who, by court decree, is responsible for providing dental or vision coverage.
   - Secondary will be the plan of the other natural parent. *
   - 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 parents, 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, extend 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 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 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 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 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 and 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 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; or
2. The last day of the calendar month in which you become ineligible; or
3. The date that you die; or
4. When you cease your contributions toward the Plan; or
5. The date you enter into military service, other than for a duty of less than 30 days, or as specified in the USERRA section of this Plan.

TERMINATION OF DEPENDENT COVERAGE

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

1. When the Employee's coverage terminates; or
2. When the Employee ceases to make the required contribution regarding Dependent coverage; or
3. The date the child becomes covered as an Employee; or
4. The last day of the calendar month the child reached the applicable age for Dependent children; or
5. When this Plan is discontinued.

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

1. When the Employee's coverage terminates; or
2. When the Employee ceases to make the required contribution regarding Dependent coverage; or
3. The last day of the calendar month the Spouse is legally separated or divorced from the Employee; or
4. When this Plan is discontinued.

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 McComb Local Schools, 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 McComb Local Schools 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 McComb Local Schools 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.

COVERAGE DURING DISABILITY LEAVE

Coverage during disability leave will be subject to Board policy and/or negotiated agreement.

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. Treasurers
2. Superintendents

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 McComb Local Schools Dental and Vision Employee Benefit 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 McComb Local Schools Dental and Vision Employee Benefit Plan Document.

D. *Plan Sponsor* –Hancock County Schools Consortium, McComb Local Schools.

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 McComb Local Schools 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 McComb Local Schools.
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 McComb Local Schools.
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.

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 McComb Local Schools 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. McComb Local Schools 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 McComb Local Schools 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.

McComb Local Schools
Attn: Treasurer
328 South Todd Street
McComb, OH 45858
(419) 293-3979

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 McComb Local Schools (advance notice to McComb Local Schools 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 McComb Local Schools as follows:
   - On the first business day following completion of military service for a leave of thirty (30) days or less; or
   - Within fourteen (14) days of completion of military service for a leave of thirty-one (31) days to one hundred-eighty (180) days; or
   - 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

Benefit Period – the period of time specified in the Schedule of Benefits during which Covered Services are rendered, and benefit maximums, Deductibles and Coinsurance Limits are accumulated. The first and/or last Benefit Periods may be less than 12 months depending on the Effective Date and the date your coverage terminates.

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

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.

Certificate of Creditable Coverage - a certification of coverage to individuals who cease to be covered under a plan.

Charges – the Provider's list of charges for services and supplies before any adjustments for discounts, allowances, incentives or settlements.

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 percentage of the Lesser Amount for which you are responsible after you have met your Deductible.

Condition – an injury, ailment, condition, disease, illness or disorder.

Covered Charges – the Billed Charges for Covered Services.

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.

Creditable Coverage - coverage under any previous health plan, individual or group coverage, private or public, including Medicare and military coverage.

Custodian – a person who, by court order, has custody of a child.

Deductible – an amount, usually stated in dollars, for which you are responsible each Benefit Period.

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.

Dental Hygienist - a person who is licensed to practice Dental hygiene and is working under the supervision and direction of a Dentist.

Dentally Necessary (or Dental Necessity) - service or supply provided by a Dental Care Provider that is required to diagnose or treat a condition, Illness or Injury and which the Plan determines is:

1. appropriate with regard to standards of good dental practice;
2. not primarily for the convenience of the patient or a Dental Care Provider;
3. the most appropriate supply or level of service which can be safely provided to the patient. When applied to the care of an inpatient, this means that your dental symptoms or condition cannot be safely or adequately provided to you as an outpatient.

Dentist - a person who is licensed to practice Dentistry.

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

Effective Date – 12:01 a.m. on the date when your Coverage begins, as determined by your Group.

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

Employee - Any common law employee of McComb Local Schools. The term "Employee" excludes any person who is not classified by McComb Local Schools 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.

Immediate Family – the Covered Person and the Covered Person's spouse, parents, stepparents, grandparents, nieces, nephews, aunts, uncles, cousins, brothers, sisters, children and stepchildren by blood, marriage or adoption.

Incurred - a charge, rendered to you by a Provider, 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.

Legal Guardian – an individual who is either the natural guardian of another or who was appointed a guardian in a legal proceeding by a court, having the appropriate jurisdiction.

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.

Medicare – the program of health care for the aged and disabled established by Title XVII of the Social Security Act of 1965, as amended.

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

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 – the McComb Local Schools Dental and Vision Employee Benefit 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 –Hancock County Schools Consortium, McComb Local Schools.

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.

Provider – a Hospital, Other Facility Provider, Physician or Other Professional Provider.

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.

McComb Local Schools 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. McComb Local Schools eliminates family coverage for all Participants.

Changes made in order to provide benefits for any Dependent pursuant to a QMCSO 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 dental or vision charges covered by this Plan.

Refund - repayment to this Plan for dental or vision benefits that it has paid toward care and treatment of the Injury or Illness.

Spouse – your legal Spouse provided you are not legally separated.

Subrogation - this Plan's rights to pursue the Covered Person's claims for dental or vision charges against the other party.

TeleDentistry - the delivery of dental services through the use of synchronous, real-time communication and the delivery of services of a dental hygienist or expanded function dental auxiliary pursuant to a Dentist's authorization.

Totally Disabled (Total Disability) - a Condition resulting from disease or Injury, as certified by a Physician:

1. 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
2. Dependent: you are substantially unable to engage in the normal activities of an individual of the same age and gender.

United States – all the states, the District of Columbia, the Virgin Islands, Puerto Rico, American Samoa, Guam and the Northern Mariana Islands.

Vision 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.

GENERAL PLAN INFORMATION

Plan Name:	McComb Local Schools Dental and Vision Employee Benefit Plan through The Hancock County Schools Consortium
Plan Sponsor:	Hancock County Schools Consortium McComb Local Schools 328 South Todd Street McComb, OH 45858
Employer Tax I.D. No.:	31-1514359
Claims Administrator:	Mutual Health Services P.O. Box 5700 Cleveland, Ohio 44101 (330) 666-0337 1-800-367-3762
Plan Number:	504
Type of Plan:	Self-Funded Employee Benefit Plan – a Group Dental and Vision Plan
Plan Year Ends:	September 30th
Statutory Agent for Service of Legal Process:	The Plan Sponsor named above