Final Draft

HANCOCK COUNTY SCHOOLS CONSORTIUM
MCCOMB LOCAL SCHOOLS
Non-Grandfathered
High Deductible Health Plan

EFFECTIVE DATE
October 1, 2014

REVISED DATE
May 1, 2025

FOR COVERAGE INQUIRIES OR
TO CONTACT THE CLAIMS ADMINISTRATOR:

MUTUAL HEALTH SERVICES
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INTRODUCTION

This booklet (otherwise known as the "Summary Plan Description" or "SPD") describes the health care 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 available to you.

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

This Plan is a self-funded benefit plan. 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. McComb Local Schools, 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 McComb 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 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 FOR MEDICAL AND PRESCRIPTION BENEFITS

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 coverage, but only one may elect Dependent coverage. In no event may an individual be covered both as an Employee and as a Dependent under the Plan. Dependent children may be covered as Dependents of either Spouse, but not both. In no event will a Dependent's coverage become effective before an Employee's coverage.

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

DEPENDENT ELIGIBILITY FOR DENTAL AND VISION BENEFITS

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.

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 not 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 or initiation of legal proceedings severing spousal or parental rights.

VERIFICATION OF INCAPACITATED DEPENDENT STATUS

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

PREFERRED PROVIDER ORGANIZATION (PPO)

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

No Surprise Billing

"Surprise billing" is an unexpected bill that can happen when you can't control who is involved in your care; for example, when you have an emergency, or when you schedule a visit to a PPO Network Provider but are unexpectedly treated by a Non-PPO Network Provider or Non-Contracting Health Care Provider.

You have protection against surprise billing and balance billing for the services described below. Non-PPO Network Providers and Non-Contracting Health Care Providers cannot balance bill you for these services; however, you are still responsible for paying any Copayments, Deductibles or Coinsurance due under this Plan. The amount of that cost-sharing will be based upon the PPO network level of benefits and will accumulate toward your PPO network Out-of-Pocket Maximum as specified in the Medical Schedule of Benefits.

- Emergency Services
- Ambulance services received from a Non-PPO Network Provider or Non-Contracting Health Care Provider. Please refer to the Ambulance Services benefit for additional information.
- Unanticipated Covered Services received from a Non-PPO Network Provider or Non-Contracting Health Care Provider at a PPO Network Provider or Contracting Hospital or ambulatory surgical center. This means: 1) items and services related to Emergency Services; 2) anesthesia, pathology, radiology, lab and neonatology; 3) items and services provided by an assistant surgeon, hospitalist, or intensivist; 4) diagnostic services, including radiology and lab services; 5) items and services provided by a Non-PPO Network Provider or Non-Contracting Health Care Provider, but only if there is no PPO Network Provider who can furnish the item or service at that facility; and 6) any additional services required by applicable state or federal law or subsequent guidance issued thereto.

There may be occasions where you knowingly and purposefully seek care from a Non-PPO Network Provider or Non-Contracting Health Care Provider and voluntarily give consent for services for which you can be balance billed. For example, if you have a complex health Condition and want to be treated by a specialist who is not in this Plan's PPO network, and that specialist will not treat you unless he or she can bill you directly, including any balance billing. Before you can consent to be balance billed, your Non-PPO Network Provider or Non-Contracting Health Care Provider must give you, or your authorized representative, a written notice, in advance of performing the service, that includes detailed information designed to ensure that you knowingly accept the out-of-pocket charges. The notice must also include an estimate of the Health Care Provider's charge for the services. **If you voluntarily give written consent after receiving the notice, your Copayments, Deductibles and Coinsurance will be based upon the Non-PPO network level of benefits shown in the Schedule of Benefits, and you will also be responsible for any balance billing for the services received.**

In addition, services rendered by a Non-PPO Network Provider or Non-Contracting Health Care Provider will be considered at the PPO level of benefits if:

- The Covered Person has no choice of a PPO Network Provider in the specialty that the Covered Person is seeking within the PPO service area;
- The Covered Person does not live within a 50-mile radius of a PPO Network Provider or Contracting Health Care Provider;
- The eligible dependent child resides outside of the PPO service area.

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

Continuity of Care when a Health Care Provider's contract with the PPO network ends without cause

If a Health Care Provider's contract with the PPO network ends:

- The Claims Administrator will notify each Covered Person enrolled in the Plan who is a Continuing Care Patient of that Health Care Provider at the time of termination of his or her right to elect continued transitional care under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under the Plan had such termination not occurred, with respect to the course of treatment furnished by the Health Care Provider to the Continuing Care Patient.
- When the Claims Administrator is notified of the Continuing Care Patient's need for transitional care, the Claims Administrator will determine if the Continuing Care Patient is eligible for a transition period. Such period will continue for ninety (90) days from the date the Continuing Care Patient was notified of the Health Care Provider's contract ending or when the Continuing Care Patient is no longer a Continuing Care Patient, whichever occurs first.

For the purpose of this provision, the definitions of "Continuing Care Patient" and "Serious and Complex Condition" are shown below.

Continuing Care Patient means an individual who, with respect to a Health Care Provider or facility:

- Is undergoing a course of treatment for a Serious and Complex Condition from the Health Care Provider or facility;
- Is undergoing a course of institutional or inpatient care from the Health Care Provider or facility;
- Is scheduled to undergo nonelective surgery from the Health Care Provider, including receipt of postoperative care from such Health Care Provider or facility with respect to such a surgery;
- Is pregnant and undergoing a course of treatment for the pregnancy from the Health Care Provider or facility; or
- Is or was determined to be terminally ill and is receiving treatment for such Illness from such Health Care Provider or facility.

Serious and Complex Condition means:

- In the case of an acute Illness, a Condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- In the case of a chronic Illness or Condition, a Condition that is:
    - Life-threatening, degenerative, potentially disabling, or congenital; and
    - Requires specialized medical care over a prolonged period of time.

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

Medical Mutual SuperMed PPO

Cigna PPO*

Please refer to your identification card to determine which network is primary for you.

*The Cigna PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna PPO for Shared Administration.

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SCHEDULE OF BENEFITS
COMPREHENSIVE MAJOR MEDICAL BENEFITS

All benefits will be based upon Allowed Amount

Overall Benefit Period Maximum per Individual .....Unlimited

<u>Network</u> (PPO Network Providers)

Calendar Year Deductible:

Per Individual.....$3,300.00
Per Family $6,600.00

Then: 100% payment on eligible charges thereafter for that Individual for the remainder of that Calendar Year.

Out-of-Pocket Maximum per Calendar Year (including any applicable Medical and Prescription Deductible and Coinsurance):

Per Individual.....$3,300.00
Per Family $6,600.00

<u>Non-Network</u> (Non-PPO Network Providers)

Calendar Year Deductible:

Per Individual.....$5,000.00
Per Family $10,000.00

Then: all eligible charges will be paid at 60% until the Out-of-Pocket Maximum has been satisfied.

With: 100% payment on eligible charges thereafter for that Individual for the remainder of that Calendar Year.

Out-of-Pocket Maximum per Calendar Year (including the Deductible and Coinsurance):

Per Individual.....$11,000.00
Per Family $22,000.00

NOTE: Deductibles and Out-of-Pocket Maximums cross apply In-Network and Non-Network.

COVERED SERVICES

Subject to Deductible unless otherwise stated:	Percentage Payable Network	Non-Network
Emergency Room		
Emergency Room Medical/Accident (Including Ancillaries and Physician)	100%	
Non-Emergency Emergency Room (Including Ancillaries and Physician)	100%	60%
Inpatient Services		
Anesthesia	100%	60%
Consultations	100%	60%
Newborn Care	100%	60%
Institutional Services (precertification is required for non-Emergency Services)	100%	60%
Physical Medicine and Rehabilitation	100%	60%
Professional Services	100%	60%
Skilled Nursing Facility	100%	60%
Surgical Services	100%	60%

Mental Illness, Alcoholism and Drug Abuse

In accordance with Federal Mental Health Parity requirements, this Plan will not apply any financial requirement or treatment limitation to Mental Illness, Alcoholism or Drug Abuse benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits in the same classification.

Office Visit (Illness/Injury)		
Physician/Specialist Office Visit (exam only) Including Scheduled Telehealth Services.	100%	60%
On-Demand, Virtual Telehealth Services	$49 until the Deductible is met, then 100%	60%
Urgent Care Office Visit (includes facility)	100%	60%
Urgent Care Related Services	Benefits are paid based on the services rendered	
Outpatient Services		
Allergy Testing and Treatment	100%	60%
Diagnostic Imaging/Lab/Medical Tests/X-ray	100%	60%
Diabetic Education and Training (not required by Health Care Reform)	100%	60%
Home Health Care	100%	60%

COVERED SERVICES

Subject to Deductible unless otherwise stated:	Percentage Payable Network	Non-Network
Outpatient Services continued		
Pre-Admission Testing	100%	60%
Surgical Services Including Anesthesia, Assistant Surgeon, Surgery Professional and Surgery Facility	100%	60%
Outpatient Therapy		
Cardiac Rehabilitation	100%	60%
Chemotherapy	100%	60%
Chiropractic Care	100%	60%
Dialysis Treatment	100%	60%
Hyperbaric Therapy	100%	60%
Occupational Therapy	100%	60%
Physical Therapy	100%	60%
Pulmonary Therapy	100%	60%
Radiation Therapy	100%	60%
Speech Therapy	100%	60%
Preventive/Wellness		
Preventive Benefits in compliance with Health Care Reform	100% no Deductible	60% Unless otherwise stated below
Women's Preventive Health Benefits	100% no Deductible	60% Unless otherwise stated below
Exam associated with Pap Test (1 per Calendar Year)	100% no Deductible	60%
Immunizations (age 21 and over)	required by Health Care Reform: 100% no Deductible not required by Health Care Reform: 100%	60%
Physical Exam (age 21 and over)	100% no Deductible	60%
Prostate Exam	100% no Deductible	60%
Bone Density Tests	required by Health Care Reform: 100% no Deductible not required by Health Care Reform: 100%	60%

Colorectal cancer screenings, including colonoscopy, sigmoidoscopy and fecal occult blood test as required by PPACA.....100% no Deductible 60%

COVERED SERVICES

Subject to Deductible unless otherwise stated:	**Percentage Payable Network**	**Non-Network**
Preventive/Wellness continued		
Lab, Medical Tests and X-rays……. required by Health Care Reform: 100% no Deductible not required by Health Care Reform: 100%		60%
Mammogram (all ages; no Deductible) 100%		100%
Supplemental Breast Cancer Screening……Benefits are paid based on the services rendered		
Pap Test (1 per Calendar Year; no Deductible).....100%		100%
PSA Tests (Office visit is covered)…….100% no Deductible		60%
Well Child Care (birth to age 21) .....100% no Deductible Including: exams, hearing exams, immunizations, and vision exams (including refractions)		60%
Well Child Labs (birth to age 21)……. required by Health Care Reform: 100% no Deductible not required by Health Care Reform: 100%		60%
Additional Services		
Abortions……..Benefits are paid based on the services rendered Spontaneous miscarriages and therapeutic only		
Ambulance.....100%		60%
Attention Deficit Disorder (ADHD)……Benefits are paid based on the services rendered		
Autism Spectrum Disorders, including Applied Behavior Analysis (ABA)…….Benefits are paid based on the services rendered		
Durable Medical Equipment.....100%		60%
Gender Affirming Surgery…..……..……Benefits are paid based on the services rendered		
Hospice.....100%		60%
Learning Disorders……Benefits are paid based on the services rendered		
Medical Supplies.....100%		60%
Oral Accident……...Benefits are paid based on the services rendered		
Organ Transplant……Benefits are paid based on the services rendered		

Private Duty Nursing.....100% 100%

Sleep Disorders……..Benefits are paid based on the services rendered

COVERED SERVICES

Subject to Deductible unless otherwise stated:	**Percentage Payable Network**	**Non-Network**
Additional Services continued		
Therapeutic Injections.....100%		60%
Diabetic Supplies as listed below.....100% no Deductible		60%

Coverage is only provided for: External infusion pumps, syringe with needle for external insulin pump, glucose monitor, transmitter (external) for use with non-DME interstitial continuous glucose monitoring, blood glucose test or reagent strips, lancets, alcohol wipes, and insulin infusion pumps.

Hearing Aids (birth to age 22)…….....…100% 60%
One per ear, up to $2,500 every 48 months

Hearing Aid Related Services (birth to age 22)… .....…100% 60%

Prescription Drug Benefits – combined with the Medical Benefits; subject to the Network Deductible and Out-of-Pocket Maximum

(Prescription Drug Benefits are administered by RxBenefits, Inc. and Express Scripts)

Preventive Drug Benefits in compliance with PPACA……..100% no Deductible Not Covered

Major Medical Drug Coverage……100% Not Covered
Including Retail Pharmacy and Mail Order Coverage up to a 90-day supply and Specialty Medication* Coverage up to a 30-day supply.

*Specialty medications must be obtained through Accredo specialty pharmacy by calling Accredo at 1-800-803-2523.

Out-of-Pocket Maximum per Calendar Year:

Any Deductibles or Coinsurance that apply to this benefit will count toward the Network Out-of-Pocket Maximum shown in the Comprehensive Major Medical Benefits section of this Schedule. (There is no Out-of-Pocket Maximum for charges received from a Non-Network Provider.)

For more information on the Prescription Drug Benefits, please contact Quantum Member Services at 1-866-790-4419 or RxBenefits Member Services at 1-800-334-8134 or visit express-scripts.com. If there are any additional questions, please contact your Human Resource Department.

NO SURPRISES ACT

Ohio's House Bill 388 and the Federal No Surprises Act establish patient protections, including surprise bills (or "balance billing") from Non-PPO Network Providers and from Non-Contracting Health Care Providers for emergency care and other specified items or services. The Plan will comply with these new state, if applicable, and federal requirements, including how claims are processed from some of these Providers.

DENTAL SCHEDULE OF BENEFITS

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

All benefits will be based upon Dental Allowed Amount

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:
- 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 SCHEDULE OF BENEFITS

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.

MYQHEALTH BY QUANTUM HEALTH'S CARE COORDINATION PROCESS

INTRODUCTION

The Plan incorporates a "Care Coordination" process by MyQHealth which leverages resources including but not limited to your employer, the Plan and the Third Party Administrator, your Provider and your community to help you best navigate the healthcare system. This process includes a staff of Care Coordinators who receive notifications regarding most healthcare services sought by Covered Persons, and coordinate activities and information flow between the Providers.

Care Coordination is intended to help Covered Persons obtain quality healthcare and services in the most appropriate setting, help reduce unnecessary medical costs, and ensure early identification of Covered Persons with complex medical Conditions. The Care Coordinators are available to Covered Persons and their Providers for information, assistance, and guidance, and can be reached toll-free by calling:

CARE COORDINATORS: 1-866-790-4419

It is important to note that clinical reviews are done to determine Plan coverage and are conducted by the clinical staff of MyQHealth.

CARE COORDINATION REQUIREMENTS

Except as otherwise stated in the "No Surprise Billing" section of this SPD, in order to receive the highest benefits available in the Plan, Covered Persons must follow the Care Coordination process outlined in this section, as well as other provisions in the Plan. In some cases, failure to follow this process can result in significant benefit reductions, penalties or even loss of benefits for specific services.

The Care Coordination process generally includes:

- Use of in-network Providers
- Designating a Coordinating Provider (PCP)
- Referrals from a PCP for all visits to specialist Providers
- The Care Coordination Process and Utilization Management
    - Preauthorization and Clinical Review
    - Concurrent Utilization Review
    - Personal Care Guide Management

Use of In-Network Providers

The Plan offers a broad network of Providers and provides the highest level of benefits when Covered Persons utilize "in-network" Providers. These networks will be indicated on your Plan identification card. **Services provided by out-of-network Providers may not be eligible for the highest benefits**. Specific benefit levels are shown in the Schedule of Benefits.

Designated Coordinating Provider

All Covered Persons are asked to designate a coordinating Primary Care Provider (PCP) for each Covered Person of their family. While such designation is not mandatory, it is strongly recommended. **To ensure the highest level of benefits (except as otherwise stated in the "No Surprise Billing" section of this SPD), and the best coordination of your care, all Covered Persons are encouraged to designate an in-network Primary Care Provider (PCP) to be their coordinating Provider.** The Care Coordination process generally begins with the coordinating Provider who maintains a relationship with the Covered Person, provides general healthcare evaluation, guidance, and management.

Covered Persons are encouraged to begin all healthcare events or inquiries with a call or visit to their designated PCP who will guide Covered Persons as appropriate. In addition to providing Care Coordination and submitting referral and preauthorization requests, the PCP may also receive notices regarding healthcare services that their designated patients receive under the Plan. This allows the PCP to provide ongoing healthcare guidance.

If you have trouble obtaining access to a PCP, the Care Coordinators will be able to assist you by providing a list of in-network PCPs. Please contact the Care Coordinators by calling:

CARE COORDINATORS: 1-866-790-4419

Referrals from a PCP for All Visits to Specialist Providers

It is recommended that the Covered Person begin every healthcare event with a call or visit to a PCP. When a PCP refers the Covered Person to a specialist, they will submit a notification of this referral to the Care Coordinators. The member ID card alerts the PCP that the Covered Person may receive the best benefits and/or coordination when a notification of referral to a specialist is submitted. Referral notices can be submitted by any PCP, including out-of-network Providers. (Please note: an office visit to an out-of-network PCP, other than Emergency Services, would be covered at the out-of-network benefit level.) The referral will be authorized for a certain time period, number of visits, or number of units, as requested by the PCP. During the authorized period, further referrals are not required for additional visits or treatments associated with the initial referral.

The Schedule of Benefits included in the Summary Plan Document specifies the benefit reduction, if any, that occurs for specialty services that are received without an authorized specialty referral in place.

The PCP is responsible for submitting any required referral notice with all required information to the Care Coordinators, who will process the referral and notify the PCP's office upon authorization. While the referral process is initiated by the PCP, the Covered Person is ultimately responsible for ensuring that the required referral authorization is in place **before** the specialty visit. Whenever possible, notice of this referral is sent to the Covered Person; however, Covered Persons can verify that the referral is in place by calling the Care Coordinators at **1-866-790-4419** or visiting the website on your ID card. Please refer to Emergency Admissions and Procedures for additional information regarding those circumstances.

OB/Gyn Office Visits: To ensure open and unhindered access to OB/Gyn care, all office visits to OB/Gyn specialists receive the same benefit level as a PCP Office Visit. Covered Persons do not

have to obtain a referral from a PCP to see their OB/Gyn specialist or receive the highest level of benefits for an office visit to an OB/Gyn.

Utilization Management

Preauthorization and Clinical Review

To be covered at the highest level of benefit and to ensure complete Care Coordination, the Plan requires that certain care, services, and procedures be preauthorized before they are provided. Preauthorization requests are submitted to the Care Coordinators by a designated PCP, other PCP, specialty Provider or other Health Care Provider. Your Plan identification card includes instructions and the phone number for them to call. Depending on the request, the Care Coordinators may contact the requesting Provider to obtain additional clinical information to support the request for the preauthorization and to ensure that the care, service and/or procedure meet Plan and nationally accepted medical criteria. If a pre-authorization request does not meet Plan and nationally accepted medical criteria, the Covered Person and Health Care Provider will be notified, and the Care Coordinators will assist in redirecting care if appropriate.

The following care, services and procedures are subject to preauthorization:

- Inpatient and Skilled Nursing Facility Admissions
- Outpatient Surgeries
- MRI/MRA and PET scans
- Oncology Care and Services (chemotherapy, radiation therapy, clinical trials)
- Genetic Testing
- Dialysis
- Organ, Tissue, and Bone Marrow Transplants
- Home Health Care
- Hospice Care
- Durable Medical Equipment - all rentals and any purchase over $1500.
- Partial Hospitalization and Intensive Outpatient for Mental Health/Substance Use Disorders

All preauthorizations and clinical review services are conducted by MyQHealth. Care Coordinators will assist Covered Persons in understanding what services require preauthorization.

PENALTIES FOR NOT OBTAINING PREAUTHORIZATION

A non-notification penalty is the amount you must pay if required preauthorization is not requested for a service prior to receiving the service. Covered expenses will be reduced, if any, as shown in the Medical Schedule of Benefits if a Covered Person receives services but did not obtain the required preauthorization for:

- Inpatient and Skilled Nursing Facility Admissions
- Outpatient Surgeries
- MRI/MRA and PET scans
- Oncology Care and Services (chemotherapy, radiation therapy, clinical trials)
- Genetic Testing
- Dialysis
- Organ, Tissue, and Bone Marrow Transplants
- Home Health Care
- Hospice Care
- Durable Medical Equipment - all rentals and any purchase over $1500.

- Partial Hospitalization and Intensive Outpatient for Mental Health/Substance Use Disorders

For preauthorization, Providers should call the number listed on the Plan identification card.

Concurrent Utilization Review

MyQHealth will regularly monitor an inpatient hospital stay, other institutional admission, or ongoing course of care for any Covered Person, and evaluate the appropriateness of the level of care and if the stay is meeting Medical Necessity. If necessary, they will examine the possible use of alternate levels of care or facilities. MyQHealth will communicate regularly with attending Providers, the utilization management staff and/or discharge planners of such facilities, and the Covered Person and/or family to monitor the Covered Person's progress and anticipate and initiate planning for discharge needs. Such concurrent review, and authorization for Plan coverage of inpatient days, is conducted in accordance with the utilization criteria adopted by the Plan, MyQHealth, and nationally accepted medical criteria.

Personal Care Guide Management

MyQHealth utilizes a primary nurse model for chronic Condition as well as acute Condition management. This enhanced approach provides one nurse to address clinical needs for all chronic and acute issues. The Personal Care Guide (PCG) nurse will consult with the Covered Person, their family (if requested), the attending Physician, and other members of the Covered Person's treatment team to assist in facilitating/implementing proactive plans of care which provide the most appropriate health care and services in a timely, efficient and cost-effective manner. They assist with benefits, incidental health care issues, becoming healthier, finding resources or an unexpected healthcare journey.

During outreach, the Personal Care Guide will touch on the Covered Person's treatment and perform a physical assessment, perform a medication reconciliation to ensure there are no duplications or interactions, perform a depression screening with subsequent referrals to EAP or in-network Providers, as well as focus on the physical and emotional needs of the Covered Person.

The Personal Care Guide will look at the Covered Person's psychosocial needs and social determinants of health. In addition to the depression screening, they will evaluate the Covered Person's financial issues, knowledge deficits, as well as any cultural barriers that may exist. Conversations with the Covered Person would occur at least monthly, if not more frequently, and continue until the Covered Person's health goals and needs are met.

The primary Personal Care Guide nurse will align with the Covered Person and be the single point of contact them, and their family and caregivers, and Providers.

The primary Personal Care Guide nurse will:

- Provide comprehensive benefit education/utilization support
- Drive PCP designation and steerage to in-network Providers
- Encourage Provider involvement
- Deliver pre-certification assistance
- Perform pre-admission, pre-discharge, and post-discharge engagement
- Coordinate for utilization review and discharge planning
- Identify gaps in care and alleviate clinical, financial, and humanistic barriers

- Coordinate second opinions, drive utilization to other third-party vendor tools, and introduce community resources
- Perform behavioral health screening
- Our primary nurse model has three foundational drivers for the changes:
- Humanistic: to help members with acute and chronic needs by assigning a single nurse to the Covered Person and their family as well as a heightened attention to psychosocial issues that can negatively affect health, quality of life and financial outcomes.
- Clinical: identify and prioritize members in need of clinical outreach. Improve adherence to quality measures for preventive health and management of chronic Conditions.
- Financial: identify and outreach to members at risk for future high costs while encouraging Preventive Care and chronic Condition management to improve health and reduce costs.

GENERAL PROVISIONS FOR CARE COORDINATION

Authorized Representative

The Covered Person, or his or her authorized representative, is ultimately responsible for ensuring that all required referrals and preauthorization are approved and in place prior to the time of service to receive the highest level of benefits. However, in most cases, the actual referral and preauthorization process will be executed by the Covered Person's Primary Care Provider or other Providers. By subscribing to this Plan, the Covered Person authorizes the Plan and its designated service Providers (including MyQHealth, the Third Party Administrator, and others) to accept Health Care Providers or those Providers who otherwise have knowledge of the Covered Person's medical Condition, as their authorized care representative in matters of Care Coordination, including referral and preauthorization requests. Communications with and notifications to such Health Care Providers shall be considered as notification to the Covered Person.

Time of Notice

The referral and preauthorization request should be made to the Care Coordinators within the following timeframe:

- At least **three business days,** before a scheduled (elective) Inpatient admission
- By the next business day after, an emergency Hospital admission
- Upon being identified as a potential organ or tissue transplant recipient
- At least **three business days** before receiving any other services requiring preauthorization

For preauthorization, Providers should call the number listed on the Plan identification card.

Special Note: The Covered Person will not be penalized for failure to obtain preauthorization if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who receive care on this basis must contact the Care Coordinators as soon as possible within 24 hours of the first business day after receiving care or Hospital admittance. Care Coordinators will then coordinate with MyQHealth Utilization Management to review services provided within 48 hours of being contacted.

"Emergency" Admissions and procedures

Any inpatient admission or outpatient procedure that has not been previously scheduled and cannot be delayed without harming the Covered Person's health is considered an emergency for purposes of the Utilization Management notification. No precertification is required for Emergency Services.

Maternity Admissions

A notice regarding admissions for childbirth should be submitted to the Care Coordinators in advance, preferably 30 days prior to expected delivery. The Plan and the Care Coordination process complies with all state and federal regulations regarding Utilization Management for maternity admissions. The Plan will not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require preauthorization or authorization for prescribing a length of stay not in excess of these periods. If the mother's or newborn's attending Provider, after consulting with the mother, discharges the mother or her newborn earlier than the applicable 48 or 96 hours, the Plan will only consider benefits for the actual length of the stay. The Plan will not set benefit levels or out-of-pocket costs so that any later portion of the 48 or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Care Coordination is Not a Guarantee of Payment of Benefits

The Care Coordination process does not provide a guarantee of payment of benefits. Approvals of required preauthorization for procedures, hospitalizations and other services indicate that the medical Condition, services, and care settings meet the utilization criteria established by the Plan. The Care Coordination approvals do not indicate that the service is a Covered Service, that the Covered Person is eligible for such benefits, or that other benefit conditions such as Copay, Deductible, Coinsurance, or maximums have been satisfied. Final determinations regarding coverage and eligibility for benefits are made by the Plan.

Appeal of Care Coordination Determinations

Covered Person have certain appeal rights regarding adverse determinations in the Care Coordination process, including reduction of benefits and penalties. The appeal process is detailed in the Claims and Appeal Procedures section within this document.

COMPREHENSIVE MAJOR MEDICAL BENEFITS

BENEFITS PAYABLE

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

DEDUCTIBLE

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

Common Accident Deductible

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

LIFETIME DOLLAR LIMITS

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

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum applies each Calendar Year. Once a Covered Person has met the Out-of-Pocket Maximum as listed in the Schedule of Benefits, benefits for that Covered Person's eligible expenses will be payable at 100% of the Allowed Amount for the remainder of the Calendar Year.

METHOD OF PAYMENT

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

COVERED SERVICES

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

HOSPITAL SERVICES

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

Non-covered Hospital services include but are not limited to:

1. Gowns and slippers;
2. Shampoo, toothpaste, body lotions and hygiene packets;
3. Take-home drugs;
4. Telephone and television; and
5. Guest meals or gourmet meals.

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

1. A room with two or more beds;
2. A private room, when Medically Necessary. The private room allowance is the Hospital's average semi-private room rate;
3. A bed in a special care unit approved by the Plan. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients; and
4. Miscellaneous Hospital expenses for a physical Injury or Illness received by a Covered Person while the Covered Person is Confined in a Hospital.

Coverage is not provided for an Inpatient admission, the primary purpose of which is:

1. Diagnostic services;
2. Custodial care;
3. Rest care;
4. Environmental change; or
5. Physical therapy

Coverage for Inpatient care is not provided when the services could have been performed on an Outpatient basis, and it was not Medically Necessary for the Covered Person to be an Inpatient to receive them.

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

1. Operating, delivery and treatment rooms and equipment;
2. Prescribed drugs;
3. Anesthesia, anesthesia supplies and services given by an employee of the Hospital or Other Provider;
4. Medical and surgical dressings, supplies, casts and splints;
5. Diagnostic services;
6. Therapy services;
7. Oxygen and other gases; and
8. Surgically inserted prosthetics such as pacemakers and artificial joints.

Blood and Blood Plasma

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

Outpatient Hospital Services

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

MEDICAL-SURGICAL BENEFITS

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

ALCOHOLISM & DRUG ABUSE BENEFITS

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

1. Individual and group psychotherapy;
2. Psychological testing; and
3. Family counseling: counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Covered Persons under this Plan. Charges will be applied to the Covered Person who is receiving family counseling services, not necessarily the patient receiving treatment for Drug Abuse or Alcoholism.

Inpatient Benefits

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

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

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

Outpatient Benefits

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

Benefits are provided for outpatient care by a licensed Psychologist, Psychiatrist, or Licensed Social Worker. Coverage will include services provided in a certified Day Treatment Program.
Please note: Excluded from coverage are Conditions that do not fall under any of the diagnostic categories listed as a mental or behavioral disorder due to psychoactive substance use (or equivalent category) in the mental, behavioral, and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the International Classification of Diseases (ICD) manual or that are not listed as a substance-related and addictive disorder (or equivalent category) in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Unless the Plan Administrator has instructed the Claims Administrator to do otherwise, and the Summary Plan Description states such exception, substance-related and addictive disorders newly added to the ICD or DSM will start to be covered no later than on the first day of the plan year on or after the date that is one year after the Condition is added to the ICD or DSM.

ALLERGY TESTS AND TREATMENTS

Allergy tests which are performed and related to a specific diagnosis are Covered Services. Desensitization treatments are also covered.

AMBULANCE SERVICE

Transportation services must be certified by the Covered Person's Physician and are subject to medical review to determine Medical Necessity. Transportation by a vehicle designed, equipped and used only to transport the sick and injured:

1. From the Covered Person's home, scene of accident or medical emergency to a Hospital;
2. Between Hospitals;
3. Between Hospital and Skilled Nursing Facility;
4. From a Hospital or Skilled Nursing Facility to the Covered Person's home; or
5. From the Covered Person's home to a Physician's office, and then to a Hospital.

Trips must be to the closest facility that is medically equipped to provide Covered Services appropriate for the Covered Person's Condition. If none, coverage is available for trips to the closest such facility outside the Covered Person's local area. Air ambulance service is covered under the Plan only when special treatment is required and the transportation is to the nearest Hospital qualified to provide the special treatment.

Transportation services provided by an ambulette or wheelchair van are not Covered Services.

ANESTHESIA

This Plan covers anesthesia for any Covered Service when administered by a Physician, Other Provider or certified registered nurse anesthetist who is not the surgeon or the assistant at surgery or by the surgeon in connection with covered oral surgical procedures. This benefit includes care before and after the administration. The services of a stand-by anesthesiologist are only covered during coronary angioplasty surgery. Some anesthesiologists are not considered PPO Network Providers. Many anesthesiologists are independent contractors and not Hospital employees.

ATTENTION DEFICIT DISORDER

Services for the treatment of attention deficit disorder are covered.

AUTISM SPECTRUM DISORDERS

Benefits are payable for the screening, diagnosis, and treatment of autism spectrum disorders.

Covered Services include:

- Speech/language therapy, occupational therapy and physical therapy performed by a licensed therapist.
- Clinical therapeutic intervention which includes, but is not limited to, applied behavior analysis. This intervention must be provided by, or be under the supervision of, a professional who is licensed, certified, or registered by an appropriate agency of Ohio to perform such services in accordance with a treatment plan.
- Mental/behavioral health outpatient services performed by a licensed psychologist, psychiatrist, or Physician providing consultation, assessment, development, or oversight of treatment plans.

CASE MANAGEMENT

Case management is an economical, common sense approach to managing health care benefits. Quantum Care Coordinators' case management staff evaluates opportunities to cover cost-effective alternatives to the patient's current health care needs. Case management has proven to be very effective with catastrophic cases, long-term care, and psychiatric and Alcoholism and Drug Abuse treatments. In such instances, benefits not expressly covered in this Plan may be approved. All case management programs are voluntary for the patient.

Coverage for these services must be approved in advance and in writing by Quantum Care Coordinators.

To learn more about these services, you may contact Quantum Care Coordinators' case management staff.

CLINICAL TRIALS

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

In order to be eligible for benefits, the Covered Person must be eligible to participate in an Approved Clinical Trial, according to the trial protocol with respect to treatment of cancer or other Life-threatening Conditions.

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

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or Condition and is described in any of the following:

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

"Life-threatening Condition" means any disease or Condition from which the likelihood of death is probable unless the course of the disease or Condition is interrupted.
"Routine Patient Costs" means all health care services that are otherwise covered under the Group Contract for the treatment of cancer or other Life-threatening Condition that is typically covered for a patient who is not enrolled in an Approved Clinical Trial.

"Subject of a Clinical Trial" means the health care service, item, or drug that is being evaluated in the Approved Clinical Trial and that is not a Routine Patient Cost. No benefits are payable for the following:

- A health care service, item, or drug that is the subject of the Approved Clinical Trial;
- A health care service, item, or drug provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;
- An Experimental or Investigational drug or device that has not been approved for market by the United States Food and Drug Administration;
- Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the Approved Clinical Trial;
- An item or drug provided by the Approved Clinical Trial sponsors free of charge for any patient;
- A service, item, or drug that is provided at no charge or that is eligible for reimbursement by an entity other than the Plan, including the sponsor of the Approved Clinical Trial;
- A service, item, or drug that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

CONCURRENT MEDICAL CARE

The Plan covers care by two or more Physicians during one Hospital stay when you have two or more unrelated Conditions. You are also covered for care for a medical Condition by a Physician who is not your surgeon while you are in the Hospital for Surgery.

CONSULTATION

A personal bedside examination by another Physician or Other Professional Provider when requested by the Covered Person's attending Physician.

If the consulting Physician takes charge of your care, consultation services are not covered. When this occurs, the consulting Physician is considered to be the new attending Physician. Coverage is not provided for both the new attending Physician and the Physician who was initially treating you for Services rendered at the same time.

Staff consultations required by Hospital rules are excluded.

DENTAL SERVICES

For Accidental Injury

Dental services rendered by a Physician or dentist for an accidental Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident. Dental services must begin within one (1) year from the date of the accident. Injury as a result of chewing or biting is not considered an accidental Injury.

The above exclusion for Injuries as a result of biting or chewing shall not apply if such Injury was the result of domestic violence or if an underlying medical Condition caused the biting or chewing-related Injury. For example, a Covered Person with epilepsy involuntarily clamps down on his teeth and breaks one during a seizure.
The underlying Illness must cause the chewing or biting accident that results in the Injury to the jaws, sound natural teeth, mouth or face. If a Covered Person has an underlying Illness that causes the teeth to be more susceptible to Injury, dental services related to such Injury will not be covered as an Injury sustained in an accident.

Oral Surgery

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

1. Surgical removal of impacted non-erupted teeth;
2. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;
3. Surgical procedures to correct injuries to the jaw, cheeks, lips, tongue, roof, and floor of the mouth;
4. Apicoectomy (excision of the apex of the tooth root);
5. Root canal therapy, if performed simultaneously with an apicoectomy;
6. Excision of exostosis (bony outgrowth) of the jaws and hard palate;
7. Frenotomy (incision of the membrane connecting the tongue to the floor of the mouth);
8. Incision of drainage of cellulitis (tissue inflammation) of the mouth;
9. Incision of accessory sinuses, salivary glands, or ducts;
10. Gingivectomy (excision of gum tissue to eliminate infection);
11. Alveolectomy; if performed for reasons other than for dentures;
12. Functional osteotomies.

DIAGNOSTIC SERVICES

A diagnostic service is a test or procedure performed, when you have specific symptoms, to detect or monitor your Condition. It must be ordered by a Physician or Other Professional Provider. The following services when performed for diagnosis of a Condition, disease, or Injury and the Physician's interpretation of these exams are covered under your Plan:

1. X-ray Examinations;
2. Laboratory and Pathology Services;
3. Radiology, Ultrasound and Nuclear medicine;
4. Electronic Diagnostic Medical Examinations such as EKG's, EEG's and MRI’s;
5. Cardiographic, Encephalographic and Radioisotope Tests.

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

DRUGS AND BIOLOGICALS

You are covered for Prescription Drugs and biologicals that cannot be self-administered and are furnished as part of a Physician's professional service in the course of the diagnosis or treatment of a Condition.

EMERGENCY SERVICES

Your Plan covers Medically Necessary Emergency Services for an Emergency Medical Condition. Emergency Services are available 24 hours a day, 7 days a week.

In the event of an emergency:

- call 911 or go to the nearest Hospital or Independent Freestanding Emergency Department; and
- notify the Claims Administrator within 24 hours, or as soon as medically possible, if the nearest Hospital or Independent Freestanding Emergency Department is not in the PPO network.

Emergency Services do not require precertification and are payable at the PPO network level of benefits shown in the Medical Schedule of Benefits, regardless of whether these services are obtained from a PPO Network Provider or a Non-PPO Network Provider or Non-Contracting Health Care Provider.

Services are no longer considered "Emergency Services" when all of the following conditions are met:

1. The Covered Person's Heath Care Provider determines the Covered Person is able to travel using nonmedical transportation or nonemergency medical transportation to an available PPO Network Provider located within a reasonable travel distance, taking into consideration the Covered Person's medical Condition.
2. The Covered Person's Health Care Provider satisfies the notice and consent criteria of the applicable federal or state law prohibiting balance billing as well as any guidance subsequently issued thereto.
3. The Covered Person is in a condition to receive the notice and consent information and provide an informed consent, thereby giving up his or her rights to be protected from balance billing for the Emergency Services.

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

GENDER AFFIRMING SURGERY

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

HEARING AIDS FOR COVERED PERSONS UNDER AGE 22

For Covered Persons under age twenty-two (22) who are verified as being deaf or hearing impaired by a licensed audiologist, an otolaryngologist or other licensed Physician, benefits are provided for Hearing Aids and Related Services, subject to the limitations shown in the Schedule of Benefits.

For the purposes of this coverage, the following definitions apply:

a. "Hearing Aid" means any wearable instrument or device designed or offered for the purpose of aiding or compensating for impaired human hearing, including all attachments, accessories, and arts thereof, except batteries and cords, that is dispensed by a licensed audiologist, a licensed hearing aid dealer or fitter, or an otolaryngologist.

b. "Related Services" means services necessary to assess, select, and appropriately adjust or fit a hearing aid, to ensure optimal performance.

A Covered Person may choose a higher priced Hearing Aid and may pay the difference in cost above the benefit maximum appearing in the Schedule of Benefits, without any financial or contractual penalty to the Covered Person or to the Health Care Provider of the Hearing Aid.

Coverage is provided only for Hearing Aids that are considered medically appropriate to meet the needs of the Covered Person, according to professional standards established by the state speech and hearing professionals' board.

HOME HEALTH CARE SERVICES

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

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

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

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

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

5. Nutrition counseling provided or supervised by a registered dietician;

6. Evaluation of the need for a home care plan by a registered nurse, Physician extender, or medical social services (such as the counseling of patients). The Covered Person's attending Physician must request or approve this evaluation;

7. Oxygen and its administration; and

8. Home health aide visits when you are also receiving covered nursing or therapy services.

Non-covered Home Care Services:

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

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

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

4. If home care is covered under two or more health benefit plans, coverage is payable under only one of them, except as stated in the Coordination of Benefits;

5. The maximum weekly benefit payable for this coverage won't be more than the benefits payable for the total weekly charges for Skilled Nursing Care available in a licensed Skilled Nursing Facility, as determined by the Plan;

6. Homemaker services;

7. Food or home delivered meals; and

8. Custodial care, rest care or care which is only for someone's convenience.

HOSPICE BENEFITS

Hospice services consist of health care services provided to a Covered Person who is a patient with a reduced life expectancy due to advanced Illness. Hospice services must be provided through a Hospice Facility or a Hospice program sponsored by a Hospital or Home Health Care Agency. Hospice services may be received by the Covered Person in a private residence.

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

1. Professional services of a registered or licensed practical nurse;
2. Treatment by physical means, occupational therapy, and speech therapy;
3. Medical and surgical supplies;
4. Prescription Drugs; limited to a two-week supply per Prescription Order or refill (these Prescription Drugs must be required in order to relieve the symptoms of a Condition, or to provide supportive care);
5. Oxygen and its administration;
6. Medical social services, such as the counseling of patients;
7. Home health aide visits when you are also receiving covered nursing or therapy services;

8. Acute inpatient Hospice services;
9. Respite care;
10. Dietary guidance; counseling and training needed for a proper dietary program;
11. Durable Medical Equipment; and
12. Bereavement counseling for family members.

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

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

1. Volunteer services;
2. Spiritual counseling;
3. Homemaker services;
4. Food or home delivered meals;
5. Chemotherapy or radiation therapy if other than to relieve the symptoms of a Condition; and
6. Custodial Care, rest care or care which is provided solely for someone's convenience.

HUMAN ORGAN AND TISSUE TRANSPLANTS

Organ/Tissue Transplant Pre-Certification

In order for an organ/tissue transplant to be a Covered Service, the proposed course of treatment must be pre-certified and approved by Quantum Care Coordinators. No benefits will be provided for organ/tissue transplant services which have not been pre-certified.

After your Physician has examined you, he must provide Quantum Care Coordinators with:

1. The proposed course of treatment for the transplant;
2. The name and location of the proposed Transplant Center;
3. Copies of your medical records, including diagnostic reports for Quantum Care Coordinators to determine the suitability and Medical Necessity of the transplant services. This determination will be made in accordance with uniform medical criteria that have been specifically tailored to each organ/tissue. You may also be required to undergo an examination by a Physician chosen by Quantum Care Coordinators. You and your Physician will then be notified of Quantum Care Coordinators' decision.

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

A list of PPO Network Provider transplant facilities can be obtained by contacting the Customer Care Center at the phone number shown on your identification card. If you receive your transplant from a PPO Network Provider facility, Covered Services will be payable at the designated level of benefits for organ transplants, subject to any Deductible and Coinsurance set forth in the Schedule of Benefits. Failure to use a PPO Network Provider facility will increase your out-of-pocket expense significantly. Refer to the Schedule of Benefits for any additional penalty that may apply.

When the recipient is the Covered Person, the donor's expenses will be considered expenses of the recipient and will apply toward the recipient's benefit for the transplant procedure as listed in the Schedule of Benefits.

Tissue Transplants

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

Benefits are payable as shown in the Schedule of Benefits for the following transplants:

1. Cornea transplants;
2. Allogenic and autologous bone marrow transplants for certain diagnoses.

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

Human Organ Transplants

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

1. Heart transplants;
2. Heart/Lung transplants;
3. Liver transplants;
4. Lung transplants;
5. Pancreas transplants;
6. Pancreas/Kidney transplants;
7. Kidney transplants.

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

1. Evaluation of the organ;
2. Removal of the organ from the donor; and
3. Transportation of the organ to the Transplant Center.

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

Exclusions

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

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

6. Human-to-human bone marrow, organ, or tissue transplants other than those specifically covered under this section;
7. Treatment, services, and supplies not covered by the Plan; and
8. Services, supplies or charges which are not provided during a transplant Benefit Period.

A transplant Benefit Period is a period of time which starts five days before the day the first covered transplant was received and ends 12 months later. A new transplant Benefit Period starts only if the next covered transplant occurs more than 12 months after the last covered transplant was performed.

INPATIENT HOSPITAL MEDICAL CARE

The Plan covers Physician's visits to a registered bed-patient in a Hospital. The examinations given by the Physician or Other Professional Provider while in the Hospital are Covered Services. Benefits are provided for one visit each Inpatient day.

If the Covered Person’s group changes health care benefits, causing an increase or decrease in inpatient medical care visits allowed, the number of inpatient medical care visits already used will be deducted from the number of visits available under the new coverage.

MASTECTOMY

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

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

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

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

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

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

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

In addition, a Plan may not, under Federal law, require that a Physician or other Health Care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. Therefore, if your Plan contains a precertification requirement, you or your Provider must still pre-certify the stay to avoid any additional out-of-pocket expenses; however, your stay will automatically be pre-certified for 48 or 96 hours as required by this Federal law.

Maternity/Abortion Services

Hospital, medical and surgical services for a normal pregnancy, complications of pregnancy and miscarriage are covered. Therapeutic abortions are also a Covered Service.

Ohio law prohibits funds of the State of Ohio or any political subdivision thereof, as defined in ORC 9.04, from being used, directly or indirectly, to pay for the costs associated with nontherapeutic abortions*. As a result, this Plan does not contain benefits for nontherapeutic abortions.

*As used in this section, “nontherapeutic abortion” means an abortion that is performed or induced when the life of the mother would not be endangered if the fetus were carried to term or when the pregnancy of the mother was not the result of rape or incest reported to a law enforcement agency.”

Birthing Center

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

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

Newborn Exam

Inpatient visits to examine a newborn, including circumcision.

Surgical Sterilizations

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

MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES

This section describes supplies and equipment that are covered when prescribed by your Physician. These supplies and equipment must serve a specific, therapeutic purpose in the treatment of a Condition.

Medical and Surgical Supplies

Disposable supplies such as: elastic support stockings (e.g. Jobst stockings) syringes, needles, oxygen, casts, surgical dressings, trusses, braces (other than dental braces), crutches, splints and other similar items which serve only a medical purpose. These supplies prescribed by your Physician: catheters, colostomy bags, rings and belts, flotation pads, needles and syringes, and initial contact lenses or eyeglasses after cataract surgery will also be eligible for coverage. Covered services do not include items usually stocked in the home for general use like adhesive bandages, thermometers, corn and bunion pads and petroleum jelly.

Durable Medical Equipment

Equipment which serves only a medical purpose and must be able to withstand repeated use is covered. Rental of, or at the Plan’s option, purchase of Durable Medical Equipment such as, but not limited to: wheel chairs; Hospital-type beds; home dialysis equipment; crutches; and artificial respiration equipment. When the equipment is purchased, benefits are payable for subsequent repairs necessary to restore the equipment to a serviceable condition. Routine periodic maintenance and replacement of batteries are not covered. The equipment must be prescribed by

the Physician. Benefits are payable only if the Plan approves the equipment as being appropriate for a Covered Person's medical Condition. If use of equipment is needed for more than six months, the Physician may be required to recertify that continued use is Medically Necessary.
The Plan will not cover more in total rental costs than the customary purchase price as determined by the Plan for each Condition.

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

Non-Covered equipment includes but is not limited to:

1. Rental costs if in a facility which provides such equipment;
2. Repair costs which are more than the rental price of another unit for the estimated period of use, or more than the purchase price of a new unit;
3. Physician's equipment, such as blood pressure cuff or stethoscope;
4. Deluxe equipment such as specially designed wheelchairs for use in sporting events; and
5. Items not primarily medical in nature such as:
    - An exercise, treadmill, bidet toilet seat, sauna baths, elevator and chair lifts;
    - Items for comfort and convenience;
    - Disposable supplies and hygienic equipment; and
    - Self-help devices such as: bed boards, bathtubs, overbid tables, adjustable beds, telephone arms and air conditioners.

Orthotic Devices

A rigid or semi-rigid supportive device which limits or stops motion of a weak or diseased body part, such as: casts, splints; strapping; trusses; back and special surgical corsets; orthopedic braces (for the leg, arm, neck or back); and crutches. These do not include orthotics, garter belts, arch supports, corsets and corn and bunion pads, special shoes, or devices to protect the feet or improve comfort unless the device is a permanent part of an orthopedic leg brace.

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

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

Prosthetic Appliances

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

1. Replace all or part of a missing body organ and its adjoining tissues; or
2. Replace all or part of the function of a permanently useless or malfunctioning body organ.

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

Covered prosthetic appliances include but are not limited to the following:

1. Artificial hands, arms, feet, legs and eyes, including permanent lenses; and
2. Appliances needed to effectively use artificial limbs or corrective braces.

Non–covered appliances include but are not limited to:

1. Dentures, unless as a necessary part of a covered prosthetic;
2. Dental appliances;
3. Eyeglasses, including lenses and frames, unless used to replace an absent lens of the eye;
4. Replacement of cataract lenses unless needed because of a lens prescription change;
5. Taxes included in the purchase of a covered prosthetic appliance; and
6. Wigs and hairpieces.

MENTAL ILLNESS BENEFITS

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

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

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

The following are Covered Services for the treatment of Mental Illness:

1. Individual and group psychotherapy;
2. Electroshock therapy and related anesthesia only if given in a Hospital or Psychiatric Hospital;
3. Psychological testing;
4. Family counseling: counseling with family members to assist with diagnosis and treatment. This coverage will provide payment for Covered Services only for those family members who are considered Covered Persons under this Plan. Charges will be applied to the Covered Person who is receiving family counseling services, not necessarily the patient.

The course of treatment which your Physician or Other Professional Provider recommends must be acceptable to Quantum Care Coordinators. Inpatient care, other than Emergency Services, must be approved by Quantum Care Coordinators prior to admission.

Excluded from coverage are Conditions that do not fall under any of the diagnostic categories listed in the mental, behavioral, and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the International Classification of Diseases (ICD) manual or that are listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Unless the Plan Administrator has instructed the Claims Administrator to do otherwise, and the Summary Plan Description states such exception, newly added mental health Conditions added to the ICD or DSM will start to be covered no later than on the first day of the plan year on or after the date that is one year after the Condition is added to the ICD or DSM.

OUTPATIENT MEDICAL CARE

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

Telehealth Services

This Plan provides coverage for Telehealth Services payable as shown in the Schedule of Benefits. Telehealth Services are covered as appropriate for the services being rendered by the Covered Person's provider. For example, audio-only Telehealth Services are generally Covered Services, unless it is not clinically appropriate to provide such services without a face-to-face interaction.

OUTPATIENT INSTITUTIONAL SERVICES

The Covered Services listed below are covered when services are performed in an Outpatient setting, except as specified.

Covered Institutional services include but are not limited to:

1. Operating, delivery and treatment rooms and equipment;
2. Whole blood, blood derivatives, blood plasma and blood components, including administration and blood processing;
3. Anesthesia, anesthesia supplies and services; and
4. Surgically inserted prosthetics such as pacemakers and artificial joints.

Pre-Admission Testing – Outpatient tests and studies required before a scheduled Inpatient Hospital admission or Outpatient surgical service are covered.

Post-Discharge Testing – Outpatient tests and studies required as follow-up to an Inpatient Hospital stay or an Outpatient surgical service are covered.

PRIVATE DUTY NURSING SERVICES

Services of a practicing registered nurse (R.N.), licensed vocational nurse or licensed practical nurse (L.P.N.) when ordered by a Physician will be covered as follows: skilled nursing services received in a patient's home or as an Inpatient. Nursing services do not include care that is primarily non-medical or custodial in nature such as bathing, exercising and feeding.

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

Inpatient Services

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

SKILLED NURSING FACILITY/REHABILITATION FACILITY BENEFITS

Benefits are available for Covered Services in a Skilled Nursing Facility / Rehabilitation Facility as listed in the Schedule of Benefits. No coverage is provided for services for Custodial Care; or care for senile deterioration or intellectual disability (except in accordance with Federal Mental Health Parity requirements). Your Physician must certify initially and every two weeks, thereafter, that you are receiving Skilled Care and not Custodial Care.
Confinement in the facility:

1. Must begin within two days after the Covered Person has been Confined in a Hospital for which room and board charges were paid; and
2. Is for treatment of the Illness causing the Hospital Confinement, unless the patient can no longer significantly improve from treatment for the current Condition and it is determined to be Medically Necessary by Quantum Care Coordinators;
3. Is one for which a Physician visits the Covered Person at least once every 30 days; and
4. Is not for routine Custodial Care, rest care or care which is only for someone's convenience.

SURGICAL SERVICES

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

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

Coverage is also provided for the following specified services:

1. Sterilization, regardless of Medical Necessity;
2. Removal of bony impacted teeth;
3. Maxillary or mandibular frenectomy;
4. Mandibular staple implant. This is not a Covered Service when performed to prepare the mouth for prosthetics; and
5. Surgery to improve a functional deficiency.

Diagnostic Surgical Procedures

Coverage is provided for surgical procedures to diagnose your Condition while you are in the Hospital. If you are an Inpatient for fewer than four days, only the diagnostic surgical procedure is covered. If you are hospitalized four days or more, the diagnostic surgical procedure and Medical Care visits except for the day the surgical procedure was performed are covered.

Surgical Assistance

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

Multiple Surgical Procedures

If two or more surgical procedures are performed through the same body opening during the course of the same operative period, you are only covered for the most complex procedure. In no event shall any additional allowance be made for any incidental procedures performed during the operative session. However, if each surgery is mutually exclusive of the other or the result of a multiple trauma, you will be covered for each surgery.

If two or more surgical procedures are performed through more than one body opening during the course of the same operative period, you are covered for the most complex procedure, and the Allowed Amount for the secondary procedures will be half of the Allowed Amount for a single procedure. In no event shall any additional allowance be made for any incidental procedures performed during the operative session.

If two or more foot surgeries (podiatric surgical procedures) are performed, you are covered for the most complex procedure, and the Allowed Amount will be half of the Allowed Amount for the next two most complex procedures. For all other procedures, the Allowed Amount will be one-fourth of the full Allowed Amount.

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

Second Surgical Opinion

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

The second surgical opinion must be provided by a surgeon other than the first surgeon who recommended the Surgery. This benefit is not covered while you are an Inpatient of a Hospital.

Some of the procedures, which are recommended for a voluntary second surgical opinion, are:

1. Breast Surgery (Augmentation or reduction);
2. Bunionectomy (Foot surgery);
3. Cholecystectomy (Removal of gallbladder);
4. Coronary Artery Bypass Surgery;
5. Hemorrhoidectomy (Internal or external);
6. Hernia Repair (Inguinal or hiatal);
7. Hysterectomy (Removal of uterus);
8. Laminectomy (Back surgery);
9. Ligation and/or Stripping of Varicose Veins in Legs;
10. Meniscectomy (Knee surgery);
11. Septoplasty and/or Submucous Resection (Nose surgery);
12. Tonsillectomy and/or Adenoidectomy (Removal of tonsils or adenoids); and
13. Transurethral Prostatectomy (Removal of Prostate).

NOTE: A third opinion will be covered if the first two conflict. The Surgery is a Covered Service even if the Physician's opinions conflict.

THERAPY SERVICES

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

Cardiac Rehabilitation

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

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

Chemotherapy

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

Dialysis Treatments

The treatment of an acute or chronic kidney ailment by dialysis methods, including chronic ambulatory peritoneal dialysis, which may include the supportive use of an artificial kidney machine.

Hyperbaric and Pulmonary Therapy

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

Occupational Therapy

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

The expectation must exist that the therapy will result in a significant improvement in the level of functioning within 60 days of the first treatment. No benefits are provided for diversional, recreational, and vocational therapies (such as hobbies, arts and crafts). Therapy must be ordered by a Physician and provided on a regular basis by a certified, licensed occupational therapist or physical therapist.

Occupational therapy services are not covered services when a patient suffers temporary loss or reduction of function which is expected to improve on its own with increased normal activities.

Radiation Therapy

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

Respiratory Therapy

Treatment by the introduction of dry or moist gases into the lungs, and other respiratory therapy related services.

Speech Therapy

Treatment for the correction of a speech impairment limited to medical Illness and accident victims.

In order to be considered a Covered Service, this therapy must be performed by a certified, licensed therapist and be Medically Necessary due to a medical Condition such as, but not limited to:

1. A stroke;
2. Aphasia;
3. Dysphasia; or
4. Post-laryngectomy.

Spinal Treatment/Chiropractic (non-surgical)

Detection or non-surgical correction (by manual or mechanical means) of a condition of the vertebral column including distortion, misalignment or subluxation to relieve the effects of nerve interference which results from or relates to such conditions of the vertebral column. Please refer to the Schedule of Benefits pages for Plan limitations.

Benefits for x-rays received in connection with non-surgical spinal treatment are payable in the same manner as they are for other covered x-rays.

Therapy by Physical Means

Treatment given to relieve pain, restore maximum function and prevent disability following disease, Injury or loss of body part. Services include physical treatments, hydrotherapy; heat or similar modalities; physical agents; hyperbaric therapy; biomechanical, neurophysiological principles and devices. Braces and molds are not covered under this benefit.

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

WELLNESS BENEFITS

Preventive services will be covered under this Plan, as required under applicable federal and state law. In accordance with those laws and their associated guidance, limitations on coverage may apply, based upon the Covered Person's actual Condition, age, gender and the frequency of the service.

The following categories of preventive services are covered without application of a Deductible, Copayment or Coinsurance, when provided by a PPO Network Provider:

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

Examples of preventive services that fall within the above categories are:

- Health education services
  - Behavioral counseling to promote a healthy diet - Intensive behavioral dietary counseling for adults with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic diseases.

- Gynecological services
  - PAP tests; and
  - Mammogram services
    a. Screening Mammography for Covered Persons as specified in the Schedule of Benefits
    b. Supplemental Breast Cancer Screening for adult Covered Persons who meet either of the following conditions:

i. The Covered Person's Screening Mammography demonstrates, based on the breast imaging reporting and data system established by the American College of Radiology, that the Covered Person has dense breast tissue;
ii. The Covered Person is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by the Covered Person's Health Care Provider.

The total benefit for a Screening Mammography or Supplemental Breast Cancer Screening under this Plan, regardless of the number of claims submitted by Health Care Providers, will not exceed one hundred thirty percent (130%) of the Medicare reimbursement rate in Ohio for a Screening Mammography or Supplemental Breast Cancer Screening. If a Health Care Provider, Hospital, or other health care facility provides a service that is a component of the Screening Mammography or Supplemental Breast Cancer Screening and submits a separate claim for that component, a separate payment shall be made to the Health Care Provider, Hospital or other health care facility in an amount that corresponds to the ratio paid by Medicare in Ohio for that component. The benefit paid for Screening Mammography and Supplemental Breast Cancer Screening constitutes full payment under this Plan. No Health Care Provider, Hospital, or other health care facility shall seek or receive compensation in excess of the payment made that corresponds to the ratio paid by Medicare in Ohio, except for approved Deductibles, Copayments or Coinsurance.

- Physical Examinations

- Screenings
  - Blood glucose screenings and screening for type 2 diabetes
  - Bone density screenings
  - Chlamydia screenings, limited to pregnant and sexually active women
  - Cholesterol screenings
  - Colorectal cancer screenings: using fecal occult blood testing, sigmoidoscopy or colonoscopy
  - Hepatitis B virus screenings; limited to pregnant women in their first prenatal visit.

- Smoking cessation services

- Well child care services

- Women's preventive services
  - These services include, but are not limited to: well-woman visits; screening for gestational diabetes, human papillomavirus (HPV), human immunodeficiency virus (HIV) and sexually transmitted disease; Contraceptives and counseling for Contraceptives for women with reproductive capacity; sterilization procedures; breastfeeding; and domestic violence.

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

is one year after the new recommendations or guideline, went into effect. You will be notified at least sixty (60) days in advance, if any item or service is removed from the list of eligible services.

Direct Access to Obstetricians and Gynecologists

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

Selection of a Primary Care Provider

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

GENERAL LIMITATIONS AND EXCLUSIONS

The following are not covered by the Plan:

1. **Abdominal surgery.** Services and/or supplies for abdominal surgery and/or reconstructive surgery which is related but not limited to gastric related bypass surgery, or stomach stapling type surgery will not be eligible unless the Covered Person is two times his or her ideal weight. This includes surgical intervention for infections, chaffing, pain, diabetes, etc;

2. **Abortion.** For costs associated with nontherapeutic abortions;

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

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

5. **Acupuncture / Acupressure;**

6. **Biofeedback.** Biofeedback, recreational, or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing, unless authorized by the Plan;

7. **Blood.** Whole blood or plasma when donated or otherwise replaced by or on behalf of the patient. For blood storage services provided by other than a Hospital;

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

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

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

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

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

13. **Contraceptives.** For male contraceptives and over-the-counter birth control without a prescription;

14. **Cosmetic services.** Surgery and services rendered for cosmetic purposes, unless made necessary by accidental Injury, or to treat a mental or emotional Condition through a change in body form. This includes, but is not limited to stomach stapling, breast augmentation and face lifting;

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

16. **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care;

17. **Dental procedures,** to include treatments associated with teeth, dental x-rays, or dentistry, including Orthognathic (jaw) surgery, except as specified in the Plan or as required by PPACA;

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

19. **Educational Services.** Educational services, including special education and remedial education, vocational services, recreational services, other non-clinical services, or services provided for training purposes, except as may be required by PPACA or otherwise shown as covered under the Plan;

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

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

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

23. **Eye care.** Radial keratotomy or other eye surgery to correct sight, including refractions, lenses for the eyes and exams for their fitting, unless otherwise specified. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages, and initial cataract lenses after cataract surgery;

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

25. **Foot care.** For arch supports and other foot care or foot support devices only to improve comfort or appearance which include, but are not limited to, treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia, subluxations or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease) and routine foot care; Nail trimming, Hygienic and preventative maintenance foot care including but not limited to:

    - Cleaning and soaking of feet
    - Applying skin creams in order to maintain skin tone
    - Other services that are performed when there is not a localized illness, injury or symptom involving the foot;

26. **For an interpretation charge by a pathologist when the interpretation or result is already automatically provided by a machine-read or automated laboratory test;**

27. **For radiologic imaging with no preserved film image or digital record;**

28. **Genetic counseling or testing**. Counseling or testing concerning inherited (genetic) disorders except as required by PPACA;

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

30. **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician;

31. **Hearing Care.** Hearing aids or examinations for prescribing or fitting them except as otherwise stated in the SPD;

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

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

34. **Hypnosis;**

35. **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence not caused by organic disease. This exclusion does not apply if the care, treatment services, supplies or medication are provided in conjunction with a diagnosis of Mental Illness, Alcoholism or Drug Abuse, or as otherwise required by the Mental Health Parity and Addiction Equity Act (MHPAE) and its implementing regulations and guidance;

36. **Infertility.** Reproductive infertility services including but not limited to - family planning; fertility tests; infertility (male or female) including any services or supplies rendered for the purpose or with the intent of inducing conception. Examples of fertilization procedures are ovulation induction procedures, in vitro fertilization, artificial insemination; embryo transfer or similar procedures that augment or enhance the reproductive ability; premarital examinations;

37. **Intraoral prosthetic devices.** For treatment with intraoral prosthetic devices or by any other method, to alter vertical dimension;

38. **Marital counseling**. Treatment, services and supplies for marriage counseling, health education, holistic medicine or other programs with an objective to provide complete personal fulfillment. This exclusion does not apply if the treatment, services, or supplies are provided in conjunction with a diagnosis of Mental Illness, Alcoholism or Drug Abuse, or as otherwise required by the Mental Health Parity and Addiction Equity Act (MHPAE) and its implementing regulations and guidance;

39. **Massotherapy.** Charges billed by a massotherapist;

40. **Medicare Part B.** For which benefits would have been payable under Part B of Medicare if a Covered Person had enrolled in Part B coverage. For the purposes of the calculation of

benefits, if the Covered Person is eligible for, but has not enrolled in, Medicare Part B, Mutual Health Services will calculate benefits as if he or she had enrolled. This provision only applies where Medicare is the primary payer under the law;

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

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

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

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

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

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

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

48. **Nuclear accident**;

49. **Nutritional supplements.** Including those prescribed by a Physician except as authorized by the Plan or as required by PPACA;

50. **Obesity.** Care and treatment, by methods such as dietary supplements, vitamins and any care which is primarily dieting or exercise for obesity, weight loss or dietary control, whether or not it is a part of the treatment plan for another Illness. This exclusion includes Gastric Bypass surgery or any surgical interventions, unless your weight is at least twice the ideal amount;

51. **Outside the United States.** Services rendered outside the United States, except in the event of an Emergency Medical Condition. Please refer to the provision entitled, "Foreign Travel" for more information;

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

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

54. **Physical Examinations.** Physical examinations or services required by an insurance company to obtain insurance, a governmental agency such as the FAA and DOT, or an employer in order to begin or to continue working, premarital examinations, screening examinations except as specified;

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

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

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

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

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

60. **Temporomandibular Joint Dysfunction (TMJ);**

61. **Topical Anesthetic**;

62. **Transportation services provided by an ambulette or wheelchair van;**

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

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

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

66. **Wilderness therapy, therapeutic living communities (including therapeutic farms), adventure-based therapy or similar programs;**

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

68. **Work related**. Expenses Incurred as a result of accidental bodily Injury or sickness arising out of or in the course of any occupation or employment for wage or profit, or for which the Covered Person may be entitled to benefits under any Workers Compensation or occupational disease policy, whether or not any such policy is actually in force. However,

this exclusion only applies to persons who can elect, or could have elected for them, coverage under a worker's compensation act, policy or similar law.

VISION COVERAGE

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.

DENTAL BENEFITS

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 months).

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.

GENERAL INFORMATION

NO SURPRISES ACT

Ohio's House Bill 388 and the Federal No Surprises Act establish patient protections, including surprise bills (or "balance billing") from Non-PPO Network Providers and from Non-Contracting Health Care Providers for emergency care and other specified items or services. The Plan will comply with these new state, if applicable, and federal requirements, including how claims are processed from some of these Providers.

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. With respect to prior authorization requests submitted by health care practitioners (as defined in Ohio Revised Code 3923.041(A)) through the Plan's or its designee's electronic software system only, a Claim Involving Urgent Care also means a claim for Medical Care or other service for a Condition where the application of the timeframes for making non-urgent care determinations (a) could seriously jeopardize the life, health, or safety of the claimant or others due to the claimant's psychological state; or (b) in the opinion of a practitioner with knowledge of the claimant's medical or behavioral Condition, would subject the claimant to adverse health consequences without the care or treatment that is the subject of the request.
>
> **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. For medical claims, PPO Network Providers will submit a claim for you. 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.

If your health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submits a Claim Involving Urgent Care through the Plan's or its designee's electronic software system, the Plan or its designee will respond to the request within 48 hours of receipt and indicate whether the request is denied, approved, or if additional information is needed to process the request.

If additional information is needed to process the request, the Plan or its designee will notify the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) within 24 hours of receipt of the Claim Involving Urgent Care and the health care practitioner will have 48 hours to respond. Because we are required to make a decision within 48 hours after receipt of the Claim Involving Urgent Care, your claim may still be denied when we request additional information.

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. For Pre-Service Claims submitted in writing, 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.

If your health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submits a Pre-Service Claim through the Plan's or its designee's electronic software system, the Plan or its designee will respond to the request within 10 days of receipt and indicate whether the request is denied, approved, or if additional information is needed to process the request. If additional information is needed to process the request, the health care practitioner will then have 45 days to respond with the additional information. If your health care practitioner does not provide the information, your claim may be denied.

For only those prior authorization requests that are submitted by a health care practitioner (as defined in Ohio Revised Code 3923.041(A)) through the Plan's or its designee's electronic software system that are approved by the Plan or its designee, except in cases of fraudulent or materially incorrect information, the Plan or its designee will not retroactively deny a prior authorization for a health care service, drug, or device when all of the following are met: (1) the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submits a prior authorization request to the Plan or its designee for a health care service, drug, or device; (2) the Plan or its designee approves the prior authorization request after determining that all of the following are true: (a) the claimant is eligible under the health benefit plan; (b) the health care service, drug, or device is covered under the claimant's health benefit plan; and (c) the health care service, drug, or device meets the Plan's or its designee's standards for medical necessity and prior authorization; (3) the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) renders the health care service, drug, or device pursuant to the approved prior authorization request and all of the terms and conditions of the health care practitioner's contract with the Plan or its designee; (4) on the date the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) renders the prior approved health care service, drug, or device, all of the following are true: (a) the claimant is eligible under the health benefit plan; the claimant's condition or circumstances related to the claimant's care has not changed; (c) the health care practitioner submits an accurate claim that matches the information submitted by the health care practitioner in the approved prior authorization request; and (5) if the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submits a claim that includes an unintentional error and the error results in a claim that does not match the information originally submitted by the health care practitioner in the approved prior authorization request, upon receiving a denial of services from the Plan or its designee, the health care practitioner may resubmit the claim with the information that matches the information included in the approved prior authorization.

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.

If you file a Post-Service Claim for a service where prior authorization was required but not obtained, upon written request, the Plan or its Designee shall permit a retrospective review if the service in question meets all of the following: (i) the service is directly related to another service for which the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submitted a prior authorization request through the Plan's or its Designee's electronic software system, prior approval has already been obtained from the Plan or its Designee on such request, and the original prior authorized service has already been performed; (ii) the new service was not known to be needed at the time the original prior authorized service was performed; and (iii) the need for the new service was revealed at the time the original authorized service was performed. Once the written request and all necessary information is received, the Plan or its Designee will review the claim for coverage and medical necessity. The Plan or its Designee will not deny a claim for such a new service based solely on the fact that a prior authorization approval was not received for the new service in question.

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, Health Care 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 non-employer 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 – please refer to the definition of this term in the Definitions section of this SPD.

Emergency Services – please refer to the definition of this term in the Definitions section of this SPD.

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. If your health care practitioner (as defined in Ohio Revised Code 3923.041(A)) uses the Plan or its designee's electronic software system to request an appeal of a Claim Involving Urgent Care, the Plan or its designee will respond to the appeal within 48 hours of receipt.

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, if the Plan or its designee receives a pre-service claim appeal in writing. When the Plan or its designee receives a pre-service claim appeal from your health care practitioner (as defined in Ohio Revised Code 3923.041(A)) when you have authorized him or her to appeal on your behalf and the health care practitioner uses the Plan's or its designee's electronic software system for prior authorization, the Plan or its designee will respond to the appeal within 10 calendar days of receipt.

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, Health Care Provider, and claim amount (if applicable);
2. The specific reason(s) for the Final Adverse Benefit Determination, including the denial code and its corresponding meaning;
3. Reference to the specific plan provision(s) on which the Final Adverse Benefit Determination is based;
4. A statement that you may request reasonable access to and copies of all documents, records and other information relevant to your appealed claim for benefits, which shall be provided to you without charge;
5. If the Final Adverse Benefit Determination relied upon any internal rules, guidelines or protocols, a statement that you may request a copy of the rule, guideline or protocol, which will be provided to you without charge;
6. If the Final Adverse Benefit Determination was based in whole or in part on Medical Necessity, Experimental/Investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided to you without charge;

7. Notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
8. Disclosure of the availability of assistance with the appeal process from the Ohio Department of Insurance if your Plan is regulated by the Ohio Department of Insurance;
9. A discussion of the decision;
10. A description of the Plan's or its designee's applicable appeal procedures.

What Happens After the First Level Mandatory Internal Appeal

If your claim is denied at the mandatory first level internal appeal level, you may be eligible for either the External Review Process by an Independent Review Organization for Adverse Benefit Determinations involving medical judgment or the External Review Process by the Ohio Department of Insurance for contractual issues that do not involve medical judgment.

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

A. Contact Information for Filing an External Review

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

B. Understanding the External Review Process

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

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

C. Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. The Covered Person does not pay for the external review. There is no minimum cost of Health Care Services denied in order to qualify for an external review. However, the Covered Person must generally exhaust the Plan's mandatory internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the Adverse Benefit Determination.

1. External Review by an IRO

A Covered Person is entitled to an external review by an IRO in the following instances:

- The Adverse Benefit Determination involves a medical judgment or is based on any medical information
- The Adverse Benefit Determination indicates the requested service is Experimental or Investigational, the requested Health Care Service is not explicitly excluded in the Covered Person's Health Benefit Plan, and the treating Physician certifies at least one of the following:
    - Standard Health Care Services have not been effective in improving the Condition of the Covered Person
    - Standard Health Care Services are not medically appropriate for the Covered Person
    - No available standard Health Care Service covered by the Plan is more beneficial than the requested Health Care Service

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

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

- The Covered Person's treating Physician certifies that the Final Adverse Benefit Determination involves a medical Condition that could seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function if treatment is delayed until after the time frame of a standard external review.
- The Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or Health Care Service for which the Covered Person received Emergency Services, but has not yet been discharged from a facility.
- An expedited internal appeal is already in progress for an Adverse Benefit Determination of Experimental or Investigational treatment and the Covered Person's treating Physician certifies in writing that the recommended Health Care Service or treatment would be significantly less effective if not promptly initiated.

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

2. External Review by the Ohio Department of Insurance

A Covered Person is entitled to an external review by the Department in either of the following instances:

- The Adverse Benefit Determination is based on a contractual issue that does not involve a medical judgment or medical information.
- The Adverse Benefit Determination for an Emergency Medical Condition indicates that medical Condition did not meet the definition of emergency AND the Plan's decision has already been upheld through an external review by an IRO.

D. Request for External Review

Regardless of whether the external review case is to be reviewed by an IRO or the Department of Insurance, the Covered Person, or an Authorized Representative, must request an external review through the Plan within 180 days of the date of the notice of final adverse benefit determination issued by the Plan.

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

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

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

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

E. IRO Assignment

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

F. Reconsideration by the Plan

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

G. IRO Review and Decision

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

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

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

NOTE: Written decisions of an IRO concerning an Adverse Benefit Determination that involves a health care treatment or service that is stated to be Experimental or Investigational also includes the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

H. Binding Nature of External Review Decision

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

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

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

You may contact the Plan at the Customer Care Center telephone number listed on your identification card. You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300
Columbus, Ohio 43215-4186
Telephone: 800.686.1526 / 614-644-2673
Fax: 614-644-3744
TDD: 614-644-3745

Contact ODI Consumer Affairs:
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.

FOREIGN TRAVEL

Benefits include coverage for the treatment of Emergency Medical Conditions rendered worldwide. Your coverage is in effect whether your treatment is received in a foreign country or in the United States. When you receive medical treatment in another country, you may be asked to pay for the service at the time it is rendered. To receive reimbursement for the care provided, make sure to obtain an itemized bill from the Provider at the time of service. Mutual Health Services cannot process a bill unless the Provider lists separately the type and cost of each service you received. All billing submitted for consideration must be translated into the English language and dollar amounts converted to the current rate of exchange. To receive reimbursement for Hospital and/or medical expenses, the services rendered must be eligible for coverage in accordance with the benefits described in this Summary Plan Description.

HEALTH CARE FRAUD

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

PLAN AMENDMENTS

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

RESCISSION OF COVERAGE

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

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

RIGHT TO RELEASE CLAIMS AND RECEIVE NECESSARY INFORMATION

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

PHYSICAL EXAMINATION

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

FACILITY OF PAYMENT

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

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.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

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

LARGE CASE MANAGEMENT

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

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

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

COORDINATION OF BENEFITS

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

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

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

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

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 medical 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. For Medical and Prescription Benefits: The date the child becomes eligible and chooses to be covered as an Employee; or
4. For Dental and Vision Benefits: The date the child becomes covered as an Employee; or
5. The last day of the calendar month the child reached the applicable age for Dependent children; or
6. 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. For Medical and Prescription Benefits: The date the Spouse becomes covered as an Employee; or
4. The last day of the calendar month the Spouse is legally separated or divorced from the Employee; or
5. 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 a 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 - Disclosure by the Plan Sponsor

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 Non-Grandfathered High Deductible Health 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 Non-Grandfathered High Deductible Health Plan Document.

D. *Plan Sponsor* – Hancock County School 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 St.
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

Alcoholism – a Condition classified as a mental disorder and described in the most recent version of the International Classification of Diseases, as alcohol dependence, abuse or alcoholic psychosis.

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

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

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

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

Benefit Period – the period of time specified in the Schedule of Benefits during which Covered Services are rendered, and benefit maximums, Deductibles, Coinsurance Limits and Non-PPO Network 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.

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

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

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

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

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

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

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

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

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

Coinsurance - a percentage of the Lesser Amount for Contracting Institutional Providers and Physicians and Other Professional Providers or the Covered Charges for Non-Contracting Institutional Providers for which you are responsible after you have met your Deductible.

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

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

Confinement/Confined - the period starting with a Covered Person's admission on an inpatient basis to a Hospital or other licensed health care facility for treatment of an Illness or Injury.

Confinement ends with the Covered Person's discharge from the same Hospital or other facility. If the Covered Person is transferred to another Hospital or other facility for continued treatment of the same or related Illness or Injury, it is considered one Confinement.

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

Contracting - the status of a Health Care Provider:

- that has an agreement with Mutual Health Services about payment for Covered Services; or
- that is designated by Mutual Health Services as Contracting.

Convalescent Facility/Skilled Nursing Facility/Rehabilitation Facility

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

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

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

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

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

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

Day Treatment Programs - nonresidential programs for treatment of Alcoholism and Drug Abuse, which are operated by certified inpatient and outpatient Alcoholism and Drug Abuse Treatment Facilities, that provide case management, counseling, Medical Care, and therapies on a routine basis for a scheduled part of the day and a scheduled number of days per week; also known as partial Hospitalization.
Day/Night Psychiatric Facility- a facility that is primarily engaged in providing diagnostic services and therapeutic services for the Outpatient treatment of Mental Illness. These services are provided through either a day or night treatment program.

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

Dental Allowed Amount – the maximum amount determined and allowed by the Plan for a Covered Service.

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

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

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

Drug Abuse - a Condition classified as a mental disorder and described in the most recent version of the International Classification of Diseases, as drug dependence abuse or drug psychosis.

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

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

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.

Emergency Admission – an Inpatient admission to a Hospital directly from a Hospital emergency room.

Emergency Medical Care - medical services provided by a Health Care Provider to treat a Covered Person's medical emergency. A medical emergency is the sudden and unexpected onset of one or more acute Conditions calling for medical services which the Covered Person receives right after the onset of such Condition(s). For example, such an emergency includes heart attack, cardiovascular accident, poisoning, loss of consciousness or loss of breathing. These and other

acute Conditions are medical emergencies when all of the following are met, as determined by the Plan:

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

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

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

Emergency Services – a medical screening examination as required by federal law that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, or the Independent Freestanding Emergency Department, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to Stabilize the patient, regardless of the department of the Hospital in which such further examination or treatment is furnished; and appropriate transfers undertaken prior to an Emergency Medical Condition being Stabilized.

"Emergency Services" also includes services for which benefits are provided under the Plan and that are furnished by a Non-PPO Network Provider or Non-Contracting Health Care Provider (regardless of the department of the Hospital in which such items or services are furnished) after the Covered Person is Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are furnished.

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.

Essential Health Benefits - is defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; Emergency Services; Hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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

1. The device drug or medicine cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug, or medicine is furnished;
2. Reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I, II or III clinical trials or is under study to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis; or
3. Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocols used by the treating facility and the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine. Determination will be made by Quantum Care Coordinators at its sole discretion and will be final and conclusive.

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

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

Home Health Care Agency - a facility which:

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

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

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

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

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

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

A Hospital does not include, as determined by the Plan: (a) a convalescent or extended care facility unit within or affiliated with the Hospital; (b) a clinic; (c) a nursing, rest or convalescent home or extended care facility; (d) an institution operated mainly for care of the aged or for treatment of Mental Illness or Alcoholism and Drug Abuse; (e) a health resort, spa or sanitarium; or (f) a sub-acute care center.

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

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.

Independent Freestanding Emergency Department – a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable State law; and
- Provides any Emergency Services.

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.

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

Institution (Institutional) – a Hospital or Other Facility Provider.

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.

Medical Care – professional services received from a Physician or an Other Professional Provider to treat a condition.

Medical Emergency – the sudden and unexpected onset of a severe medical ailment, condition, disease, illness or disorder, including severe pain, requiring Emergency Services.

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

- Consistent with the diagnosis and treatment of the patient's condition
- Consistent with professionally recognized standards of health care;
- Not solely for the convenience of the patient, Physician or supplier; and
- Performed in the least costly, most appropriate supply or level of service which can be safely provided to you, setting required by the patient's medical Condition. When applied to the care of an Inpatient, this means that your medical symptoms or Condition require that the services cannot be safely or adequately provided to you as an Outpatient. When applied to Prescription Drugs, this means the Prescription Drug is cost effective compared to alternative Prescription Drugs which will produce comparable effective clinical results.

The fact that a Physician may have prescribed, ordered, recommended, or approved the services, supplies or treatment does not necessarily mean that they satisfy the above criteria.

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

Mental Illness – all Conditions covered under the Plan, except for substance use disorders, that fall under any of the diagnostic categories listed in the mental, behavioral, and neurodevelopmental disorders chapter (or equivalent chapter) of the most current version of the International Classification of Diseases (ICD) manual or that are listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Unless the Plan Administrator has instructed the Claims Administrator to do otherwise, and the Summary Plan Description states such exception, newly added mental health Conditions added to the ICD or DSM will start to be covered no later than on the first day of the plan year on or after the date that is one year after the Condition is added to the ICD or DSM.

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

Network Pharmacy- a Pharmacy that has a network agreement to provide Prescription Drug services.

Non-Contracting - the status of a Health Care Provider that does not have a contract with Mutual Health Services or one of its networks.

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

Non-PPO Network Provider - a Contracting Health Care Provider that does not meet the definition of a PPO Network Provider.

Other Facility Provider - the following institutions which are licensed (where required) and where Covered Services are provided in exchange for compensation. Other than incidentally, these facilities are not used as offices or clinics for the private practice of a Physician or Other

Professional Provider. Quantum Care Coordinators will only provide benefits for services or supplies for which a charge is made.

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

2. Ambulatory Surgical Facility – a facility with an organized staff of Physicians that has permanent facilities and equipment for the primary purpose of performing surgical procedures strictly on an Outpatient basis. Treatment must be provided by or under the supervision of a Physician and also includes nursing services.

3. Day/Night Psychiatric Facility – a facility which is primarily engaged in providing diagnostic services and therapeutic services for the Outpatient treatment of Mental Illness. These services are provided through either a day or night treatment program.

4. Dialysis Facility - a facility which mainly provides dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.
5. Drug Abuse Treatment Facility - a facility which mainly provides detoxification and/or rehabilitation treatment for Drug Abuse.

6. Home Health Care Agency - a facility which:
    - meets the specifications of Chapter 3701.88 of the Ohio Revised Code, except for the requirement that such an Institution be operated within the state of Ohio.
    - provides skilled nursing and other services on a visiting basis in the Covered Person's home, as specified in the Home Health Care Services section of this Plan; and
    - is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

7. Hospice Facility – a facility which provides supportive care for terminally ill patients as specified in the Hospice Services section of this Plan.

8. Psychiatric Facility – a facility which is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental Illness on an Outpatient basis.

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

10. Skilled Nursing Facility – a facility which primarily provides 24-hour Inpatient Skilled Care and related services to patients requiring convalescent and rehabilitative care. Such care must be provided by either a registered nurse, licensed practical nurse or physical therapist performing under the supervision of a Physician.

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

Other Professional Providers include the following:

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

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

Other Provider Facilities include the following institutions:

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

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

Outpatient – the status of a Covered Person who receives services or supplies through a Hospital, Other Facility Provider, Physician or Other Professional Provider while not confined as an Inpatient.

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 Non-Grandfathered High Deductible Health 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 School Consortium, McComb Local Schools.

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

PPO Network Provider - a Physician, Other Professional Provider, Contracting Hospital or Contracting Other Provider Facility which is included in a limited panel of Health Care Providers for which the greatest benefit will be payable when one of these Health Care Providers is used.

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

1. such tests are related to the performance of scheduled surgery;
2. such tests have been ordered by a duly qualified Physician after a Condition requiring such surgery has been diagnosed and Hospital admission for such surgery has been requested by the Physician; and
3. you or your Dependent are subsequently admitted to the Hospital, or the Confinement is canceled or postponed because a Hospital bed is unavailable or because there is a change in your or your Dependent's condition which precludes the surgery.

Prescription Drug (Federal Legend Drug) – any medication which by federal or state law may not be dispensed without a Prescription Order.

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

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

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

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

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

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

1. An Other Professional Provider who is licensed or certified as a Psychologist, having either a doctorate in psychology or a minimum of five years clinical experience, by the appropriate governmental authority having jurisdiction over such licensure or certification, as the case may be, in the jurisdiction where such person renders service to you or your dependent.
2. A person who is a Member or Fellow of the American Psychological Association, if there is no licensure or certification in the jurisdiction where such person renders service to you or your dependent.

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

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

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

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

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

1. The name and last known mailing address of the Participant;
2. The name and address of each Alternate Recipient;

3. A reasonable description of the type of coverage to be provided by the group health plan or the manner in which such coverage is to be determined;
4. The period for which coverage must be provided; and
5. Each Plan to which the order applies.

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

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 medical or dental charges covered by this Plan.

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

Residential Treatment Facility – a facility that meets all of the following:

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

Screening Mammography - a radiologic examination utilized to detect unsuspected breast cancer at an early stage in an asymptomatic Covered Person and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. "Screening Mammography" includes

digital breast tomosynthesis. "Screening Mammography" includes two views for each breast. The term also includes the professional interpretation of the film. "Screening Mammography" does not include diagnostic mammography.

Skilled Nursing Care - care furnished on a Physician's orders which require the skill of professional personnel such as a registered or licensed practical nurse, or physical therapist and is provided either directly by or under the supervision of Physicians. In the absence of such care, the Covered Person's health would be seriously impaired. Such care cannot be taught to or administered by a lay person. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

1. Minimal custodial, ambulatory, or part-time care; or
2. Treatment for pulmonary tuberculosis.

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

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

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

Supplemental Breast Cancer Screening - any additional screening method deemed Medically Necessary by a treating Health Care Provider for proper breast cancer screening in accordance with applicable American College of Radiology guidelines, including magnetic resonance imaging, ultrasound, or molecular breast imaging.

Surgery

1. the performance of general accepted operative and other invasive procedures;
2. the correction of fractures and dislocations;
3. usual and related preoperative and postoperative care; or
4. other procedures as reasonably approved by Quantum Care Coordinators.

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.

Telehealth Services – health care services provided through the use of information and communication technology by a health care professional, within the professional's scope of practice, who is located at a site other than the site where either of the following is located: (a) The patient receiving the services; (b) Another health care professional with whom the provider of the services is consulting regarding the patient.

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.

Transplant Center – a facility approved by Quantum Care Coordinators that is an integral part of a Hospital and which:

1. has consistent, fair and practical criteria for selecting patients for transplants;
2. has a written agreement with an organization that is legally authorized to obtain donor organs; and
3. complies with all federal and state laws and regulations that apply to transplants covered under this Plan.

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

Urgent Care Provider – an Other Professional Provider that performs services for health problems that require immediate medical attention which are not Emergencies.

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 Non-Grandfathered High Deductible Health Plan through the Hancock County Schools Consortium
Plan Sponsor:	Hancock County Schools Consortium McComb Local Schools 328 South Todd St. 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:	503
Type of Plan:	Self-Funded Employee Benefit Plan - a Group Health Plan
Plan Year Ends:	September 30th
Statutory Agent for Service of Legal Process:	The Plan Sponsor named above