MUTUAL HEALTH SERVICES
BUCKEYE OHIO RISK MANAGEMENT ASSOCIATION (BORMA)

CITY OF NAPOLEON

HIGH DEDUCTIBLE

HEALTH AND PRESCRIPTION DRUG CARE PLAN

PLAN DOCUMENT

AND

EMPLOYEE BENEFIT BOOKLET

NON-GRANDFATHERED

Effective: January 1, 2014
Revised: January 1, 2015

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ADOPTION

Buckeye Ohio Risk Management Association (BORMA) has caused this Buckeye Ohio Risk Management Association (BORMA) City of Napoleon High Deductible Health and Prescription Drug Plan (***Plan***) to take effect as of the first day of January, 2015, at Napoleon, Ohio. I have read the document herein and certify the document reflects the terms and conditions of the High Deductible ***employee*** welfare benefit plan as established by Buckeye Ohio Risk Management Association (BORMA).

BY: Gregory J. Heath DATE: May 13, 2015

Gregory J. Heath, Finance Director/
Clerk of Council

FACTS ABOUT THE PLAN

Name of Plan:

Buckeye Ohio Risk Management Association (BORMA) City of Napoleon High Deductible Health Care Plan

Name, Address and Phone Number of Employer/Plan Sponsor:

Buckeye Ohio Risk Management Association (BORMA)
City of Napoleon
255 W. Riverview
Napoleon, Ohio 43546
419-599-1235

Group Number:

167

Type of Plan:

Welfare Benefit Plan: medical and prescription drug benefits

Type of Administration:

Contract administration: The processing of claims for benefits under the terms of the ***Plan*** is provided through one or more companies by the ***employer*** and shall hereinafter be referred to as the ***claims processor***.

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent for Service of Legal Process:

Buckeye Ohio Risk Management Association (BORMA)
City of Napoleon
255 W. Riverview
Napoleon, Ohio 43546
419-599-1235

Legal process may be served upon the ***plan administrator***.

Eligibility Requirements:

For detailed information regarding a person's eligibility to participate in the ***Plan,*** refer to the following section:

Eligibility, Enrollment and Effective Date of Coverage

For detailed information regarding a person being ineligible for benefits through reaching ***maximum benefit*** levels, termination of coverage or ***Plan*** exclusions, refer to the following sections:

Schedule of Benefits
Termination of Coverage
Plan Exclusions

SCHEDULE OF BENEFITS

The following *Schedule of Benefits* is designed as a quick reference. For complete provisions of the ***Plan's*** benefits, refer to the following sections: *Claim Filing and Appeal Procedure, Medical Expense Benefit and Prescription Drug Program Plan Exclusions and* ***preferred provider or nonpreferred provider.***

MEDICAL BENEFITS

Annual Maximum Amount Payable per Individual	
Medical and Prescription Drug	Unlimited
Maximum Benefit **Per covered person Per Calendar Year, Unless Otherwise Specified, For:**	
Durable Medical Equipment ▪ Jobst stockings ▪ Mastectomy Bras	 Two pair Two
Routine Mammogram Services	One Test
Routine Pap Tests	One Test
Routine Physical Examinations (age 21 and over)	One Examination
Bone Density Tests (women age 50 and over)	One Test every 24 months
Maximum Benefit **Per covered person Per Lifetime:**	
Diabetic Training	One program following initial diagnosis
Hospice Care	180 days
Wigs following Chemotherapy	One wig

	preferred provider	***nonpreferred provider***
Deductible Per Calendar Year: Individual Deductible (Per Person) Family Deductible (Aggregate) [1]	 $2,700 $5,400	 $4,000 $8,000
Coinsurance	100%	50%
Out-of-Pocket Maximum Per Calendar Year: (including any applicable Copayments, Deductible and Coinsurance): Individual (Per Person) Family (Aggregate)	 $2,700 $5,400	 $16,000 $32,000
Refer to *Medical Expense Benefit, Out-of-Pocket Maximum* for a listing of charges not applicable to the Out-of-Pocket Maximum. Amounts applied toward satisfaction of the ***preferred provider*** Deductible will not be applied toward satisfaction of the ***nonpreferred*** provider Deductible. Amounts applied toward satisfaction of the ***nonpreferred*** provider Deductible will not be applied toward satisfaction of the ***nonpreferred*** provider Deductible.		
Coinsurance: The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by a ***covered person*** during a calendar year after the individual or family Deductible has been satisfied and until the individual or family Out-of-Pocket Maximum has been reached. Thereafter, the ***Plan*** pays one hundred percent (100%) of ***covered expenses*** for the remainder of the calendar year. Refer to *Medical Expense Benefit, Out-of-Pocket Maximum, for* a listing of charges not applicable to the one hundred percent (100%) ***coinsurance***.		

Benefit Description	***preferred provider* (% of *negotiated rate*, if applicable, other % of *allowed amount***	***nonpreferred provider* (% of *allowed amount*)**
Emergency Room		
Emergency use of an Emergency Room and all other related Facility and Emergency Room Professional charges	100%	
Non-Emergency Use of an Emergency Room and other related Emergency Room Professional charges	100%	50%
Inpatient Services		
Anesthesia	100%	50%
Consultations	100%	50%
Newborn Care	100%	50%
Institutional Services- precertification is required	100%	50%
Physical Medicine and Rehabilitation	100%	50%
Professional Services (semi-private room)	100%	50%
Skilled Nursing Care Facility	100%	50%
Surgical Services	100%	50%
Office Visit (Illness/Injury)		
Medically Necessary PCP/Specialist Visits/Consultations	100%	50%
Urgent Care Office Visit and related services	100%	50%
Outpatient Services		
Allergy Testing and Treatment	100%	50%
Diagnostic Imaging, Laboratory Services, X-ray and Medical Tests	100%	50%
Diabetic Education and Training	100%	50%
Home Health Care	100%	50%
Immunizations (other than those required by PPACA)	100%	50%
Pre-Admission Testing	100%	
Surgical Services-including Anesthesia, Assistant Surgeon, Surgery Professional and Surgery Facility	100%	50%
Mental Health Care, Drug Abuse and Alcoholism Services 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.		
Outpatient Therapy		
Physical and Occupational Therapy – Facility and Professional	100%	50%
Cardiac Rehabilitation	100%	50%
Speech Therapy	100%	50%
Chiropractic Therapy	100%	50%
Chemotherapy and Radiation Therapy	100%	50%
Dialysis Treatment, Hyperbaric Therapy, Pulmonary Therapy	100%	50%
Respiratory Therapy	100%	50%
Preventive/Routine/Well Child		
Preventive Services in accordance with state and federal law including Women's Preventive Health, routine Screenings and Adult Immunizations	*100%	50%
Women's Preventive Health	*100%	50%
Immunizations as required by PPACA	*100%	50%
Physical Exam (age 21 and over, 1 per benefit period)	*100%	50%
Bone Density Tests(1 every 24 months for women age 50 and older)	*100%	50%
Endoscopic Services	*100%	50%
Routine Lab, Medical Tests and X-rays	*100%	50%
Mammogram (all ages, 1 per benefit period)	*100%	50%
Pap Test (all ages, 1 per benefit period) (includes GYN exam)	*100%	50%
PSA Tests (including prostate exam)	*100%	50%
Well Child Care (to age 21) – including exams, hearing exams, immunizations, labs and vision exams	*100%	50%

Benefit Description	***preferred provider* (% of *negotiated rate*, if applicable, other % of *allowed amount***	***nonpreferred provider* (% of *allowed amount*)**
Additional Services		
Abortions	100%	50%
Ambulance	100%	50%
Approved Clinical Trial – benefits based on services rendered		
Durable Medical Equipment ▪ **Jobst stockings(two pair per benefit period)**	100%	50%
Wigs (cranial prosthesis) (1 per lifetime)	100%	
Bras following Mastectomy (2 per benefit period)	100%	
Hospice (180 days per lifetime)	100%	50%
Infertility Testing	100%	50%
Medical Supplies	100%	50%
Oral Accident	100%	50%
Organ Transplant	100%	50%
Private Duty Nursing	100%	50%
Therapeutic Injections	100%	50%
TMJ	100%	50%
Prescription Drug Benefits combined with Medical Benefits		
Prescription Drugs in compliance with Health Care Reform including Women's Health	*100%	Not Covered
Prescription Drugs (not required by Health Care Reform)	100% after Deductible	Not Covered
Prescription Drug Out-of-Pocket Maximum per Calendar Year: Any Copayments, 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.) However, if a brand name Prescription Drug is purchased when a generic Prescription Drug is available and medically appropriate (as determined by the Covered Person's Physician), the difference between the cost of the generic and brand name Prescription Drug that the Covered Person pays is not counted toward the Out-of-Pocket Maximum.		
All Other *covered expenses*	100%	70%

*Not subject to the Deductible

Note:

Deductible and ***coinsurance*** expenses incurred for services by a ***nonpreferred provider*** will not apply to the network Deductible and ***coinsurance*** Out-of-Pocket Maximum. Deductible and ***coinsurance*** expenses incurred for services by a ***preferred provider*** will not apply to the ***nonpreferred*** Deductible and ***coinsurance*** Out-of-Pocket Maximum.

Benefits will be determined based on Mutual Health Services' medical and administrative policies and procedures.

This Schedule of Benefits is only a partial listing of benefits. No person other than an officer of Mutual Health Services may agree, orally or in writing, to change the benefits listed here. The benefit booklet will contain the complete listing of covered services.

In certain instances, Mutual Health Services' payment may not be equal the percentage listed above. However, the ***covered person's coinsurance*** will always be based on the lesser of the provider's billed charges or the ***negotiated rate*** with the provider.

1. Maximum family Deductible. Member Deductible is the same as single Deductible.

PREFERRED PROVIDER OR *NONPREFERRED PROVIDER*

Covered persons have the choice of using either a ***preferred provider*** or a ***nonpreferred provider***.

PREFERRED PROVIDERS

A ***preferred provider*** is a ***physician***, ***hospital*** or ancillary service provider which has an agreement in effect with the P***referred Provider Organization*** (PPO) to accept a reduced rate for services rendered to ***covered persons***. This is known as the ***negotiated rate***. The ***preferred provider*** cannot bill the ***covered person*** for any amount in excess of the ***negotiated rate***. ***Covered persons*** should contact the ***employer's*** Human Resources Department for a current listing of ***preferred providers***.

NONPREFERRED PROVIDERS

A ***nonpreferred provider*** does not have an agreement in effect with the ***Preferred Provider Organization***. This ***Plan*** will allow only the ***allowed amount*** as a ***covered expense***. The ***Plan*** will pay its percentage of the ***allowed amount*** for the ***nonpreferred provider*** services, supplies and treatment. The ***covered person*** is responsible for the remaining balance. This results in greater out-of-pocket expenses to the ***covered person***.

REFERRALS

Referrals to a ***nonpreferred provider*** are covered as ***nonpreferred provider*** services, supplies and treatments. It is the responsibility of the ***covered person*** to assure services to be rendered are performed by ***preferred providers*** in order to receive the ***preferred provider*** level of benefits.

EXCEPTIONS

The following listing of exceptions represents services, supplies or treatments rendered by a ***nonpreferred provider*** where ***covered expenses*** shall be payable at the ***preferred provider*** level of benefits:

1. Treatment rendered for an ***emergency medical condition*** at a ***nonpreferred facility***. If the ***covered person*** is admitted to the ***hospital*** on an emergency basis, ***covered expenses*** shall be payable at the ***preferred provider*** level.

2. ***Nonpreferred*** anesthesiologist if the operating surgeon is a ***preferred provider***.

3. Radiologist or pathologist services for interpretation of x-rays and diagnostic laboratory and surgical pathology tests rendered by a ***nonpreferred provider*** when the ***facility*** rendering such services is a ***preferred provider***.

4. Diagnostic laboratory and surgical pathology tests referred to a ***nonpreferred provider*** by a ***preferred provider***.

5. While the ***covered person*** is confined to a ***preferred provider hospital***, the ***preferred provider physician*** requests a consultation from a ***nonpreferred provider*** or a newborn visit is performed by a ***nonpreferred provider***.

6. ***Medically necessary*** services, supplies and treatments not available through any ***preferred provider***.

7. When a covered ***dependent*** resides outside the service area of the ***Preferred Provider Organization***, for example a ***full-time student*** or due to a divorce situation, ***covered expenses*** shall be payable at the ***preferred provider*** level of benefits.

8. Treatment received while temporarily living outside the service area (for no longer than sixty (60) days) or while traveling.

PRECERTIFICATION OF BENEFITS

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

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

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

- All hospital admissions
- Reconstructive surgeries
- Durable medical equipment and devices
- MRI's and PET scans
- Therapy
- Home health care

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

Emergency Admissions

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

Medical-Surgical
(800) 338-4114

Behavioral Health
(800) 258-3186

MEDICAL EXPENSE BENEFIT

This section describes the ***covered expenses*** of the ***Plan***. All ***covered expenses*** are subject to applicable ***Plan*** provisions including, but not limited to: Deductible, ***copay***, ***coinsurance*** and ***maximum benefit (if applicable)*** provisions as shown on the *Schedule of Benefits*, unless otherwise indicated. Any portion of an expense ***incurred*** by the ***covered person*** for services, supplies or treatment that is greater than the ***allowed amount*** will not be considered a ***covered expense*** by this ***Plan***. Specified preventive care expenses will be considered to be ***covered expenses***.

DEDUCTIBLES

Individual Deductible

The individual Deductible is the dollar amount of ***covered expense*** that each ***covered person*** must have ***incurred*** during each calendar year before the ***Plan*** pays applicable benefits. The individual Deductible amount is shown on the *Schedule of Benefits*.

Family Deductible

If, in any calendar year, covered members of a family ***incur covered expenses*** that are subject to the Deductible that are equal to or greater than the dollar amount of the family Deductible shown on the *Schedule of Benefits*, then the family Deductible will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family Deductible amount, but no more than each person's individual Deductible amount may be applied toward satisfaction of the family Deductible by any family member.

Common Accident

If two or more covered members of a family are ***injured*** in the same ***accident*** and, as a result of that ***accident***, ***incur covered expenses***, only one individual Deductible amount will be deducted from the total ***covered expenses*** of all covered family members related to the ***accident*** for each calendar year in which such accident related expenses are incurred.

COINSURANCE

The ***Plan*** pays a specified percentage of ***covered expenses*** at the ***allowed amount.*** That percentage is specified on *the Schedule of Benefits*. For ***nonpreferred providers***, the ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and 100% of the billed amount. The ***covered person's*** portion of the ***coinsurance*** represents part of the Out-of-Pocket Maximum.

OUT-OF-POCKET MAXIMUM

After the ***covered person*** has ***incurred*** an amount equal to the Out-of-Pocket Maximum listed on the *Schedule of Benefits* for ***covered expenses***, the ***Plan*** will begin to pay 100% for ***covered expenses*** for the remainder of the calendar year.

After a covered family has ***incurred*** a combined amount equal to the family Out-of-Pocket Maximum shown on the *Schedule of Benefits*, the ***Plan*** will pay 100% of ***covered expenses*** for all covered family members for the remainder of the calendar year.

Out-of-Pocket Maximum Exclusions

The following items do not apply toward satisfaction of the calendar year Out-of-Pocket Maximum:

1. Expenses for services, supplies and treatments not covered by this ***Plan***, to include charges in excess of the ***allowed amount***.

2. Expenses ***incurred*** as a result of failure to obtain precertification.

MAXIMUM BENEFIT

The ***maximum benefit*** payable on behalf of a ***covered person*** is shown on the Schedule of Benefits. The ***maximum benefit*** applies, as shown in the Schedule of Benefits, to the ***covered person*** when covered under the ***Plan***, either as an ***employee, dependent, alternate recipient*** or under COBRA. If the ***covered person's*** coverage under the ***Plan*** terminates and at a later date he again becomes covered under the ***Plan***, the ***maximum benefit*** will include all benefits paid by the ***Plan*** for the ***covered person*** during any period of coverage as defined in the Schedule of Benefits.

The *Schedule of Benefits* may contain separate ***maximum benefit*** limitations for specified conditions and/or services. Any separate ***maximum benefit*** will include all such benefits paid by the ***Plan*** for the ***covered person*** during any and all periods of coverage under this ***Plan***. All separate ***maximum benefits*** are part of, and not in addition to, the ***maximum benefit***. No more than the maximum benefit will be paid for any ***covered person*** while covered by this ***Plan.***

Notwithstanding any provision of this ***Plan*** to the contrary, all benefits received by an individual under any benefit option, package or coverage under the ***Plan*** shall be applied toward the ***maximum benefit*** paid by this Plan for any one ***covered person*** for such option, package or coverage under the ***Plan***, and also toward the ***maximum benefit*** under any other options, packages or coverages under the ***Plan*** in which the individual may participate in the future.

HOSPITAL/AMBULATORY SURGICAL FACILITY

Inpatient hospital admissions are subject to precertification. Failure to obtain precertification will result in a reduction of benefits (refer to the Precertification of Benefits section).

Covered expenses shall include:

1. ***Room and board*** for treatment in a ***hospital***, including ***intensive care units***, cardiac care units and similar ***medically necessary*** accommodations. ***Covered expenses*** for ***room and board*** shall be limited to the ***hospital's semiprivate*** rate. ***Covered expenses*** for ***intensive care*** or cardiac care units shall be the ***allowed amount.*** A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the ***covered person***. In a ***hospital*** that has only private rooms, a full private room rate is covered.

2. Miscellaneous ***hospital*** services, supplies and treatments including, but not limited to:

    a. Admission fees, and other fees assessed by the ***hospital*** for rendering services, supplies and treatments;
    b. Use of operating, treatment or delivery rooms;
    c. Anesthesia, anesthesia supplies and its administration by an ***employee*** of the ***hospital***;
    d. Medical and surgical dressings and supplies, casts and splints;
    e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
    f. Drugs and medicines (except drugs not used or consumed in the ***hospital***);

g. X-ray and diagnostic laboratory procedures and services;
h. Oxygen and other gas therapy and the administration thereof;
i. Therapy services.
j. Inpatient physical medicine and rehabilitation.

3. Services, supplies and treatments described above furnished by an ***ambulatory surgical facility***, including follow-up care provided within seventy-two (72) hours of a procedure.

4. Charges for preadmission testing (x-rays and lab tests) performed within seven (7) days prior to a ***hospital*** admission which are related to the condition which is necessitating the ***confinement***. Such tests shall be payable even if they result in additional medical treatment prior to ***confinement*** or if they show that ***hospital confinement*** is not ***medically necessary***. Such tests shall not be payable if the same tests are performed again after the ***covered person*** has been admitted. No benefits are payable for preadmission tests for any surgical procedure which is not covered by this ***Plan*** or for preadmission tests for minor surgery which does not require hospital confinement.

FACILITY PROVIDERS

Services of ***facility*** providers if such services would have been covered if performed in a ***hospital*** or ***ambulatory surgical facility***.

AMBULANCE SERVICES

Ambulance services must be by a regularly scheduled airline, railroad or by a licensed air or ground ambulance.

Covered expenses shall include:

1. Ambulance services for air or ground transportation for the ***covered person*** from the place of ***injury*** or serious medical incident to the nearest ***hospital*** where treatment can be given.

2. Ambulance service is covered for a non-***emergency medical condition*** only to transport the ***covered person*** to or from a ***hospital*** or between ***hospitals*** for required treatment when such transportation is certified by the attending ***physician*** as ***medically necessary***. Such transportation is covered only from the initial ***hospital*** to the nearest ***hospital*** qualified to render the special treatment.

3. Emergency services actually provided by an advance life support unit, even though the unit does not provide transportation.

In the event a disability required specialized emergency treatment not available at a local ***hospital***, transportation for such treatment is covered when ordered by a ***physician***. The transportation which the United States and Canada must be by regularly scheduled airlines, railroad or by air ambulance. The covered transportation is only from the city or town where the disability occurred to the nearest ***hospital*** qualified to render special treatment.

CLINICAL TRIAL PROGRAMS

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

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

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

Provider's Billed Charges for the services.

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

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

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

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

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

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

EMERGENCY ROOM SERVICES

Coverage for emergency room treatment shall be paid in accordance with the *Schedule of Benefits*, provided the condition meets the definition of ***emergency medical condition*** herein.

Emergency Services

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

Your Plan covers Emergency Services for an Emergency Medical Condition treated in any Hospital emergency department.

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

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

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

NON-EMERGENCY USE OF THE EMERGENCY ROOM

Emergency room treatment for conditions that do not meet the definition of ***emergency medical condition*** will be considered non-emergency use of the emergency room and shall be paid in accordance with the *Schedule of Benefits*.

IMMEDIATE CARE CENTER

Covered expenses shall include charges for treatment in an immediate care center, payable as specified on the Schedule of Benefits.

PHYSICIAN SERVICES

Covered expenses shall include:

1. Medical treatment, services and supplies including, but not limited to: office visits, ***inpatient*** visits, home visits.

2. Surgical treatment. Separate payment will not be made for ***inpatient*** pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

   For related operations or procedures performed through the same incision or in the same operative field, ***covered expenses*** shall include the surgical allowance for the highest paying procedure, plus fifty (50) percent of the surgical allowance for each additional procedure.

   When two (2) or more unrelated operations or procedures are performed at the same operative session, ***covered expenses*** shall include the surgical allowance for each procedure.

   No benefits are payable for "incidental" procedures, i.e. procedures which would be an integral part of the primary procedure or that is unrelated to the diagnosis.

3. Surgical assistance provided by a ***physician*** if it is determined that the condition of the ***covered person*** or the type of surgical procedure requires such assistance. Covered expenses for the services of an assistant surgeon are limited to twenty-five percent (25%) of the surgical allowance.

4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.

5. Consultations requested by the attending ***physician*** during a ***hospital confinement***. Consultations do not include staff consultations which are required by a ***hospital's*** rules and regulations.

6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.

8. Allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy tests.

SECOND SURGICAL OPINION

Benefits for a second surgical opinion will be payable according to the *Schedule of Benefits* if an elective surgical procedure (non-emergency surgery) is recommended by the ***physician***.

The ***physician*** rendering the second opinion regarding the ***medical necessity*** of such surgery must be a board certified specialist in the treatment of the ***covered person's illness*** or ***injury*** and must not be affiliated in any way with the ***physician*** who will be performing the actual surgery.

In the event of conflicting opinions, a request for a third opinion may be obtained. The ***Plan*** will consider payment for a third opinion the same as a second surgical opinion.

The second surgical opinion benefit includes physician services only. Any diagnostic services will be payable under the standard provisions of the Plan.

DIAGNOSTIC SERVICES AND SUPPLIES

Covered expenses shall include services and supplies for diagnostic laboratory, electronic tests, pathology, ultrasound, nuclear medicine, magnetic imaging and x-ray.

TRANSPLANT

Transplant procedures are subject to precertification. Failure to obtain precertification will result in a reduction of benefits for the ***hospital confinement*** as specified in the *Precertification of Benefits* section of this document.

Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered ***covered expenses*** subject to the following conditions:

1. In order for the transplant to be covered, the following requirements must be met:

    a. The transplant must be for treatment of a life-threatening condition;

    b. The transplant for the life-threatening condition must be the subject to an ongoing phase III clinical trial;

    c. Such transplant follows a written protocol that has been reviewed and approved by an institutional review board, federal agency or other such organization recognized by medical specialists who have appropriate expertise; and

    d. The patient must be a suitable candidate for the transplant.

2. When the recipient is covered under this ***Plan***, the ***Plan*** will pay the recipient's ***covered expenses*** related to the transplant.

3. When the donor is covered under this ***Plan***, the ***Plan*** will pay the donor's ***covered expenses*** related to the transplant, to the extent that benefits are not provided for those expenses under any other group benefit plan.

4. Expenses ***incurred*** by the donor who is not ordinarily covered under this ***Plan*** according to eligibility requirements will be ***covered expenses*** to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this ***Plan.*** The donor's expense shall be applied to the recipient's benefit. In no event will benefits be payable in excess of the benefit available to the recipient.

5. Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a ***covered expense*** under this ***Plan***.

If a ***covered person's*** transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.

PREGNANCY

Covered expenses shall include services, supplies and treatment related to ***pregnancy*** or ***complications of pregnancy*** for a covered female ***employee***, a covered female spouse of a covered ***employee***, and ***dependent*** female children.

In the event of early discharge from a ***hospital*** or ***birthing center*** following delivery, the ***Plan*** will cover one (1) Registered Nurse home visit.

The ***Plan*** shall cover services, supplies and treatments for ***medically necessary*** and elective abortions and complications from an abortion.

BIRTHING CENTER

Covered expenses shall include services, supplies and treatments rendered at a ***birthing center*** provided the ***physician*** in charge is acting within the scope of his license and the ***birthing center*** meets all legal requirements. Services of a midwife acting within the scope of his/her license or registration are a ***covered expense*** provided that the state in which such service is performed has legally recognized midwife delivery.

STERILIZATION

Covered expenses shall include elective sterilization procedures for the covered ***employee*** or covered spouse. Reversal of sterilization is not a ***covered expense***.

INFERTILITY SERVICES

Covered expenses shall include expenses for infertility testing for ***employees*** and their covered spouse.

Covered expenses for infertility testing are limited to the actual testing for a diagnosis of infertility. Any outside intervention procedures (e.g. artificial insemination) will not be considered a ***covered expense***.

WELL NEWBORN CARE

The ***Plan*** shall cover well newborn care while the mother is confined for delivery as part of the mother's claim, whether or not the newborn child is enrolled for coverage.

Such care shall include, but is not limited to:

1. ***Physician*** services, limited to one (1) ***inpatient*** routine newborn examination performed by a ***physician*** other than the ***physician*** who delivered the baby or administered anesthesia during delivery.
2. ***Hospital*** services

3. Circumcision

Covered expenses for services, supplies or treatment of illness or injury of the newborn child shall be payable if the child is properly enrolled for coverage under this Plan and shall be considered charges of the child and as such, subject to a separate Deductible and coinsurance from the mother.

ROUTINE PREVENTIVE CARE

Covered expenses shall include the following routine services and supplies which are not required due to ***illness*** or ***injury:***

- Routine examinations;
- Immunizations;
- Gynecological examinations and Papanicolaou (Pap) tests;
- Prostate examinations and prostate specific antigen (PSA) tests;
- Routine mammograms; and
- Routine laboratory services, diagnostic services and Human Papillomavirus (HPV) tests.

Routine preventive care and wellness benefits are paid as specified on the *Schedule of Benefits*.

Preventive Health Benefits

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

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

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

Women's Preventive Services

These services will be provided in accordance with the age and frequency requirements of the Affordable Care Act, including, but not limited to: well-woman visits; screening for gestational diabetes, human papillomavirus (HPV), human immunodeficiency virus (HIV) and sexually transmitted disease; and counseling for contraceptive methods, breastfeeding and domestic violence.

Coverage is provided for FDA-approved contraceptive methods and counseling. Prescribed contraceptive medication will be paid in accordance with any applicable Prescription Drug benefit.

Additional Preventive Services

If not shown above as a Covered Service, the following services will also be covered without regard to any Deductible, Copayment or Coinsurance requirement that would otherwise apply:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;

- With respect to Covered Persons who are infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Service Administration.

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

Direct Access to Obstetricians and Gynecologists

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

Selection of a Primary Care Provider

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

THERAPY SERVICES

Therapy services provided in a home setting as outlined under Home Health Care and Hospice Care are subject to pre-certification. Failure to obtain pre-certification will result in a reduction of benefits.

Therapy services must be ordered by a ***physician*** to aid restoration of normal function lost due to ***illness*** or ***injury*** or congenital anomaly. ***Covered expenses*** will be payable in accordance with the *Schedule of Benefits*.

Covered expenses shall include:

1. Services of a ***professional provider*** for physical therapy or occupational therapy. Coverage ends once maximum medical recovery has been achieved and further treatment is primarily for maintenance purposes. Only therapy designed to restore motor functions needed for activities of daily living (such as walking, eating, dressing, etc.) is covered.

2. Radiation therapy and chemotherapy.

3. Dialysis therapy or treatment.

4. Services of a ***professional provider*** for speech therapy to:

    a. restore already established speech loss;

    b. correct an impairment due to a congenital defect for which corrective surgery has been performed; or

    c. correct an impairment caused by an ***injury*** or ***illness*** (not caused by a ***mental and nervous disorder***).

5. Respiratory Therapy.

SKILLED NURSING CARE FACILITY

Skilled nursing care facility confinement is subject to pre-certification. Failure to obtain pre-certification shall result in a reduction of benefits as specified in the *Precertification of Benefits* section of this document.

Skilled nursing facility services, supplies and treatments shall be a ***covered expense*** provided the ***covered person*** is under a ***physician's*** continuous care and the ***physician*** certifies that the ***covered person*** must have twenty-four (24) hours-per-day nursing care.

Covered expenses shall include:

1. ***Room and board*** (including regular daily services, supplies and treatments furnished by the ***skilled nursing care facility***) limited to the ***facility's*** average ***semiprivate*** room rate; and

2. Other services, supplies and treatment ordered by a ***physician*** and furnished by the ***skilled nursing care facility*** for ***inpatient*** medical care.

HOME HEALTH CARE

Home health care enables the ***covered person*** to receive treatment in his home for an ***illness*** or ***injury*** instead of being confined in a ***hospital*** or ***skilled nursing care facility***. The ***covered person's physician*** must certify in writing the treatment plan, diagnosis, that the patient would require *confinement* in ***a hospital*** or ***skilled nursing care facility*** in the absence of home health care, and the type and extent of treatment.

Covered expenses shall include the following services and supplies provided by a ***home health care agency:***

1. Part-time or intermittent nursing care by a Registered ***Nurse***, Licensed Practical ***Nurse*** or a Licensed Vocational ***Nurse***;

2. Physical, respiratory, occupational or speech therapy;

3. ***Part-time*** or intermittent ***home health aide services*** for a ***covered person*** who is receiving covered nursing or therapy services;

4. Medical social service consultations;

5. Nutritional guidance by a registered dietitian and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be ***medically necessary***;

6. Drugs, medicines, dressing, and laboratory tests ordered by a physician;

No ***home health care*** benefits will be provided for dietitian services (except as may be specifically provided herein), homemaker services, maintenance therapy, dialysis treatment, food or home delivered meals, rental or purchase of ***durable medical equipment.***

HOSPICE CARE

Hospice care is a health care program providing a coordinated set of services rendered at home, in ***outpatient*** settings, or in ***facility*** settings for a ***covered person*** suffering from a condition that has a terminal prognosis.

Hospice benefits will be covered only if the ***covered person's*** attending ***physician*** certifies that:

1. The ***covered person*** is terminally ill, and

2. The ***covered person*** has a life expectancy of six (6) months or less.

Covered expenses shall include:

1. ***Confinement*** in a ***hospice*** to include ancillary charges and ***room and board***.
2. Services, supplies and treatment provided by a ***hospice*** to a ***covered person*** in a home setting.
3. ***Physician*** services and/or nursing care by a Registered ***Nurse***, Licensed Practical ***Nurse*** or a Licensed Vocational ***Nurse***.
4. Physical therapy, occupational therapy, speech therapy or respiratory therapy.
5. Nutrition services to include nutritional advice by a registered dietitian, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be ***medically necessary***.
6. Counseling services provided through the ***hospice***.
7. Bereavement counseling is a supportive service to ***covered persons*** in the terminally ill ***covered person's*** immediate family. Benefits will be payable, provided:
    a. On the date immediately before death, the terminally ill person was covered under the ***Plan*** and receiving ***hospice*** care benefits; and
    b. Services are ***incurred*** by the ***covered person*** within three (3) months of the terminally ill person's death.

Hospice benefits are payable as stated on the *Schedule of Benefits*.

Charges ***incurred*** during periods of remission are not eligible under this provision of the ***Plan***. Any ***covered expense*** paid under ***hospice*** benefits will not be considered a ***covered expense*** under any other provision of this ***Plan***.

DURABLE MEDICAL EQUIPMENT

Rental or purchase, whichever is less costly, of ***medically necessary durable medical equipment*** which is prescribed by a ***physician*** and required for therapeutic use by the ***covered person*** shall be a ***covered expense***. A charge for the purchase or rental of ***durable medical equipment*** is considered ***incurred*** on the date the equipment is received/delivered. ***Durable medical equipment*** that is received/delivered after the termination date of a ***covered person's*** coverage under this ***Plan*** is not covered.

Repair or replacement of purchase ***durable medical equipment*** which is ***medically necessary*** due to normal use or a physiological change in the patient's condition will be considered a ***covered expense***.

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the ***covered person's*** condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the ***covered person's*** medical needs.

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

- Rental costs if you are in a ***facility*** which provides such equipment;
- Repair costs that are more than the rental price of another unit for the estimated period of use, or more than the purchase price of a new unit;
- ***Physician***'s equipment, such as a blood pressure cuff or stethoscope;
- Deluxe equipment, such as specially designed wheelchairs for use in sporting events;

- Items not primarily medical in nature, such as:
    - An exercycle, treadmill, bidet toilet seat, elevator and chair lifts, lifts for vans for motorized wheelchairs and scooters;
    - Items for comfort and convenience; disposable supplies and hygienic equipment;
    - Self-help devices, such as bed boards, bathtubs, sauna baths, over-bed tables, adjustable beds, special mattresses, telephone arms, air conditioners and electric cooling units.

PROSTHESES

The initial purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ shall be a ***covered expense***. A charge for the purchase of prosthesis is considered ***incurred*** on the date the prosthesis is received/delivered. A prosthesis that is received/delivered after the termination date of a ***covered person's*** coverage under this ***Plan*** is not covered.

Repair or replacement of a prosthesis which is ***medically necessary*** due to normal use or a physiological change in the patient's condition will be considered a ***covered expense***.

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

- Dentures, unless as a necessary part of a covered prosthesis;
- Dental appliances;
- Eyeglasses, including lenses or frames, unless used to replace an absent lens of the eye;
- Replacement of cataract lenses, unless needed because of a lens prescription change;
- Taxes included in the purchase of a covered prosthetic appliance;
- Deluxe prosthetics that are specially designed for uses, such as sporting events.

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a ***covered expense***. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet shall not be covered. Replacement will be covered only after five (5) years from the date of original placement, unless a physiological change in the patient's condition necessitates earlier replacement.

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

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

DENTAL SERVICES

Covered expenses shall include repair of injury to the jaw or sound natural teeth or surrounding tissue provided it is the result of an ***injury***. Treatment must be completed within twelve (12) months of the ***injury***. Damage to the teeth as a result of chewing or biting shall not be considered an ***injury*** under this benefit.

Covered expenses shall also include charges for oral surgery procedures:

1. Excision of tumors or cysts from the mouth;

2. Excision of exotoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures);

3. Treatment of fractures of facial bones;

4. External incision and drainage of cellulitis;

5. Incision of accessory sinuses, salivary glands or ducts.

Facility charges for oral surgery or dental treatment that ordinarily could be performed in the provider's office will be covered only if the ***covered person*** has a concurrent hazardous medical condition that prohibits performing the treatment safely in an ***outpatient*** setting.

TEMPOROMANDIBULAR JOINT DYSFUNCTION

Surgical and nonsurgical treatment of temporomandibular joint dysfunction (TMJ), myofascial pain syndrome or orthognathic treatment shall be a ***covered expense***, but shall be limited to the following:

1. Examinations;

2. Diagnostic procedures having uniform professional endorsement;

3. Prescription medications and injection therapy;

4. Appropriate physical therapy, including electrical neural stimulation;

5. Appropriate orthopedic splint therapy; and

6. Surgical correction.

SPECIAL EQUIPMENT AND SUPPLIES

Covered expenses shall include ***medically necessary*** special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; insulin, insulin needles and syringes and other diabetic supplies; allergy serums; crutches; electronic pacemakers; oxygen and the administration thereof; the initial pair of eyeglasses or contact lenses due to cataract surgery or cataract lenses (replacement of cataract lenses only when prescription changes); soft lenses or sclera shells intended for use in the treatment of ***illness*** or ***injury*** of the eye; support stockings, such as Jobst stockings, limited to two (2) pairs per calendar year; a wig or hairpiece when required due to chemotherapy; surgical dressings and other medical supplies ordered by a ***professional provider*** in connection with medical treatment, but not common first aid supplies.

COSMETIC/RECONSTRUCTIVE SURGERY

Cosmetic surgery or ***reconstructive surgery*** shall be a ***covered expense*** provided:

1. A ***covered person*** receives an ***injury*** as a result of an ***accident*** and as a result requires surgery. ***Cosmetic*** or ***reconstructive surgery*** and treatment must be for the purpose of restoring the ***covered person*** to his normal function immediately prior to the ***accident***.

2. It is required to correct a congenital anomaly, for example, a birth defect, for a child.

3. It is required due to infection or other disease.

MASTECTOMY (WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998)

This ***Plan*** will comply with the provisions of the federal law known as the Women's Health and Cancer Rights Act of 1998.

Covered expenses will include eligible charges related to ***medically necessary*** mastectomy.

For a ***covered person*** who elects breast reconstruction in connection with such mastectomy, ***covered expenses*** will include:

a. reconstruction of a surgically removed breast; and

b. surgery and reconstruction of the other breast to produce a symmetrical appearance.

Prostheses (and ***medically necessary*** replacements) and physical complications from all stages of mastectomy, including lymphedemas, will also be considered ***covered expenses*** following all ***medically necessary*** mastectomies.

MENTAL ILLNESS/ALCOHOLISM AND DRUG ABUSE

Inpatient or Partial Confinement

Subject to the precertification provisions of the ***Plan***, the ***Plan*** will pay the applicable ***coinsurance***, as shown on the *Schedule of Benefits*, for ***confinement*** in a ***hospital*** or ***treatment center*** for treatment, services and supplies related to the treatment of ***Mental Illness, Alcoholism and Drug Abuse***.

Covered expenses shall include:

1. ***Inpatient hospital confinement***;
2. Individual psychotherapy;
3. Group psychotherapy;
4. Psychological testing;
5. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same ***professional provider***.

Outpatient

The ***Plan*** will pay the applicable ***coinsurance***, as shown on the *Schedule of Benefits*, for ***outpatient*** treatment, services and supplies related to the treatment of ***Mental Illness, Alcoholism and Drug Abuse***.

Covered expenses shall include:

1. Treatment in subacute treatment centers;
2. Treatment in a half-way house or day facility;
3. Expanded outpatient treatment; and
4. Period office visits.

For the purposes of this provision, the following definitions shall apply:

"Subacute Treatment" means treatment received at a ***facility*** which may or may not be equipped or licensed to treat medical ***emergencies***, but which maintains close ties with acute care ***facilities***. Skilled professional therapists practice in these ***facilities***, and ***physicians*** and Registered Nurses area available on call. Therapy is available for recovering chemically dependent patients and those with ***Mental Illness, Alcoholism and Drug Abuse disorders*** requiring some medical management.

"Day treatment" means a structured program of therapy and activities which requires that the patient attend

sessions and return to their own living arrangement at night. Day treatment programs are offered by ***hospitals,*** freestanding subacute ***facilities*** and mental health clinics.

"Halfway house" means a ***facility*** in which the patient lives and often leaves for work or vocational training, and then returns for meals and sleep. Halfway houses are used by patients who have received prior treatment with structured therapy, but who are not ready to return home.

"Expanded outpatient treatment" means a therapy program intended to give the patient and the patient's family an opportunity to address specific problems with multiple weekly ***outpatient*** sessions. These sessions are intended to avoid a ***hospital confinement*** and are planned to be intensive and short term. Expanded ***outpatient*** therapy can be used prior to or in lieu of a ***hospital*** admission or following an acute or subacute course of therapy.

PRESCRIPTION DRUGS

Prescription drugs are payable as listed in the Schedule of Benefits.

PODIATRY SERVICES

Covered expenses shall include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

PRIVATE DUTY NURSING

Medically necessary services of a private duty ***nurse*** shall be a ***covered expense***.

CHIROPRACTIC CARE

Covered expenses include initial consultation, x-rays and treatment (but not maintenance care), payable as shown on the *Schedule of Benefits*.

PATIENT EDUCATION

Covered expenses shall include ***medically necessary*** patient education programs including, but not limited to diabetic education and ostomy care. Coverage for diabetic education is limited to one (1) program following the initial diagnosis of diabetes. The program must be billed by a ***hospital.***

SURCHARGES

Any excise tax, sales tax, surcharge, (by whatever name called) imposed by a governmental entity for services, supplies and/or treatments rendered by a ***professional provider, physician, hospital, facility*** or any other health care provider shall be a ***covered expense*** under the terms of the ***Plan***.

SURGICAL TREATMENT OF MORBID OBESITY

Covered expenses shall include charges for surgical treatment of morbid obesity for covered persons with health problems that are aggravated by or related to the morbid obesity, including, but not limited to gastric by-pass, gastric stapling or gastric balloon.

SMOKING CESSATION

Covered expenses shall include services, supplies and treatment for smoking cessation programs or related to the treatment of nicotine addiction. Charges for prescription drugs for smoking cessation or treatment of nicotine addiction shall be covered under the Medical Expense Benefits, Prescription Drug benefit.

OUTPATIENT CARDIAC/PULMONARY REHABILITATION PROGRAMS

Covered expenses shall include charges for qualified ***medically necessary outpatient*** cardiac/pulmonary rehabilitation programs.

MEDICAL EXCLUSIONS

In addition to *Plan Exclusions*, no benefit will be provided under this ***Plan*** for medical expenses for the following:

1. Charges for services, supplies or treatment for the reversal of sterilization procedures.

2. Charges for services, supplies or treatment related to the treatment of infertility or to enhance the possibility of reproduction and artificial reproductive procedures, including, but not limited to: artificial insemination, invitro fertilization, surrogate mother, fertility drugs, embryo implantation, or gamete intrafallopian transfer (GIFT).

3. Charges for male contraceptives and over-the-counter birth control without a prescription.

4. Charges for services, supplies or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment or complications therefrom.

5. Charges for treatment or surgery for sexual dysfunction or inadequacies.

6. Charges for ***hospital*** admission on Friday, Saturday or Sunday unless the admission is for an ***emergency medical condition***, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, ***hospital*** expenses will be payable commencing on the date of actual surgery.

7. Charges for ***inpatient room and board*** in connection with a ***hospital confinement*** primarily for observation, diagnostic tests or physical therapy unless it is determined by the ***Plan*** that ***inpatient*** care is ***medically necessary***.

8. Charges for services, supplies or treatment for attention deficit disorders, behavior or conduct disorders, development delay, hyperactivity, learning disorders, mental retardation, autistic disease, or senile deterioration. However, the initial examination, office visit and diagnostic testing to determine the ***illness and as required by PPACA*** shall be a ***covered expense***.

9. Charges for biofeedback therapy.

10. Charges for services, supplies or treatments which are primarily educational in nature; except as specified in *Medical Expense Benefit, Patient Education* or as required by PPACA*;* charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

11. Charges for marriage, career or legal counseling.

12. Except as specifically stated in *Medical Expense Benefit Services*, charges for or in connection with: treatment of ***injury*** or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.

13. Charges for routine vision examinations and eye refractions except as required by PPACA; orthoptics; eyeglasses or contact lenses, except as specifically stated under *Medical Expense Benefit, Special Equipment and Supplies*; dispensing optician's services.

14. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.

15. Except as ***medically necessary*** for the treatment of metabolic or peripheral-vascular ***illness***, charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.

16. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a ***physician***, such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-***hospital*** adjustable beds, exercise equipment.

17. Charges for nonprescription over-the-counter drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements except as required by PPACA.

18. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist's charge) or shoe inserts.

19. Expenses for a ***cosmetic surgery*** or procedure and all related services, except as specifically stated in *Medical Expense Benefit,* ***Cosmetic/Reconstructive Surgery***.

20. Charges ***incurred*** as a result of, or in connection with Cosmetic surgery or any procedure or treatment excluded by this ***Plan*** which has resulted in medical complications.

21. Charges for services, supplies, drugs or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; behavior modifications with or without medication; diet control; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and ***hospital confinements*** for weight reduction programs.

22. Charges for surgical weight reduction procedures and all related charges, unless resulting from ***morbid obesity***.

23. Charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid; or for a cochlear implant.

24. Charges for routine or periodic physical examinations, such as annual physical, screening examination, employment physical, or any related charges, such as premarital lab work, laboratory services, diagnostic services, and other care not associated with treatment or diagnosis of an ***illness*** or ***injury,*** except as specified herein or as required by PPACA.

25. Charges related to hypnosis and acupuncture treatment.

26. Except as specifically stated in *Medical Expense Benefit, Temporomandibular Joint Dysfunction*, charges for treatment of temporomandibular joint syndrome and myofascial pain syndrome.

27. Charges for ***custodial care***, domiciliary care or rest cures.

28. Charges for travel or accommodations, whether or not recommended by a ***physician***, except as specifically provided herein.

29. Charges for wigs, artificial hairpieces, artificial hair transplants, or any drug - prescription or otherwise - used to eliminate baldness or stimulate hair growth. This exclusion does not apply when baldness is the result of burns, chemotherapy, radiation therapy, or surgery. Under these conditions, purchase of a wig or artificial hairpiece is limited to one per lifetime.

30. Charges for professional services billed by a ***physician*** or Registered ***Nurse***, Licensed Practical ***Nurse*** or Licensed Vocational ***Nurse*** who is an ***employee*** of a ***hospital*** or any other ***facility*** and who is paid by the

hospital or other ***facility*** for the service provided.

31. Charges for environmental change including ***hospital*** or ***physician*** charges connected with prescribing an environmental change.

32. Charges for ***room and board*** in a ***facility*** for days on which the ***covered person*** is permitted to leave (a weekend pass, for example).

33. Charges for functional therapy for learning or vocational disabilities or for speech, hearing, and/or occupational therapy, except as specified herein.

34. Charges for any services, supplies or treatment not specifically provided herein.

35. After hours care.

36. Excess charges. Charges that exceed the ***allowed amount***, if applicable.

37. Charges for massage therapy, sex therapy, diversional therapy or recreational therapy.

38. ***Medicare*** **Part B.** Services for which payment was made or would have been made under Medicare Part B if benefits were claimed. This applies when the Covered Person is eligible for Medicare, even if the Covered Person did not apply for or claim Medicare benefits; However, if under law, the Covered Person may elect this coverage (instead of Medicare) to pay first, and if does so elect, then this exclusion will not apply.

39. Specialized camps;

40. Tattoo removal;

41. Topical anesthestics;

42. Vertebral column. Treatment of the vertebral column, unless related to a specific neuromusculoskeletal related diagnosis;

43. Waived ***copays*** or ***coinsurance***. In the event that a ***nonpreferred provider*** waived ***copays***, Deductibles or ***coinsurance***, no benefits are provided for the health service for which the ***copays***, Deductibles or ***coinsurance*** were waived;

44. Water Aerobics.

45. Charges for chelation therapy, except as treatment of heavy metal poisoning.

46. Charges for procurement and storage of one's own blood, unless incurred within three (3) months prior to a scheduled surgery.

47. Charges for holistic medicines or providers or naturopathy.

48. Charges for structural changes to a house or vehicle.

49. Charges for treatment of sleep disorders.

50. Charges for exercise programs for treatment of any condition, except for physician-supervised cardiac rehabilitation, occupational or physical therapy as specified herein.

51. Charges for speech therapy for remedial or educational purposes or for initial development of natural speech. This would not apply to children who have not established a natural speech pattern for reasons that do not relate to a congenital defect. In these cases, speech therapy would be considered education in nature and not eligible for coverage. Speech therapy would not meet coverage criteria for the following conditions: chronic voice strain, congenital deafness, delayed

speech, developmental or learning disorders, environmental or cultural speech habits, hoarseness, infantile articulation, listing, mental retardation, resonance, stuttering and voice defects of pitch, loudness and quality.

52. Charges for or related to the following types of treatment:
    a. Primal therapy;
    b. Rolfing;
    c. Psychodrama;
    d. Megavitamin therapy; and
    e. Visual perceptual training

PRESCRIPTION DRUG PROGRAM

PHARMACY OPTION

Participating pharmacies have contracted with the ***Plan*** to charge ***covered persons*** reduced fees for covered prescription drugs.

PHARMACY OPTION COPAY

The ***coinsurance*** is applied to each covered pharmacy drug charge and is shown on the *Schedule of Benefits*. Any one prescription is limited to a thirty (30) day supply.

If a drug is purchased from a ***nonparticipating pharmacy*** or a ***participating pharmacy*** when the ***covered person's*** ID card is not used, the ***covered person*** must pay the entire cost of the prescription, including ***copay***, and then submit the receipt to the prescription drug card vendor for reimbursement. If a ***nonparticipating pharmacy*** is used, the ***covered person*** will be responsible for the cost between the ***participating pharmacy*** and ***nonparticipating pharmacy***.

MAIL ORDER OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.).

MAIL ORDER OPTION COPAY

The ***coinsurance*** is applied to each covered mail order prescription charge and is shown on the *Schedule of Benefits*. Any one prescription is limited to a ninety (90) day supply.

COVERED PRESCRIPTION DRUGS

1. Drugs prescribed by a ***physician*** that require a prescription either by federal or state law, including injectables and insulin, except drugs excluded by the ***Plan***.
2. Compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.
3. Insulin, insulin needles and syringes and diabetic supplies.
4. Oral contraceptives.
5. Fertility drugs, oral and injectable.
6. Migraine medications, oral and injectable.
7. Chemotherapy drugs, injectable and oral.
8. Anabolic drugs, oral or injectable.
9. Diet medications.
10. Retin A.

11. Drugs used to treat nicotine addiction or for the purpose of smoking cessation.

12. Drugs used to treat Erectile Dysfunction (impotence); however, Viagra, shall be limited to eight (8) tablets per thirty (30) day period, with prior authorization from the ***pharmacy organization***.

13. Injectables.

14. Blood modifiers, oral and injectable.

15. Drugs used to treat Crohn's Disease, oral and injectable.

16. Drugs used to treat Cystic Fibrosis and Genetic Emphysema, oral and injectable

17. Drugs used to treat Hemophilia, oral and injectable.

18. Drugs used to treat Hepatitis C, oral and injectable.

19. Drugs used to treat immune disorders, oral and injectable

20. Drugs used to treat Multiple Sclerosis, oral and injectable.

21. Drugs used to treat RSV or for disease prevention, oral and injectable.

22. Drugs used to treat Rheumatoid Arthritis, oral and injectable

23. Preventive Drugs in compliance with Health Care Reform

LIMITS TO THIS BENEFIT

This benefit applies only when a ***covered person incurs*** a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a ***physician***.

2. Refills up to one year from the date of order by a ***physician***.

EXPENSES NOT COVERED

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin.

2. Immunization agents or biological sera, blood or blood plasma.

3. A drug or medicine labeled: “Caution - limited by federal law to ***investigational*** use.”

4. ***Experimental*** drugs and medicines, even though a charge is made to the ***covered person***, including DESI drugs (drugs determined by the FDA as lacking substantial evidence of effectiveness).

5. Any charge for the administration of a covered prescription drug.

6. Any drug or medicine that is consumed or administered at the place where it is dispensed.

7. A drug or medicine that is to be taken by the ***covered person***, in whole or in part, while ***hospital*** confined. This includes being confined in any institution that has a ***facility*** for dispensing drugs.

8. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.

9. A charge for hypodermic syringes and/or needles

10. A charge for glucose monitors.

11. A charge for male contraceptives or over-the-counter birth control without a prescription.

12. A charge for minerals.

13. A charge for growth hormones.

14. A charge for vitamins, including pre-natal vitamins except as required by PPACA.

15. A charge for medications that are cosmetic in nature (i.e., treating hair loss, wrinkles, etc.) including Renova.

16. A charge for ostomy supplies.

17. A charge for nutritional supplements or prescription diet supplements.

18. A charge for over the counter medications.

PLAN EXCLUSIONS

The ***Plan*** will not provide benefits for any of the items listed in this section, regardless of ***medical necessity*** or recommendation of a ***physician*** or ***professional provider***.

1. Charges for services, supplies or treatment from any ***hospital*** owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.

2. Charges for an ***injury*** sustained or ***illness*** contracted while on active duty in military service, unless payment is legally required.

3. Charges for services, treatment or supplies for treatment of ***illness*** or ***injury*** which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.

4. Any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Workers' Compensation law, ***Employer***'s liability law, or occupational disease law, even though the ***covered person*** fails to claim rights to such benefits or fails to enroll or purchase such coverage.

5. Charges in connection with any ***illness*** or ***injury*** arising out of or in the course of any employment intended for wage or profit, including self-employment.

6. Charges made for services, supplies and treatment which are not ***medically necessary*** for the treatment of ***illness*** or ***injury***, or which are not recommended and approved by the attending ***physician***, except as specifically stated herein, or to the extent that the charges exceed the ***allowed amount.***

7. Charges in connection with any ***illness*** or ***injury*** of the ***covered person*** resulting from, or occurring during the commission or attempted commission of a criminal battery or felony by the ***covered person*** for which criminal charges are filed. Claims which are submitted to the ***Plan*** which are the result of such activities shall not be payable until a final determination has been made by a court of law regarding the guilt or innocence of the ***covered person***. If the ***covered person*** is found guilty, any related expenses will be denied by the ***Plan***.

8. To the extent that payment under this ***Plan*** is prohibited by any law of any jurisdiction in which the ***covered person*** resides at the time the expense is ***incurred***.

9. Charges for services rendered and/or supplies received prior to the ***effective date*** or after the termination date of a person's coverage.

10. Any services, supplies or treatment for which the ***covered person*** is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.

11. Charges for services, supplies or treatment that are considered ***experimental/investigational***.

12. Charges ***incurred*** outside the United States if the ***covered person*** traveled to such a location for the sole purpose of obtaining services, supplies or treatment.

13. Charges for services, supplies or treatment rendered by any individual who is a ***close relative*** of the

covered person or who resides in the same household as the ***covered person***.

14. Charges for services, supplies or treatment rendered by ***physicians*** or ***professional providers*** beyond the scope of their license; for any treatment, ***confinement*** or service which is not recommended by or performed by an appropriate ***professional provider***.

15. Charges for ***illnesses*** or ***injuries*** suffered by a ***covered person*** due to the action or inaction of any party if the ***covered person*** fails to provide information as specified in *Subrogation/Reimbursement.*

16. Claims not submitted within the ***Plan's*** filing limit deadlines as specified in the *Claim Filing Procedure* section of this document.

17. Charges for telephone or email consultations, completion of claim forms, charges associated with missed appointments.

18. If the primary ***plan*** has a restricted list of healthcare providers and the ***covered person*** chooses not to use a provider from the primary ***plan***'s restricted list, this ***Plan*** will not pay for any charges disallowed by the primary ***plan*** due to the use of such provider, if shown on the primary carrier's explanation of benefits.

19. This ***Plan*** will not pay for any charge which has been refused by another ***plan*** covering the ***covered person*** as a penalty assessed due to non-compliance with that ***plan***'s rules and regulations, if shown on the primary carrier's explanation of benefits.

20. Charges for services, supplies or treatment received from a dental or medical department maintained by or on behalf of an ***employer***, a mutual benefits association, labor union, trustees, or similar person or group.

ELIGIBILITY, ENROLLMENT AND *EFFECTIVE DATE*

This section identifies the ***Plan's*** requirements for a person to participate in the ***Plan***.

EMPLOYEE ELIGIBILITY

All ***full-time employees*** regularly scheduled to work at least thirty hours or more per work week (or 130 hours per month) shall be eligible to enroll for coverage under this ***Plan***. This does not include ***part-time***, temporary or seasonal employees.

EMPLOYEE ENROLLMENT

An ***employee*** must file a written application with the ***employer*** for coverage hereunder for himself within thirty-one (31) days of becoming eligible for coverage. The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder.

EMPLOYEE(S) EFFECTIVE DATE

Provided the ***employee*** has enrolled for coverage as described in *Employee Enrollment*, eligible ***employees***, as described in *Employee Eligibility*, are covered under the ***Plan*** 30 days following date of hire.

DEPENDENT ELIGIBILITY

You may enroll yourself alone or you and your eligible ***dependent(s***). An eligible ***dependent*** includes:

- Your lawful spouse (marriage between a man and a woman), provided you are not legally separated;
- Your natural children, adopted children, children ***placed for adoption*** with you, stepchildren or legal wards from birth to the end of the month of age 26.

Ohio Law

COVERAGE EXTENSION TO AGE 28 (Applies to Medical and Prescription Benefits Only)

In order for ***dependent*** children to receive benefits to the end of the month of age of 28, the unmarried child must be:

1. The natural child, stepchild, or adopted child of the ***Employee***;
2. An Ohio resident or a ***Full-time Student*** at an accredited public or private institution of higher education;
3. Not employed by an ***employer*** that offers any health benefit ***plan*** under which the child is eligible for coverage; and
4. Not eligible for coverage under Medicaid or ***Medicare***.

Please note that the older age child does not have to live with the parent, be financially ***dependent*** upon the parent or be a student.

An older age child may enroll at the following times:

1. When the child reaches the ***Plan's*** limiting age.
2. When the child experiences a change in circumstances.
3. During the annual open enrollment period.

The full cost of the premium for the ***dependent*** coverage will be the responsibility of the ***Employee/Dependent***.

The coverage ends at the end of the month of age 28.

Michelle's Law

If an eligible ***dependent*** child is being covered as a ***full-time student***, and a ***Medically Necessary Leave of Absence*** causes such child to stop being a ***full-time student*** under the terms of the ***Plan***, the eligible ***dependent*** will continue to be covered under the ***Plan*** until the earlier of one year, or the date coverage would otherwise end under the terms of the ***Plan.***

Medically Necessary Leave of Absence means a ***leave of absence*** from a postsecondary educational institution (including an institution of higher education as defined in section 102 of the Higher Education Act of 1965), or any other change in enrollment of such child at such an institution, that:

1. commences while such child is suffering from a serious ***illness*** or ***injury***;
2. is ***Medically Necessary***; and
3. causes such child to lose student status for purposes of coverage under the terms of the ***Plan***.

The treating ***physician*** of the ***dependent*** child must certify that the child is suffering from a serious ***illness*** or ***injury*** and that the ***leave of absence*** (or other change of enrollment) is ***Medically Necessary***.

To be eligible for continuing coverage due to a ***Medically Necessary Leave of Absence***, the eligible ***dependent*** must have been enrolled in the ***Plan*** as a result of ***Full-time Student*** status at a postsecondary educational institution immediately before the first day of the ***Medically Necessary Leave of Absence***. Continuing coverage due to a ***Medically Necessary Leave of Absence*** begins as of the first day of the eligible ***dependent's Medically Necessary Leave of Absence*** and ends on the date that is the earlier of:

1. the date that is one year after the first day of the ***Medically Necessary Leave of Absence***; or
2. the date on which such coverage would otherwise terminate under the ***Plan's*** terms or by termination of the Plan as a whole.

An eligible ***dependent*** who receives benefits due to a ***Medically Necessary Leave of Absence*** will be entitled to the same benefits (during the ***Medically Necessary Leave of Absence***) as if the child or ward continued to be a covered student at the institution of higher education and was not on a ***Medically Necessary Leave of Absence***.

Any future change in the ***Plan's*** coverage terms or conditions that would apply to an eligible ***dependent*** will apply equally to an eligible ***dependent*** who receives continuing coverage under the ***Plan*** due to a ***Medically Necessary Leave of Absence***.

Each quarter or semester, the ***claims processor*** will require proof of an eligible ***dependent's*** eligibility for extended coverage due to a ***Medically Necessary Leave of Absence***.

This provision is applicable only to those ***plans*** that require student status to continue coverage for a ***dependent*** child beyond the ***dependent*** age limit, as shown on the Schedule of Benefits.

DEPENDENT ENROLLMENT

An ***employee*** must file a written application with the ***employer*** for coverage hereunder for his eligible ***dependents*** within thirty-one (31) days of becoming eligible for coverage; and within thirty-one (31) days of marriage or the acquiring of children or birth of a child. The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder.

DEPENDENT(S) EFFECTIVE DATE

Eligible ***dependent(s)***, as described in *Eligibility*, will become covered under the ***Plan*** on the later of the dates listed below, provided the ***employee*** has enrolled them in the ***Plan*** within thirty-one (31) days of meeting the ***Plan's*** eligibility requirements.

1. The date the ***employee's*** coverage becomes effective.
2. The date the ***dependent*** is acquired, provided any required contributions are made and the ***employee*** has applied for ***dependent*** coverage within thirty-one (31) days of the date acquired.
3. Newborn children shall be covered from birth, regardless of ***confinement***, provided the ***employee*** has applied for ***dependent*** coverage within thirty-one (31) days of birth.
4. Coverage for a newly adopted or to be adopted child shall be effective on the date the child is ***placed for adoption*** provided the ***employee*** has applied for ***dependent*** coverage within 31 days of the date the child is placed for adoption.

WAIVER OF COVERAGE

Employees who elect not to enroll themselves and/or their ***dependents*** must complete a waiver of coverage form. The waiver of coverage must be submitted to the ***employer*** within thirty-one (31) days of meeting the ***Plan's*** eligibility requirements.

SPECIAL ENROLLMENT RIGHTS

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

1. In order to qualify for special enrollment rights because of loss of coverage, you or your eligible Dependent must have had other group health plan coverage at the time coverage under this Plan was previously offered. You or your eligible Dependent must have also stated, in writing, at that time that coverage was declined because of the other coverage, but only if the Plan required such a statement at the time coverage was declined, and you were notified of this requirement and the consequences of declining coverage at that time.

2. If coverage was non-COBRA, loss of eligibility or the Group's contributions must end. A loss of eligibility for special enrollment includes:

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

3. If you or your eligible Dependent has COBRA coverage, the coverage must be exhausted in order to trigger a

special enrollment right. Generally, this means the entire 18, 29 or 36-month COBRA period must be completed in order to trigger a special enrollment for loss of other coverage.

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

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

OPEN ENROLLMENT

Open enrollment is the period designated by the ***employer*** during which the ***employee*** may change benefit plans or enroll in the ***Plan*** if he did not do so when first eligible or does not qualify for a special enrollment period. An open enrollment will be permitted once in each calendar year during the month of November.

During this open enrollment period, an ***employee*** and his ***dependents*** that are covered under this ***Plan*** or covered under any ***employer*** sponsored health plan may elect coverage or change coverage under this ***Plan*** for himself and his eligible ***dependents***. An ***employee*** must make written application as provided by the ***employer*** during the open enrollment period to change benefit plans.

The ***effective date*** of coverage as the result of an open enrollment period will be the following January 1st.

Except for a status change listed below, the open enrollment period is the only time an ***employee*** may change benefit options or modify enrollment. Status changes include:

1. Change in family status. A change in family status shall include only:
    a. Change in ***employee's*** legal marital status;
    b. Change in number of ***dependents***;
    c. Termination or commencement of employment by the ***employee***, spouse or ***dependent***;
    d. Change in work schedule;
    e. ***Dependent*** satisfies (or ceases to satisfy) ***dependent*** eligibility requirements;
    f. Change in residence or worksite of ***employee***, spouse or ***dependent***.
2. Change in the cost of coverage under the ***employer's*** group medical plan.
3. Cessation of required contributions.
4. Taking or returning from a ***leave of absence*** under the Family and Medical Leave Act.
5. Significant change in the health coverage of the ***employee*** or spouse attributable to the spouse's employment.
6. A Special Enrollment Period as mandated by the Health Insurance Portability and Accountability Act.
7. A court order, judgment or decree.
8. Entitlement to ***Medicare*** or Medicaid.
9. A COBRA qualifying event.

TERMINATION OF COVERAGE

Except as provided in the ***Plan's*** *Continuation of Coverage* (COBRA) provision, coverage will terminate on the earliest of the following dates:

TERMINATION OF EMPLOYEE COVERAGE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health plan.
2. The last day of the month in which the ***employee*** ceases to meet the eligibility requirements of the ***Plan***.
3. The last day of the month in which employment terminates, as defined by the ***employer's*** personnel policies.
4. The date the ***employee*** becomes a ***full-time***, active member of the armed forces of any country.
5. The date the ***employee*** ceases to make any required contributions.
6. The date of retirement.

TERMINATION OF DEPENDENT(S) COVERAGE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health plan.
2. The date the ***employee's*** coverage terminates. However, if the ***employee*** remains eligible for the ***Plan***, but elects to discontinue coverage, coverage may be extended for ***alternate recipients***.
3. The date such person ceases to meet the eligibility requirements as described in the Dependent Eligibility section of the ***Plan***.
4. The date the ***employee*** ceases to make any required contributions on the ***dependent's*** behalf.
5. The date the ***dependent*** becomes a ***full-time***, active member of the armed forces of any country.
6. The date the ***Plan*** discontinues ***dependent*** coverage for any and all ***dependents***.

LEAVE OF ABSENCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***employees*** and/or ***dependents***, when the ***employee*** is on an authorized ***leave of absence*** from the ***employer***. In no event will coverage continue beyond the end of the month in which the ***employee's active service*** ends.

LAYOFF

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***employees*** and/or ***dependents***, when the ***employee*** is subject to an ***employer layoff***. In no event will coverage continue beyond the end of the month in which the ***employee's active service*** ends.

DISABILITY

Coverage may be continued for a limited time, when the employee is absent from work due to illness or injury. In no event will coverage continue beyond the period determined by the employer. This coverage shall run concurrently with any leave available under the Family and Medical Leave Act (FMLA).

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

An ***employee*** who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this ***Plan*** for up to twelve (12) weeks during any twelve (12) month period.

Contributions

During this leave, the ***employer*** will continue to pay the same portion of the ***employee's*** contribution for the ***Plan***. The ***employee*** shall be responsible to continue payment for eligible ***dependent's*** coverage and any remaining ***employee*** contributions. If the covered ***employee*** fails to make the required contribution during a FMLA leave within thirty (30) days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

Reinstatement

If coverage under the ***Plan*** was terminated during an approved FMLA leave, and the ***employee*** returns to ***active work*** immediately upon completion of that leave, ***Plan*** coverage will be reinstated on the date the ***employee*** returns to ***active work*** as if coverage had not terminated, provided the ***employee*** makes any necessary contributions and enrolls for coverage within thirty (30) days of his return to ***active work***.

Repayment Requirement

The ***employer*** may require ***employees*** who fail to return from a leave under FMLA to repay any contributions paid by the ***employer*** on the ***employee's*** behalf during an unpaid leave. This repayment will be required only if the ***employee's*** failure to return from such leave is not related to a "serious health condition," as defined in FMLA, or events beyond the ***employee's*** control.

SURVIVOR BENEFITS

If an ***employee*** dies while covered under the ***Plan,*** coverage shall continue for any ***dependents*** that were covered under the ***Plan*** when the ***employee*** died (including the ***employee's dependent*** child born after the ***employee's*** death). Coverage under this provision of the ***Plan*** shall be provided until the earlier of:

1. The date of remarriage of the surviving spouse (at which time coverage for ***dependent*** children also ceases); or
2. The date the ***dependent*** becomes eligible for coverage under any other group health plan; or
3. The date the ***dependent*** ceases to be eligible as a ***dependent;*** or
4. The ***Plan*** terminates; or
5. The date the ***Plan*** ceases to offer ***dependent*** benefits; or
6. The end of a thirty (30) day period from the date of the ***employee's*** death.

Coverage under this provision of the ***Plan*** shall run concurrently with any COBRA coverage available.

CERTIFICATES OF CREDITABLE COVERAGE

The ***plan administrator*** shall provide, upon request only, each terminating ***covered person*** with a Certificate of Creditable Coverage, certifying the period of time the individual was covered under this ***Plan***. For ***employees*** with ***dependent*** coverage, the benefit booklet provided may include information on all covered ***dependents***. This ***Plan*** intends to, at all times, comply with the provisions of the Health Insurance Portability and Accountability Act of 1996.

Consolidated Omnibus Budget Reconciliation Act (COBRA) Coverage

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

Federal law requires most ***employer***s sponsoring group health plans to offer ***employee***s 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*** provides no greater COBRA rights than what COBRA requires; nothing in this SPD is intended to expand your rights beyond COBRA's requirements. The following paragraphs generally explain COBRA coverage, when it may become available to you and your family and what you need to do to protect the right to receive it. COBRA (and the description of COBRA coverage contained in this SPD) applies only to the group health plan benefits offered under the ***Plan*** and not to any other benefits offered under the ***Plan*** or by the ***Plan Sponsor***.

Both you (the ***employee***) and your spouse should read this summary carefully and keep it with your records.

What is COBRA Coverage?

COBRA coverage is a continuation of ***Plan*** coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section entitled "Qualifying Events".

COBRA coverage may be available to "qualified beneficiaries".

After a qualifying event occurs and any required notice of that event is properly provided to the ***Plan Administrator***, COBRA coverage must be offered to each person losing ***Plan*** coverage who is a "qualified beneficiary." You, your spouse and your eligible ***dependent*** children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the ***Plan*** is lost because of the qualifying event.

Qualifying Events
If you are an ***employee*** of City of Napoleon 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; or
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 City of Napoleon;
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; or
5. your spouse becomes disabled.

In the case of an eligible ***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 City of Napoleon;
3. parents' divorce or legal separation;
4. the ***employee*** parent becomes entitled to ***Medicare*** benefits;
5. the eligible ***dependent*** ceases to be an "eligible ***dependent*** child" under the ***Plan***; or
6. ***Employee*** parent becomes disabled.

Electing COBRA after leave under the Family and Medical Leave Act (FMLA)

Under special rules that apply if an ***employee*** does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the ***Plan*** during the leave. Contact the ***Plan Administrator*** for more information about these special rules.

Special second election period for certain eligible *employee*s who did not elect COBRA
Certain ***employees*** and former ***employees*** who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA) are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period of 60 days or less (but only if the election is made within six (6) months after the ***Plan*** coverage is lost). If you are an ***employee*** or former ***employee*** and you qualify for TAA or ATAA, contact the ***Plan Administrator*** promptly after qualifying for TAA or ATAA or you will lose any right that you may have to elect COBRA during a special second election period. Contact the ***Plan Administrator*** for more information about the special second election period.

Notification 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 eligible ***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.

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 eligible ***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.

Election Procedures
You (the ***employee***) or your qualified beneficiaries must elect continuation coverage within 60 days after the ***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.

Independent Election
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 eligible ***dependent*** children each also have an independent right to elect continuation coverage. Thus, a spouse or eligible ***dependent*** child may elect continuation coverage even if the covered ***employee*** does not (or is not deemed to) elect it.

Special Considerations in Deciding Whether to Elect COBRA
If you become entitled to elect COBRA continuation coverage when you otherwise would lose group health coverage under a group health plan, you should consider all options you may have to get other health coverage before you make your decision. There may be more affordable or more generous coverage options for you and your family through other group health plan coverage (such as a spouse's plan), the Health Insurance Marketplace, or Medicaid. Under the Health Insurance Portability and Accountability Act (HIPAA), if you or your dependents are losing eligibility for group health coverage, including eligibility for continuation coverage, you may have a right to special enroll (enroll without waiting until the next open season for enrollment) in other group health coverage. For example, an employee losing eligibility for group health coverage may be able to special enroll in a spouse's plan. A dependent losing eligibility for group health coverage may be able to enroll in a different parent's group health plan. To have a special enrollment opportunity, you or your dependent must have had other health coverage when you previously declined coverage in the plan in which you now want to enroll. You must request special enrollment within 30 days from the loss of your job-based coverage.

Losing your job-based coverage is also a special enrollment event in the Health Insurance Marketplace (Marketplace). The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for Deductibles, coinsurance and copayments), and you can see what your premium, Deductibles, and out-of-pocket costs will be before you make a decision to enroll.

Eligibility for COBRA continuation coverage won't limit your eligibility for Marketplace coverage or for a tax credit. You can apply for Marketplace coverage at HealthCare.gov or by calling 1-800-318-2596 (TTY 1-855-889-4325). To qualify for special enrollment in a Marketplace plan, you must select a plan within 60 days before or 60 days after losing your job-based coverage. In addition, during an open enrollment period, anyone can enroll in Marketplace coverage. If you need health coverage in the time between losing your job-based coverage and beginning coverage through the Marketplace (for example, if you or a family member needs medical care), you may wish to elect COBRA coverage from your former employer's plan. COBRA continuation coverage will ensure you have health coverage until the coverage through your Marketplace plan begins.

Through the Marketplace you can also learn if you qualify for free or low-cost coverage from Medicaid or the

Children's Health Insurance Program (CHIP). You can apply for and enroll in Medicaid or CHIP any time of year. If you qualify, your coverage begins immediately. Visit HealthCare.gov or call 1-800-318-2596 (TTY 1-855-889-4325) for more information or to apply for these programs. You can also apply for Medicaid by contacting your state Medicaid office and learn more about the CHIP program in your state by calling 1-877-KIDS-NOW (543-7669) or visiting insurekidsnow.gov.

If you or your dependent elects COBRA continuation coverage, you will have another opportunity to request special enrollment in a group health plan or a Marketplace plan if you have a new special enrollment event, such as marriage, the birth of a child, or if you exhaust your continuation coverage. To exhaust COBRA continuation coverage, you or your dependent must receive the maximum period of continuation coverage available without early termination. Keep in mind if you choose to terminate your COBRA continuation coverage early with no special enrollment opportunity at that time, you generally will have to wait to enroll in other coverage until the next open enrollment period for the new group health plan or the Marketplace.

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 eligible ***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. Your first payment must cover the cost of COBRA coverage from the time your coverage under the ***Plan*** would have otherwise terminated up through the end of the month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is correct. You may contact the ***Plan Administrator*** using the contact information provided below to confirm the correct amount of your first payment. 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. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the ***Plan*** will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the ***Plan***. A premium payment is made on the date it is post-marked or actually received; whichever is earlier.

Maximum Coverage Periods
COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled "Termination of COBRA before the End of Maximum Coverage Period."

36 Months. If you (spouse or eligible ***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 an eligible ***dependent*** under the ***Plan***, the maximum continuation coverage period (for spouse and eligible ***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 eligible ***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 of the maximum continuation coverage period (for the ***employee***, spouse and eligible ***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 City of Napoleon 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 eligible ***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.

***Alternate recipient*s under QMCSOs**

A child of the covered ***employee*** who is receiving benefits under the ***Plan*** pursuant to a qualified medical child support order (QMCSO) received by the ***Plan Administrator*** during the covered ***employee***'s period of employment with the ***Plan Sponsor*** is entitled to the same rights to elect COBRA as an eligible ***dependent*** child of the covered ***employee***.

Termination of COBRA before the End of Maximum Coverage Period

Continuation coverage of the ***employee***, spouse, and/or eligible ***dependent*** child will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs:

1. The City of Napoleon 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 in full.
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 eligible ***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 eligible ***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 eligible ***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 City of Napoleon 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 an eligible ***dependent*** ceases to be an eligible ***dependent*** eligible for coverage under the ***Plan*** terms, or your or your spouse's address changes, you must immediately notify the ***Plan Administrator***.

CITY OF NAPOLEON
Attn: Human Resource Department
255 West Riverview Ave.
Napoleon, OH 43545
(419) 599-4010

Military Mobilization

If an ***employee*** or an ***employee's dependent*** is called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), the ***employee*** or the ***employee's dependent*** may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the ***employee*** or ***employee's dependent*** may not be required to pay more than the ***employee's*** share, if any, applicable to that coverage. If the leave is thirty-one (31) days or longer, then the e***mployer*** may require the ***employee*** or ***employee's dependent*** to pay no more than one hundred two percent (102%) of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. 24 months from the date continuation began (or 36 months if any of the following occurs during this 24-month period: death of the reservist; divorce or separation of a reservist from the reservist's spouse; or a child ceasing to be an Eligible Dependent); or
2. A period beginning on the day that the leave began and ending on the day after the ***employee*** fails to return to employment within the time allowed.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA. Upon return from active duty, the ***employee*** or the ***employee's dependent*** coverage will be reinstated without ***pre-existing conditions*** exclusions or a waiting period.

CLAIM FILING AND APPEAL PROCEDURE

Types of Claims

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

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

> **Claim Involving Urgent Care** – A Claim Involving Urgent Care is any Pre-Service Care Claim for medical care or treatment with respect to which the application of the timeframes for making non-urgent care determinations (a) could seriously jeopardize your life or health or your ability to regain maximum function or (b) in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies. Determination of ***urgent*** will be made by an individual acting on behalf of the plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine; however, any Physician with knowledge of your medical condition can determine that a claim involves urgent care.
>
> **Concurrent Care Claim** - A Concurrent Care Claim is a claim for an extension of the duration or number of treatments provided through a previously approved pre-service claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought. Additionally, if the Plan or its designee reduces or terminates a course of treatment before the end of the course previously approved (unless the reduction or termination of benefits is due to a health plan amendment or health plan termination), then the reduction or termination is considered an adverse benefit determination. The Plan or its designee will notify you, in advance, of the reduction or termination so that you may appeal and obtain an answer on the appeal before the benefit is reduced or terminated.

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

Who Must File

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

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

Time Limit for Filing a Claim

You must file claims within 15 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 15 months.

Where to File a Claim

Medical Claims
Medical Mutual of Ohio
PO Box 94648
Cleveland, OH 44101-4648

Medical Claims within Cofinity Network
Cofinity
PO Box 2720
Farmington Hills, MI 48333

Prescription Drug Plan
CVS Caremark
PO Box 52196
Phoenix, AZ 85072-2196

Claims should be filed as indicated on your Identification Card.

What to File

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

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

Method of Claims Delivery

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

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

Timing of Claims Determinations

Claims Involving Urgent Care. If you file a Claim Involving Urgent Care in accordance with the claims procedures and sufficient information is received, you will be notified of the Plan's or its designee's benefit determination, whether adverse or not, as soon as is feasible, but not later than 72 hours after receipt of the claim. If you do not follow the claims procedures or the claim does not include sufficient information for the Plan or its designee to make a benefit determination, you will be notified within 24 hours after receipt of the claim of the applicable procedural deficiencies, or the specific deficiencies related to additional information necessary to make a benefit determination. You will have at least 48 hours to correct the procedural deficiencies and/or provide the requested information. The Plan or its designee must inform you of the benefit determination, whether adverse or not, as soon as possible, taking into account all medical exigencies, but not later than 48 hours after receipt of the additional information. The Plan or its designee may notify you of its benefit determination decision orally and follow with written or electronic notification not later than three (3) days after the oral notification.

Concurrent Care Claims. If your claim is one involving concurrent care, the Plan or its designee will notify you of its decision, whether adverse or not, within 24 hours after receiving the claim, if the claim was for urgent care and was received by the Plan or its designee at least 24 hours before the expiration of the previously approved time period

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

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

If an extension is needed because you did not provide all of the necessary information to process your claim, the Plan or its designee will notify you, in writing, within the initial 15 day response period and will specifically describe the missing information. You will then have at least 45 days to provide any additional information requested of you by the Plan or its designee. If you do not provide the requested information, your claim may be denied.

Post-Service Care Claims. If you file a Post-Service Care Claim in accordance with the claims procedures and sufficient information is received, the Plan or its designee will notify you of its benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. The 30 day time period can be extended for up to an additional 15 days, if the Plan or its designee determines that an extension is necessary due to matters beyond the Plan's or its designee's control and the Plan or its designee notifies you within the initial 30 day time period of the circumstances requiring an extension of the time period, and the date by which the Plan or its designee expects to render a decision.

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

Notice of Claims Denial (Adverse Benefit Determination)

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

1. Information sufficient to identify the claim or health care service involved, including the date of service, healthcare provider, and claim amount (if applicable);
2. The specific reason(s) for the adverse benefit determination, including the denial code and its corresponding meaning;
3. Reference to the specific plan provision(s) on which the adverse benefit determination was based;
4. If the adverse benefit determination relied upon any internal rules, guidelines or protocols, a statement that you may request a copy of the rule, guideline or protocol, which will be provided free of charge;
5. If the adverse benefit determination was based in whole or in part on Medical Necessity, Experimental/Investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided free of charge;
6. Notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
7. Disclosure of the availability of assistance with the appeal process from the Ohio Department of Insurance if your Plan is regulated by the Ohio Department of Insurance;
8. A description of additional material or information, if any, that is required to perfect the claim and an explanation of why the information is necessary; and
9. A description of the Plan's or its designee's appeal procedures and applicable time limits, including the expedited appeal process, if applicable.

FILING A COMPLAINT

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

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

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

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

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

APPEALS PROCEDURES

Definitions

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

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

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

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

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

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

Emergency Medical Condition – a medical condition that manifests itself by such acute symptoms of sufficient

severity, including severe pain that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

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

Emergency Services –

- A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition;
- Such further medical examination and treatment that are required by federal law to stabilize an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

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

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

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

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

"Health plan issuer" includes a third party administrator to the extent that the benefits that such an entity is contracted to administer under a Health Benefit Plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the Superintendent.

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

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

Stabilize – the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a Covered Person's medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

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

Superintendent – the superintendent of insurance.

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

How and When to File a Claims Appeal

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

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

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

Medical Appeals

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

Prescription Appeals

CVS Caremark
Appeals Department
MC109
PO Box 52084
Phoenix, AZ 85072
Fax: 866-689-3092

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

First Level Mandatory Internal Appeal

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

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

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

have an opportunity to respond before the Plan's or its designee's timeframe for issuing a notice of Final Adverse Benefit Determination expires; and

7. May request an external review at the same time you request an internal appeal for an urgent care claim or for a concurrent care claim that is urgent.

The claim review will be subject to the following rules:

1. The claim will be reviewed by an appropriate individual, who is neither the individual who made the initial denial nor a subordinate of that individual.
2. The review will be conducted without giving deference to the initial denial.
3. If the Adverse Benefit Determination was based in whole or in part on a medical judgment (including any determinations of Medical Necessity or Experimental/Investigative treatment), the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional shall not be an individual who was consulted on the initial claim denial nor the subordinate of such an individual. Health care professionals who conduct the appeal act independently and impartially. Decisions to hire, compensate, terminate, promote or retain these professionals are not based in any manner on the likelihood that these professionals will support a denial of benefits. Upon specific written request from you, the Plan or its designee will provide the identification of the medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.
4. You will receive continued coverage pending the outcome of the appeals process. For this purpose, the Plan or its designee may not reduce or terminate benefits for an ongoing course of treatment without providing advance notice and an opportunity for advance review. If the Plan's Adverse Benefit Determination is upheld, you may be responsible for the payment of services you receive while the appeals process was pending.

Timetable for Deciding Appeals

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

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

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

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

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

Notice of Final Adverse Benefit Determination after Appeal

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

1. Information sufficient to identify the claim or health care service involved, including the date of service, healthcare provider, and claim amount (if applicable);
2. The specific reason(s) for the Final Adverse Benefit Determination, including the denial code and its corresponding meaning;
3. Reference to the specific plan provision(s) on which the Final Adverse Benefit Determination is based;
4. A statement that you may request reasonable access to and copies of all documents, records and

other information relevant to your appealed claim for benefits, which shall be provided to you without charge;

5. If the Final Adverse Benefit Determination relied upon any internal rules, guidelines or protocols, a statement that you may request a copy of the rule, guideline or protocol, which will be provided to you without charge;
6. If the Final Adverse Benefit Determination was based in whole or in part on Medical Necessity, Experimental/Investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided to you without charge;
7. Notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
8. Disclosure of the availability of assistance with the appeal process from the Ohio Department of Insurance if your Plan is regulated by the Ohio Department of Insurance;
9. A discussion of the decision;
10. A description of the Plan's or its designee's applicable appeal procedures.

What Happens After the First Level Mandatory Internal Appeal

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

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

A. Contact Information for Filing an External Review

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

B. Understanding the External Review Process

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

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

C. Opportunity for External Review

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

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:

- **o** Standard Health Care Services have not been effective in improving the condition of the Covered Person
- **o** Standard Health Care Services are not medically appropriate for the Covered Person
- **o** No available standard Health Care Service covered by the Plan is more beneficial than the requested Health Care Service.

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

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

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

2. External Review by the Ohio Department of Insurance

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

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

D. Request for External Review

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

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

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

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

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

E. IRO Assignment

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

F. Reconsideration by the Plan

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

G. IRO Review and Decision

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

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

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

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

H. Binding Nature of External Review Decision

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

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

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

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

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

Contact ODI Consumer Affairs:
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp

File a Consumer Complaint:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

LEGAL ACTION

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

COORDINATION OF BENEFITS

The *Coordination of Benefits* provision is intended to prevent duplication of benefits. It applies when the ***covered person*** is also covered by any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all plans will not exceed 100% of "allowable expenses."

The *Coordination of Benefits* provision applies whether or not a claim is filed under the Other Plan(s). If another ***plan*** provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"Allowable Expenses" means any reasonable, necessary, and customary expenses ***incurred*** while covered under this ***Plan***, part or all of which would be covered under this ***Plan***. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this ***Plan***.

When this ***Plan*** is secondary, "Allowable Expense" will include any Deductible or ***coinsurance*** amounts not paid by the Other Plan(s).

When this ***Plan*** is secondary, "Allowable Expense" shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the ***covered person*** for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical care. Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for ***covered persons*** in a group, whether on an insured or uninsured basis, including, but not limited to, ***hospital*** indemnity benefits and ***hospital*** reimbursement-type plans;

2. ***Hospital*** or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;

3. A licensed Health Maintenance Organization (HMO);

4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;

5. Any coverage under a government program and any coverage required or provided by any statute;

6. Group automobile insurance;

7. Individual automobile insurance coverage;

8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;

9. Any ***plan*** or policies funded in whole or in part by an employer, or deductions made by an employer from a person's compensation or retirement benefits;

10. Labor/management trustee, union welfare, employer organization, or ***employee*** benefit organization plans. "This ***Plan***" shall mean that portion of the ***employer's Plan*** which provides benefits that are subject to this provision.

"Claim Determination Period" means a calendar year or that portion of a calendar year during which the ***covered person*** for whom a claim is made has been covered under this ***Plan***.

EFFECT ON BENEFITS

This provision shall apply in determining the benefits for a ***covered person*** for each claim determination period for the Allowable Expenses. If this ***Plan*** is secondary, the benefits paid under this ***Plan*** may be reduced so that the sum of benefits paid by all plans does not exceed 100% of total Allowable Expense.

If the rules set forth below would require this ***Plan*** to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this ***Plan***.

ORDER OF BENEFIT DETERMINATION

Each plan will make its claim payment according to the following order of benefit determination:

1. No Coordination of Benefits Provision
   If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).

2. Member/***Dependent***
   The plan which covers the claimant as a member (or named insured) pays as though no Other Plan existed. Remaining ***covered expenses*** are paid under a plan which covers the claimant as a ***dependent***.

3. ***Dependent*** Children of Parents not Separated or Divorced
   The plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.

4. ***Dependent*** Children of Separated or Divorced Parents
   When parents are separated or divorced, the birthday rule does not apply, instead:

   a. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent, if any, pays fourth.
   b. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody, if any, pays fourth.

5 Active/Inactive
   The plan covering a person as an active (not laid off or retired) ***employee*** or as that person's ***dependent*** pays first. The plan covering that person as a laid off or retired ***employee***, or as that person's ***dependent*** pays second.

6. Limited Continuation of Coverage
   If a person is covered under another group health ***plan***, but is also covered under this ***Plan*** for continuation of coverage due to the Other Plan's limitation for ***pre-existing conditions*** or exclusions, the Other Plan shall be primary.

7. Longer/Shorter Length of Coverage
   If none of the above rules determine the order of benefits, the ***plan*** covering a person longer pays first. The ***plan*** covering that person for a shorter time pays second.

LIMITATIONS ON PAYMENTS

In no event shall the ***covered person*** recover under this ***Plan*** and all Other Plan(s) combined more than the total Allowable Expenses offered by this ***Plan*** and the Other Plan(s). Nothing contained in this section shall entitle the ***covered person*** to benefits in excess of the benefits paid by this ***Plan*** during the claim determination period. The ***covered person*** shall refund to the ***employer*** any excess it may have paid.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this *Coordination of Benefits* provision, the ***Plan*** may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information, regarding other insurance, with respect to any ***covered person***. Any person claiming benefits under this ***Plan*** shall furnish to the ***employer*** such information as may be necessary to implement the *Coordination of Benefits* provision.

FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under this ***Plan*** in accordance with this provision have been made under any Other Plan, the ***employer*** shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this ***Plan*** and, to the extent of such payments, the ***employer*** shall be fully discharged from liability.

SUBROGATION/REIMBURSEMENT

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

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

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

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) your right 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.

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.

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 any other source possessing 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, claims, or right 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 that 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 attorneys' fees to any attorneys 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. 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 and regardless of whether the settlement or judgment 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 shall provide all information requested by the Plan, the Claims Administrator, or its representative, including, but not limited to, completing and submitting any application 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 termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the Plan's Subrogation and Recovery interests or to 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. If you fail to cooperate with the Plan in its efforts to Recover such amounts or do anything to hinder or prevent such a Recovery, you will cease to be entitled to any further Plan benefits. The Plan will also have the right to withhold or offset future benefit payments up to the amount of any settlement, judgment, or Recovery you obtain, regardless of whether the settlement, judgment, or Recovery is designated to cover future medical benefits or expenses.

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

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

Interpretation

In the event that a 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.

THIS PLAN AND *MEDICARE*

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.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The ***Plan*** is administered through the Human Resources Department of the ***employer***. The ***employer*** is the ***plan administrator***. The ***plan administrator*** shall have full charge of the operation and management of the ***Plan***. The ***employer*** has retained the services of an independent ***claims processor*** experienced in claims review.

The ***employer*** is the ***named fiduciary*** of the ***Plan*** except as noted herein. The ***claims processor*** agrees to be the ***named fiduciary*** for the purposes of administering claims and hearing appeals of adverse determinations only. As such, the ***claims processor*** maintains discretionary authority to review all denied claims under appeal for benefits under the ***Plan***. The ***employer*** maintains discretionary authority to interpret the terms of the ***Plan***, including but not limited to, determination of eligibility for and entitlement to ***Plan*** benefits in accordance with the terms of the ***Plan***; any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

ASSIGNMENT

The ***Plan*** will pay benefits under this ***Plan*** to the ***employee*** unless payment has been assigned to a ***hospital***, ***physician***, or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the ***Plan*** unless the ***claims processor*** is notified in writing of such assignment prior to payment hereunder.

Preferred providers normally bill the ***Plan*** directly. If services, supplies or treatment has been received from such a provider, benefits are automatically paid to that provider. The ***covered person's*** portion of the ***negotiated rate***, after the ***Plan's*** payment, will then be billed to the ***covered person*** by the ***preferred provider***.

This ***Plan*** will pay benefits to the responsible party of an ***alternate recipient*** as designated in a Qualified Medical Child Support Order.

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible ***covered person*** is entitled to receive benefits under this ***Plan***. Such right to benefits is not transferable.

CLERICAL ERROR

No clerical error on the part of the ***employer*** or ***claims processor*** shall operate to defeat any of the rights, privileges, services, or benefits of any ***employee*** or any ***dependent(s)*** hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered. However, if more than six (6) months has elapsed prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

CONFORMITY WITH STATUTE(S)

Any provision of the ***Plan*** which is in conflict with statutes which are applicable to this ***Plan*** is hereby amended to conform to the minimum requirements of said statute(s).

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.

EFFECTIVE DATE OF THE PLAN

The ***effective date*** of this ***Plan*** is January 1, 2015.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this ***Plan*** shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a ***hospital*** or to make a free choice of the attending ***physician*** or ***professional provider***. However, benefits will be paid in accordance with the provisions of this ***Plan***, and the ***covered person*** will have higher out-of-pocket expenses if the ***covered person*** uses the services of a ***nonpreferred provider***.

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).

INCAPACITY

If, in the opinion of the ***employer***, a ***covered person*** for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the ***Plan*** of the qualification of a guardian or personal representative for his estate, the ***employer*** may on behalf of the ***Plan***, at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the ***Plan's*** obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the ***employer*** or by the ***employee*** covered under this ***Plan*** shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this ***Plan*** or be used in defense to a claim unless they are contained in writing and signed by the ***employer*** or by the ***covered person,*** as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

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 (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 introduce themselves and answer questions. The case manager will also contact the patient's attending ***physician*** and other medical providers to introduce themselves and to assure that all available resources are considered.

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

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the ***employer*** shall not be liable for any obligation of the ***covered person incurred*** in excess thereof. The liability of the ***Plan*** shall be limited to the reasonable cost of ***covered expenses*** and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the ***plan administrator*** is unable to locate the ***covered person*** to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the ***covered person*** for the forfeited benefits within the time prescribed in the *Claim Filing and Appeal Procedure* section of this document.

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

The ***Plan*** will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a State ***plan*** for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a ***covered person*** or in determining or making any payment of benefits to that individual. The ***Plan*** will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this ***Plan*** has a legal liability to make payments for the same services, supplies or treatment, payment under the ***Plan*** will be made in accordance with any State law which provides that the State has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the ***Plan***.

MISREPRESENTATION AND RESCISSION OF COVERAGE

If the ***covered person*** or anyone acting on behalf of a ***covered person*** makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the ***Plan***, or otherwise misleads the ***Plan***, the ***Plan*** shall be entitled to recover its damages, including legal fees, from the ***covered person***, or from any other person responsible for misleading the ***Plan***, and from the person for whom the benefits were provided. Any intentional material misrepresentation on the part of the ***covered person*** in making application for coverage, or any application for reclassification thereof, or for service thereunder shall render the coverage under this ***Plan*** null and void.

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), perform an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) make 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, 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.

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

The ***Plan***, at its own expense, shall have the right to require an examination of a person covered under this ***Plan*** when and as often as it may reasonably require during the pendency of a claim.

PLAN IS NOT A CONTRACT

The ***Plan*** shall not be deemed to constitute a contract between the ***employer*** and any ***employee*** or to be a consideration for, or an inducement or condition of, the employment of any ***employee***. Nothing in the ***Plan*** shall be deemed to give any ***employee*** the right to be retained in the service of the ***employer*** or to interfere with the right of the ***employer*** to terminate the employment of any ***employee*** at any time.

PLAN MODIFICATION AND AMENDMENT

The ***employer*** may modify or amend the ***Plan*** from time to time at its sole discretion, and such amendments or modifications which affect ***covered persons*** will be communicated to the ***covered persons***. Any such amendments shall be in writing, setting forth the modified provisions of the ***Plan***, the ***effective date*** of the modifications, and shall be signed by the ***employer's*** designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the ***Plan*** on file with the ***employer***, or a written copy thereof shall be deposited with such master copy of the ***Plan***. Appropriate filing and reporting of any such modification or amendment with governmental authorities and to ***covered persons*** shall be timely made by the ***employer***.

PLAN TERMINATION

The ***employer*** reserves the right to terminate the ***Plan*** at any time. Upon termination, the rights of the ***covered persons*** to benefits are limited to claims ***incurred*** up to the date of termination. Any termination of the ***Plan*** will be communicated to the ***covered persons***.

PRONOUNS

All personal pronouns used in this ***Plan*** shall include either gender unless the context clearly indicates to the contrary.

RECOVERY FOR OVERPAYMENT

Whenever payments have been made from the ***Plan*** in excess of the maximum amount of payment necessary, the ***Plan*** will have the right to recover these excess payments. If the City of Napoleon makes any payment that, according to the terms of the ***Plan***, should not have been made, the ***Plan*** may recover that incorrect payment, whether or not it was made due to the City of Napoleon's own error, from the person or entity to whom it was made or from any other appropriate party.

STATUS CHANGE

If an ***employee*** or ***dependent*** has a status change while covered under this ***Plan*** (i.e. ***dependent*** to ***employee***, COBRA to active) and no interruption in coverage has occurred, the ***Plan*** will provide continuous coverage with respect to any Deductible(s), ***coinsurance*** and ***maximum benefit (if applicable)***.

TIME EFFECTIVE

The effective time with respect to any dates used in the ***Plan*** shall be 12:00 a.m. (midnight) as may be legally in effect at the address of the ***plan administrator***.

WORKERS' COMPENSATION NOT AFFECTED

This ***Plan*** is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.

HIPAA PRIVACY

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 Regulation.

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 45 C.F.R. §164.504 (the "504" provisions).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Required separation between the Plan and the Plan Sponsor

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

1. Human Resource Department

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 such breach, 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 the Buckeye Ohio Risk Management Association (BORMA) City of Napoleon's Employee Benefit Plan.

C. *Plan Documents* – The term "Plan Documents" means the group health plan's governing documents and instruments (*i.e.*, the documents under which the group health plan was established and is maintained), including but not limited to the Buckeye Ohio Risk Management Association (BORMA) City of Napoleon Group Health Plan Document.

D. *Plan Sponsor* – Buckeye Ohio Risk Management Association (BORMA) City of Napoleon.

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 Regulation 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.

EXCEPTIONS

Notwithstanding any other provision of this *HIPAA Regulation* Section, the ***Plan*** (or a ***health insurance issuer*** or HMO with respect to the ***Plan***) may:

1 Disclose summary health information to the ***plan sponsor***:

a. If the ***plan sponsor*** requests it for the purpose of:

i. Obtaining premium bids from health plans for providing health insurance coverage under the ***Plan***; or

ii. Modifying, amending, or terminating the ***Plan***.

2 Disclose to the ***plan sponsor*** information on whether the individual is participating in the ***Plan***, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the ***Plan***;

3 ***Use*** or ***disclose protected health information***:

a. With (and consistent with) a valid authorization obtained in accordance with the ***privacy rule***;

b. To carry out ***treatment***, ***payment***, or ***health care operations*** in accordance with the ***privacy rule***; or

c. As otherwise permitted or required by the ***privacy rule***.

DEFINITIONS

As used in this *HIPAA Regulation* Section, the terms shown in ***bold and italics*** shall have the following meanings, or if not defined below, shall have the meanings as defined in the ***privacy rule*** unless the context plainly requires otherwise.

Plan

Buckeye Ohio Risk Management Association (BORMA) City of Napoleon Health Plan

Plan Sponsor

Buckeye Ohio Risk Management Association (BORMA) City of Napoleon

Privacy Rule

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulation concerning privacy of individually identifiable health information, as published in 65 Fed. Reg. 82461 (Dec. 28, 2000) and as modified and published in 67 Fed. Reg. 53181 (Aug. 14, 2002).

Required by Law

The same meaning as the term "required by law" as defined in 45 CFR 164.501, to the extent not preempted by ERISA or other Federal law.

DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in ***bold and italics*** throughout the document:

Accident

An unforeseen event resulting in ***injury***.

Active Service

An ***employee*** performing all of the regular duties of his job while in ***active service*** with the ***employer***. On any day, an ***employee*** will be considered in ***active service*** if the ***employee*** performed the regular duties of his job on the last scheduled work day.

Actively at Work; Active Work

The expenditure of time and energy in the service of the ***employer***, except that an ***employee*** shall be deemed ***actively at work*** on each day of regular paid vacation, or on a regular non-working day, on which he is not disabled, provided he was ***actively at work*** on the last preceding regular working day.

Alcoholism

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

Allowed Amount

The negotiated amount with PPO Providers that the provider will accept as payment in full, as set forth in the applicable network's contracts. In the absence of a contract between the 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 PPO Providers for that service, and Medicare reimbursement rates for that service. In this case, the Allowed Amount will likely be less that the provider's Billed Charges. If you receive services from a Non-Participating Provider, 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 provider's Billed Charges, even if you have met your Out-of-Pocket Maximum.

Alternate Recipient

Any child of an ***employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan***.

Ambulatory Surgical Facility

A ***facility*** provider with an organized staff of ***physicians*** which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc., which:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an ***outpatient*** basis;

2. Provides treatment by or under the supervision of ***physicians*** and nursing services whenever the ***covered person*** is in the ***ambulatory surgical facility***;

3. Does not provide ***inpatient*** accommodations; and

4. Is not, other than incidentally, a ***facility*** used as an office or clinic for the private practice of a ***physician***.

Birthing Center

A ***facility*** that meets professionally recognized standards and complies with all licensing and other legal requirements that apply.

Chemical Dependency

A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-IV (diagnostic and statistical manual of mental disorders) criteria.

Chiropractic Care

Services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

Claims Processor

- Mutual Health Services for health coverage
- Caremark for prescription drug coverage

Close Relative

The ***employee's*** spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the ***employee's*** spouse.

Coinsurance

The benefit percentage of ***covered expenses*** payable by the ***Plan*** for benefits that are provided under the ***Plan***. The ***coinsurance*** is applied to ***covered expenses*** after the Deductible(s) have been met, if applicable.

Complications of Pregnancy

A disease, disorder or condition which is diagnosed as distinct from ***pregnancy***, but is adversely affected by or caused by ***pregnancy***. Some examples are:

1. Intra-abdominal surgery (but not elective Cesarean Section).

2. Ectopic ***pregnancy***.

3. Toxemia with convulsions (Eclampsia).

4. Pernicious vomiting (hyperemesis gravidarum).

5. Nephrosis.

6. Cardiac Decompensation.

7. Missed Abortion.

8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during ***pregnancy*** even if prescribed by a ***physician***; morning sickness; or like conditions that are not medically termed as ***complications of pregnancy***.

Concurrent Care

A request by a ***covered person*** or their authorized representative to the ***claims processor*** prior to the expiration of a ***covered person's*** current course of treatment to extend such treatment OR a determination by the ***claims processor*** to reduce or terminate an ongoing course of treatment.

Confinement

A continuous stay in a ***hospital***, ***treatment center***, ***skilled nursing care facility***, ***hospice***, or ***birthing center*** due to an ***illness*** or ***injury*** diagnosed by a ***physician***.

Copay

A cost sharing arrangement whereby a ***covered person*** pays a set amount to a provider for a specific service at the time the service is provided.

Cosmetic Surgery

Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.

Covered Expenses

Medically necessary services, supplies or treatments that are recommended or provided by a ***physician***, ***professional provider*** or covered ***facility*** for the treatment of an ***illness*** or ***injury*** and that are not specifically excluded from coverage herein. ***Covered expenses*** shall include specified preventive care services.

Covered Person

A person who is eligible for coverage under this ***Plan***, or becomes eligible at a later date, and for whom the coverage provided by this ***Plan*** is in effect.

Custodial Care

Care provided primarily for maintenance of the ***covered person*** or which is designed essentially to assist the ***covered person*** in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an ***illness*** or ***injury***. ***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. Such services shall be considered ***custodial care*** without regard to the provider by whom or by which they are prescribed, recommended or performed.

Room and board and skilled nursing services are not, however, considered ***custodial care*** (1) if provided during ***confinement*** in an institution for which coverage is available under this ***Plan***, and (2) if combined with other ***medically necessary*** therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the ***covered person's*** medical condition.

Deductible

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

Dentist

A Doctor of Dental Medicine (D.M.D.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Medicine (M.D.), or a Doctor of Osteopathy (D.O.), other than a ***close relative*** of the ***covered person***, who is practicing within the scope of his license.

Dependent

Refer to Eligibility, Enrollment and ***Effective Date***, ***dependent***(s) Eligibility for section for the definition of ***dependent***.

Drug Abuse

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

Durable Medical Equipment Medical equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Is generally not used in the absence of an ***illness*** or ***injury***;
4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered ***durable medical equipment***. ***Durable medical equipment*** includes, but is not limited to: crutches, wheel chairs, ***hospital*** beds, etc.

Effective Date
The date of this ***Plan*** or the date on which the ***covered person's*** coverage commences, whichever occurs later.

Emergency Medical Condition

An emergency ***medical condition*** is 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.

Employee

A person directly involved in the regular business of and compensated for services, as reported on the individual's annual W-2 form, by the ***employer***, whose regular hours of work for ***full-time*** consist thirty hours or more per work week (or 130 hours per month)

Employer

The ***employer*** is the City of Napoleon.

Enrollment Date

A ***covered person's enrollment date*** is the first day of any applicable service waiting period or the date of hire.

Essential Health Benefits

Essential Health Benefits is defined under federal law (PPACA) as including benefits in at last 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/Investigational

Services, supplies, drugs and treatments which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The ***claims processor***, ***named fiduciary for post-service claims***, ***named fiduciary for pre-service claims***, ***employer/plan administrator***, or their designee must make an independent evaluation of the ***experimental***/non-experimental standings of specific technologies. The ***claims processor***, ***named fiduciary for post-service claims***, ***named fiduciary for pre-service claims***, ***employer/plan administrator*** or their designee shall be guided by a reasonable interpretation of ***Plan*** provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The ***claims processor***, ***named fiduciary for post-service claims***, ***named fiduciary for pre-service claims***, ***employer/plan administrator*** or their designee will be guided by the following examples of ***experimental*** services and supplies:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, medical treatment or procedure, was not reviewed and approved by the treating ***facility***'s institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
3. If "reliable evidence" shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials, is in the research, ***experimental***, study or ***investigational*** arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety or its efficacy as compared with a standard means of treatment or diagnosis; or
4. If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating ***facility*** or the protocol(s) of another ***facility*** studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating ***facility*** or by another ***facility*** studying substantially the same drug, device, medical treatment or procedure.

Facility

A healthcare institution which meets all applicable state or local licensure requirements.

Full-time

Regular hours of work for ***full-time*** e***mployees*** consist of thirty hours or more per work week (or 130 hours per month)

Full-time Student or Full-time Student Status

An ***employee's dependent*** child who is enrolled in and regularly attending secondary school, an accredited college, university, or institution of higher learning for the minimum number of credit hours required by that institution in order to maintain ***full-time student status***.

Generic Drug

A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or ***physician*** and must be clearly designated by the pharmacist or ***physician*** as generic.

Home Health Aide Services

Services which may be provided by a person, other than a Registered ***Nurse***, which are ***medically necessary*** for the proper care and treatment of a person.

Home Health Care

Includes the following services: IV infusion therapy for the purposes of pre-service claims only.

Home Health Care Agency

An agency or organization which meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.
2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one ***physician*** and at least one Registered ***Nurse***. It must provide for ***full-time*** supervision of such services by a ***physician*** or Registered ***Nurse***.
3. It maintains a complete medical record on each ***covered person***.
4. It has a ***full-time*** administrator.
5. It qualifies as a reimbursable service under ***Medicare***.

Hospice

An agency that provides counseling and medical services and may provide ***room and board*** to a terminally ill ***covered person*** and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.
2. It provides service twenty-four (24) hours-per-day, seven (7) days a week.
3. It is under the direct supervision of a ***physician***.
4. It has a ***Nurse*** coordinator who is a Registered ***Nurse***.
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 ***covered person***.

9. It is licensed, if licensing is required.

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

A bodily disorder, disease, physical sickness, or ***pregnancy*** of a ***covered person***.

Incurred or incurred Date

With respect to a ***covered expense***, the date the services, supplies or treatment are provided.

Injury

A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. ***Injury*** does not include ***illness*** or infection of a cut or wound, or self-inflicted ***injury***. The Plan will not exclude coverage for self-inflicted injuries (or injuries resulted from attempted suicide) if the individual's injuries are otherwise covered by the Plan and if the injuries are the result of a medical condition (such as depression).

Inpatient

A ***confinement*** of a ***covered person*** in a ***hospital***, ***hospice***, or ***skilled nursing care facility*** as a registered bed patient, for eighteen (18) or more consecutive hours and for whom charges are made for ***room and board***.

Intensive Care

A service which is reserved for critically and seriously ill ***covered persons*** requiring constant audio-visual surveillance which is prescribed by the attending ***physician***.

Intensive Care Unit

A separate, clearly designated service area which is maintained within a ***hospital*** solely for the provision of ***intensive care***. It must meet the following conditions:

1. Facilities for special nursing care not available in regular rooms and wards of the ***hospital***;
2. Special life saving equipment which is immediately available at all times;
3. At least two beds for the accommodation of the critically ill; and
4. At least one Registered ***Nurse*** in continuous and constant attendance twenty-four (24) hours-per-day.

This term does not include care in a surgical recovery room, but does include cardiac care unit or any such other similar designation.

Layoff

A period of time during which the ***employee***, at the ***employer's*** request, does not work for the ***employer***, but which is of a stated or limited duration and after which time the ***employee*** is expected to return to ***full-time***, ***active work***. ***Layoff***s will otherwise be in accordance with the ***employer's*** standard personnel practices and policies.

Leave of Absence

A period of time during which the ***employee*** does not work, but which is of a stated duration after which time the ***employee*** is expected to return to ***active work***.

Maximum Benefit

The maximum number as outlined in the ***Plan*** as a ***covered expense***. The maximum number relates to the number of:

a. Treatments during a specified period of time, or
b. Days of ***confinement***, or
c. Visits by a ***home health care agency.***

Medically Necessary (or Medical Necessity)

Service, supply or treatment which is determined by the ***claims processor***, ***named fiduciary for post-service claims***, ***named fiduciary for pre-service claims***, ***employer/plan administrator*** or their designee to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the ***covered person's illness*** or ***injury*** and which could not have been omitted without adversely affecting the ***covered person's*** condition or the quality of the care rendered; and
2. Supplied or performed in accordance with current standards of medical practice within the United States; and
3. Not primarily for the convenience of the ***covered person*** or the ***covered person's*** family or ***professional provider***; and
4. Is an appropriate supply or level of service that safely can be provided; and
5. Is recommended or approved by the attending ***professional provider***.

The fact that a ***professional provider*** may prescribe, order, recommend, perform or approve a service, supply or

treatment does not, in and of itself, make the service, supply or treatment ***medically necessary*** and the ***claims processor***, ***named fiduciary for post-service claims***, ***named fiduciary for pre-service claims***, ***employer/plan administrator*** or its designee, may request and rely upon the opinion of a ***physician*** or ***physicians***. The determination of the ***claims processor***, ***named fiduciary for post-service claims***, ***named fiduciary for pre-service claims***, ***employer/plan administrator*** or its designee shall be final and binding.

Medicare

The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, ***Hospital*** Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; and Part C, Miscellaneous provisions regarding both programs; and including any subsequent changes or additions to those programs.

Mental Illness

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

Morbid Obesity

Sixty percent (60%) or one hundred (100) pounds over an individual's ideal body weight.

Named Fiduciary for processing claims and hearing Appeals of Adverse Benefits Determinations

Mutual Health Services
P. O. Box 5700
Cleveland, Ohio 44101

Negotiated Rate

The rate the ***preferred providers*** have contracted to accept as payment in full for ***covered expenses*** of the ***Plan***.

Nonparticipating Pharmacy

Any pharmacy, including a ***hospital*** pharmacy, ***physician*** or other organization, licensed to dispense prescription drugs which does not fall within the definition of a ***participating pharmacy***.

Nonpreferred Provider

A ***physician***, ***hospital***, or other health care provider which does not have an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered.

Nurse

A licensed person holding the degree Registered ***Nurse*** (R.N.), Licensed Practical ***Nurse*** (L.P.N.) or Licensed Vocational ***Nurse*** (L.V.N.) who is practicing within the scope of their license.

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

A ***covered person*** shall be considered to be an ***outpatient*** if he is treated at:

1. A ***hospital*** as other than an ***inpatient***;

2. A ***physician's*** office, laboratory or x-ray ***facility***; or

3. An ***ambulatory surgical facility***; and

4. The stay is less than eighteen (18) consecutive hours.

Partial Confinement

A period of less than twenty-four (24) hours of active treatment in a ***facility*** licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services.
2. Treatment of ***mental illness.***
3. ***Chemical dependency*** treatment.

It may include day, early evening, evening, night care, or a combination of these four.

Participating Pharmacy

Any pharmacy licensed to dispense prescription drugs which is contracted within the ***pharmacy organization***.

Part-time

Employees who are regularly scheduled to work on a basis as determined by the ***employer***.

Pharmacy Organization

The ***Pharmacy Organization*** is Caremark.

Physician

A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), other than a ***close relative*** of the ***covered person*** who is practicing within the scope of his license.

Placed For Adoption

The date the ***employee*** assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan

"***Plan***" refers to the benefits and provisions for payment of same as described herein.

Plan Administrator

The ***plan administrator*** is responsible for the day-to-day functions and management of the ***Plan***. The ***plan administrator*** is the ***employer***.

Plan Sponsor
The ***plan sponsor*** is Buckeye Ohio Risk Management Association (BORMA).

Plan Year End

The ***plan year end*** is December 31st.

PPACA

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

Preferred Provider

A ***physician***, ***hospital*** or other health care ***facility*** that has an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered. ***Preferred Providers*** agree to accept the ***negotiated rate*** as payment in full.

Preferred Provider Organization

An organization who selects and contracts with certain ***hospitals***, ***physicians***, and other health care providers to provide services, supplies and treatment to ***covered persons*** at a ***negotiated rate***.

Pregnancy

The physical state which results in childbirth or miscarriage.

Professional Provider

A person or other entity licensed where required and performing services within the scope of such license. The covered ***professional providers*** include, but are not limited to:

Audiologist

Certified Addictions Counselor

Certified Registered ***Nurse*** Anesthetist

Certified Registered ***Nurse*** Practitioner

Chiropractor

Clinical Laboratory

Clinical Licensed Social Worker (A.C.S.W., L.C.S.W., M.S.W., R.C.S.W., M.A., M.E.D.)

Dental Hygienist

Dentist

Dietitian

Dispensing Optician

Midwife

Nurse (R.N., L.P.N., L.V.N.)

Nurse Practitioner

Occupational Therapist

Ophthalmologist

Optician

Optometrist

Physical Therapist

Physician

Physician's Assistant

Podiatrist

Psychologist

Respiratory Therapist

Speech Therapist

Qualified Prescriber

A ***physician***, ***dentist*** or other health care practitioner who may, in the legal scope of their license, prescribe drugs or medicines.

Reconstructive Surgery

Surgical repair of abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.

Relevant Information

Relevant information, when used in connection with a claim for benefits or a claim appeal, means any document, record or other information:

1. Relied on in making the benefit determination; or
2. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or
3. That demonstrates compliance with the duties to make benefit decisions in accordance with ***Plan Documents*** and to make consistent decisions; or
4. That constitutes a statement of policy or guidance for the ***Plan*** concerning the denied treatment or benefit for the ***covered person's*** diagnosis, even if not relied upon.

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.

Retrospective Review

A review after the ***covered person's*** discharge from ***hospital confinement*** to determine if, and to what extent, ***inpatient*** care was a covered service.

Room and Board

Room and linen service, dietary service, including meals, special diets and nourishments, and general nursing service. ***Room and board*** does not include personal items.

Routine Examination

A comprehensive history and physical examination which would include services as defined in *Medical Expense Benefit, Routine Preventive Care/Wellness Benefit.*

Semiprivate

The daily ***room and board*** charge which a ***facility*** applies to the greatest number of beds in its ***semiprivate*** rooms containing two (2) or more beds.

Skilled Nursing Care Facility

An institution or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an ***inpatient*** basis, for persons convalescing from ***illness*** or ***injury***, professional nursing services, and physical restoration services to assist ***covered persons*** to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered ***Nurse*** or by a Licensed Practical ***Nurse*** under the direction of a Registered ***Nurse***.

2. Its services are provided for compensation from its ***covered persons*** and under the ***full-time*** supervision of a ***physician*** or Registered ***Nurse***.

3. It provides twenty-four (24) hour-a-day nursing services.

4. It maintains a complete medical record on each ***covered person***.

5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care.

6. It is approved and licensed by ***Medicare***.

This term shall also apply to expenses ***incurred*** in an institution referring to itself as a skilled nursing ***facility***, convalescent nursing ***facility***, or any such other similar designation.

Stabilize

To provide such medical treatment of an *emergency medical condition* as may be necessary to assure within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during

the transfer of the individual from a facility.

Subrogation

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

Total Disability or Totally Disabled

The ***employee*** is prevented from engaging in his regular, customary occupation or from an occupation for which he or she becomes qualified by training or experience, and is performing no work of any kind for compensation or profit; or a ***dependent*** is prevented from engaging in all of the normal activities of a person of like age and sex who is in good health.

Treatment Center

1. An institution which does not qualify as a ***hospital***, but which does provide a program of effective medical and therapeutic treatment for ***chemical dependency***, and

2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or

3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:

    a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.

    b. It provides a program of treatment approved by the ***physician***.

    c. It has or maintains a written, specific, and detailed regimen requiring ***full-time*** residence and ***full-time*** participation by the ***covered person***.

    d. It provides at least the following basic services:

        i. ***Room and board***

        ii. Evaluation and diagnosis

        iii. Counseling

        iv. Referral and orientation to specialized community resources.

Urgent Care

An ***emergency*** or an onset of severe pain that cannot be managed without immediate treatment.