Jefferson Health Plan Bronze Plan

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Table of Contents

I. **Jefferson Health Plan - Bronze Plan Benefit Book..... 2**

Using Your Benefit Book
Definitions
Eligibility
Schedule of Benefits and Descriptions
Non-Covered Services or Items
How to Apply for Benefits
How Claims Are Paid
Benefit Determination for Claims
Filing a Complaint
Filing an Appeal
Claim Review
Legal Actions
Coordination of Benefits
Right of Subrogation and Reimbursement
Changes in Benefits or Provisions
Termination of Coverage

Jefferson Health Plan - Bronze Plan Benefit Book

This Benefit Book describes the health care benefits available to you as a Covered Person in the Self-Funded Health Benefit Plan (the Plan) offered through the Jefferson Health Plan to you by your Employer.

There is an Administrative Services Agreement between the Claims administrator (TPA) and your Employer pursuant to which the TPA processes claims and performs certain other duties on behalf of your Employer.

All persons who meet the following criteria are covered by the Plan and are referred to as Covered Persons, you or your**.** They must:

- Enroll in the coverage and complete any necessary paperwork,
- Pay for coverage if necessary; and
- Satisfy the Eligibility conditions specified by the Employer.

Your Employer, subject to the rights of the Jefferson Health Plan, and the TPA shall have the exclusive right to interpret and apply the terms of this Benefit Book. The decision about whether to pay any claim, in whole or in part, is within the sole discretion of your Employer, subject to the rights of the Jefferson Health Plan, and further subject to any available appeal process.

This Benefit Book should be read and re-read in its entirety. Many of the provisions of this Benefit Book are interrelated; therefore, reading just one or two provisions may not give you an accurate impression of your coverage.

Your Benefit Book may be modified by the Jefferson Health Plan in accordance with federal and state regulations governing health benefit plan coverage, any of which changes will be described by the attachment of Riders and/or amendments. Please read the provisions described in these documents to determine the way in which provisions in this Benefit Book may have been changed.

Many words used in this Benefit Book have special meanings. These words will appear capitalized and are defined for you in the Definitions section. By reviewing these definitions, you will have a clearer understanding of your Benefit Book.

Special Notice

If you or your family are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors or hospitals, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the Coordination of Benefits section of your benefit booklets, and compare them with the rules of any other plan that covers you or your family.

USING YOUR BENEFIT BOOK

This Benefit Book describes your health care benefits. Please read it carefully.

The **Eligibility** section outlines how and when you and your dependents become eligible for coverage under the Plan, and when this coverage starts.

The **Schedule of Benefits** gives you information about the limits and maximums of your coverage, and explains your Coinsurance, Copayment and Deductible obligations, if applicable.

The **Health Care Benefits** section explains your benefits and some of the limitations on the Covered Services available to you.

The **Exclusions** section lists services which are not covered in addition to those listed in the Health Care Benefits section.

The **Definitions** section will help you understand unfamiliar words and phrases. If a word or phrase starts with a capital letter, it is either a title or it has a special meaning. If the word or phrase has a special meaning, it will be defined in this section or where used in the Benefit Book.

The **General Provisions** section tells you how to file a claim and how claims are paid. It explains how Coordination of Benefits and Subrogation work. It also explains when your benefits may change, how and when your coverage stops and how to obtain coverage if this coverage stops.

ELIGIBILITY

Enrolling for Coverage
Prior to receiving this Benefit Book, you enrolled, and were accepted or approved by your Employer for coverage. For either coverage, you may have completed an Enrollment Form. There may be occasions when the information on the Enrollment Form is not enough. The Employer will then request the additional data needed to determine whether your dependents are Eligible Dependents. The coverage choices offered to you will be the same choices offered to other similarly situated employees.

Eligible Employee
The benefits provided under this Plan are available to any person who receives a W-2 from an Employer participating in the Jefferson Health Plan and who otherwise meets the definition of an employee under the Affordable Care Act (ACA). Your cost for coverage under this Plan will be determined by your Employer depending on whether you are classified as a Full-Time employee, a Variable Hour employee (as defined by ACA), or a Part Time employee. Employees otherwise eligible for coverage under Medicare, Medicaid, Tri-Care, CHIP or similar programs are not eligible to elect coverage under this Plan even though they may receive a W-2 from an Employer participating in the Jefferson Health Plan.

The definition of "Eligible Employee" is subject to amendment, by the Jefferson Health Plan and/or under the guidelines of the ACA. An employee considered Part-Time, under the ACA, is also eligible to enroll in the Plan but can be charged the full cost of the program by the employer to participate in this Plan.

Eligible Dependents
An Eligible Dependent would include the employee's:

- natural children;
- children placed for adoption and legally adopted children;
- children for whom the employee is the Legal Guardian or Custodian; or
- any natural or adopted children who, by court order, must be provided health care coverage by the employee.

To be considered Eligible Dependents, children's ages must fall within the age limit specified in the Schedule of Benefits, except as provided below under "Optional Extension".

Foster children, an employee's spouse, step children, the child of a domestic partner, grandchildren, domestic partners and other relatives of the employee are excluded from coverage under this Plan. Likewise, a child under the age of 26 is not eligible for coverage under this Plan, if the child is eligible for health benefits under his or her employer's plan or his or her spouse's employer.

Optional Extension
At the option of the Card Holder and at the Card Holder's expense, coverage for an Eligible Dependent child can be provided up to age 28. Subject to all other terms and conditions of this Benefit Book, coverage can be provided if the Eligible Dependent child is:

- not married;
- the natural child, stepchild or adopted child of the Card Holder or the Card Holder's spouse;
- a resident of Ohio;
- if not an Ohio resident, a Full-time Student at an accredited public or private institution of higher education;
- not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; and
- not eligible for coverage under Medicaid or Medicare.

Eligibility will continue beyond age 26 for Eligible Dependents who are unmarried and primarily dependent upon the Card Holder for support due to a physical handicap or mental retardation which renders them unable to work. This incapacity must have started before the age limit was reached and must be medically certified by a Physician. You must notify your Employer of the Eligible Dependent's desire to continue coverage within 31 days of reaching the limiting age. After a two-year period following the date the Eligible Dependent meets the age limit, the Plan may annually require further proof that the dependence and incapacity continue.

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 this Benefit Book, the Eligible Dependent will continue to be covered under this Benefit Book until the earlier of one year, or the date coverage would otherwise end under the terms of this Benefit Book.

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:

- commences while such child is suffering from a serious illness or injury;
- is Medically Necessary; and
- causes such child to lose student status for purposes of coverage under the terms of this Benefit Book.

We must receive written certification by the treating Physician of the dependent child which states 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.

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.

Ineligible Persons
Ineligible persons under this Plan include dependents that are deemed to be ineligible for their own employer's employer health plan by virtue of being an Eligible Dependent under this Plan. Such a plan generally states that a dependent who can be covered under another plan (most commonly a spouse's plan) must enroll under that plan and is ineligible for coverage as an employee under his or her own plan's coverage. Further, any person who is covered as an eligible employee shall not also be considered an eligible dependent under this Plan.

Such plans are often, but not always, called Medical Expense Reimbursement Plan or MERPs. We will not cover any dependent who is required by the terms of his or her own plan, to enroll in this Plan.

Child Support Order
In general, a medical child support order is a court order that requires an Eligible Employee to provide medical coverage for his or her children in situations involving divorce, legal separation or paternity dispute. A medical child support order may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except as otherwise required by law. This Plan provides benefits according to the requirements of a medical child support order that is entered by a court of competent jurisdiction or by a local child support enforcement agency, if the order is related to a natural or adopted child of the employee. The Employer will promptly notify affected Card Holders if a medical child support order is received. The Employer will notify these individuals of its procedures for determining whether medical child support orders meet the requirements of the Plan; within a reasonable time after receipt of such order, the Employer will determine whether the order is acceptable and notify each affected Card Holder and of its determination. Once the dependent child is enrolled under a medical child support order, the child's appointed guardian will receive a copy of all pertinent information provided to the Eligible Employee. In

addition, should the Eligible Employee lose eligibility status, the guardian will receive the necessary information regarding the dependent child's rights for continuation of coverage under COBRA.

Effective Date
Coverage starts at 12:01 a.m. on the Effective Date. The Effective Date is determined by the Employer. No benefits will be provided for services, supplies or charges Incurred before your Effective Date.

Changes in Coverage
If you have individual coverage, you may add your eligible dependent children for coverage if you adopt or have a child during the year. You must notify the benefits administrator at your Employer, who must then notify the TPA of the change to your coverage.

Coverage for a spouse is never provided under this Plan nor is coverage available under this Plan for step children. A newborn child or an adopted child of the employee will be covered as of the date of birth or adoptive placement, provided that you request enrollment within 31 days of the date of birth or adoptive placement. Coverage will continue for an adopted child, unless the placement is disrupted prior to legal adoption and the child is removed from placement.

It is important to complete and submit your Enrollment Form promptly, because the date this new coverage begins will depend on when you request enrollment.

Under Ohio law, certain changes in circumstance (i.e., moving back to Ohio) provide for an additional enrollment opportunity for dependent children. Contact your Employer benefits administrator for additional information.

There are occasions when circumstances change and only the Card Holder is eligible for coverage. Family coverage must then be changed to individual coverage. In addition, the Employer must be notified when you or an Eligible Dependent under your Benefit Book becomes eligible for Medicare.

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

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

- If coverage was non-COBRA, loss of eligibility or the Employer's contributions must end. A loss of eligibility for special enrollment includes:
    a. Loss of eligibility for coverage as a result of divorce or legal separation,
    b. Cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the Benefit Book),
    c. Death of an Eligible Employee,
    d. Termination of employment,
    e. Reduction in the number of hours of employment that results in a loss of eligibility for plan participation (including a strike, layoff or lock-out),
    f. Loss of coverage that was one of multiple health benefit 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 a Health Care Network 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 Employer's plan under a Medicaid or CHIP plan.

- 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.

- 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 Health Care Network by the Employer 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 Health Care Network by the Employer 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.

Your Identification Card

You will receive identification cards from the TPA verifying your coverage under this Plan, if you are properly enrolled for coverage. These cards have the Card Holder's name and identification number on them. The identification card should be presented when receiving Covered Services under this benefits Plan, because it contains information you or your Provider will need when submitting a claim or making an inquiry. Your receipt or possession of an identification card does not mean that you are automatically entitled to benefits. Your identification card is the property of the Plan and must be returned to your Employer if your coverage ends for any reason. After coverage ends, use of the identification card is not permitted and may subject you to legal action.

SCHEDULE OF BENEFITS AND DESCRIPTIONS

Benefit Period	Calendar Year
PPO Network Deductible per Calendar Year for Medical Services	$5,000 Single/$10,000 Family
Coinsurance for required prescription drugs	For required prescription drugs, the Plan pays 80% of the cost of the drug and you pay 20% up to the Calendar Year Coinsurance Limit
Calendar Year Coinsurance Limit for prescription drugs	$1,250 Single/$2,500 Family Plan for 2014 $1,600 Single/$3,200 Family Plan for 2015

The benefits described in this booklet are not subject to change through the collective bargaining process, but are subject to change as required or permitted under the Affordable Care Act or any other federal or state legislation governing the provision of health benefits to employees and their dependents, and in accordance with the rules established for offering this Plan to your Employer by the Jefferson Health Plan. Your Employer has no authority to amend or modify, suspend or waive any or all of the provisions of this Plan without the express authority of the Jefferson Health Plan.

To receive benefits you must use Network Providers, other than in an emergency.

BENEFIT DESCRIPTIONS

PRIMARY CARE VISIT

In-Network	$45 Co-pay per office visit, which co-pays are limited to the deductible under the Plan

SPECIALIST CARE VISIT

Including second surgical opinion.

In-Network	$45 Co-pay per office visit, which co-pays are limited to the deductible under the Plan

OTHER PRACTITIONER OFFICE VISIT/NURSE, PHYSICIAN ASSISTANT

Including other practitioner office visits where the professional may be a Nurse, Physician Assistant, Podiatrist, Psychologist, or other professional whose services require payment under State Code or Federal mandate and may include covered therapy modalities.

In-Network	$45 Co-pay per office visit, which co-pays are limited to the deductible under the Plan

OUTPATIENT SURGERY SERVICES (INCLUDING OUTPATIENT FACILITY SURGERY CHARGE)

Physician medical and surgical services in an outpatient setting performed within the scope of provider's license, including ambulatory Surgery Centers and outpatient facilities, but not including an office or clinic used for the private practice of a physician or other provider. Such services may include therapy services such as: radiation, chemotherapy, dialysis, physical therapy, respiratory, hyperbaric, pulmonary,

speech and occupational modalities.

In-Network	100% Coverage after you meet the annual deductible

Exclusions: Oral surgery that is dental in origin, such as, but not limited to, removal of impacted wisdom teeth. Further, such exclusions include the reversal of voluntary sterilizations, radial keratotomy, keraplasty, Lasik and other surgical procedures to correct refractive defects, surgeries for sexual dysfunction, surgeries or services for sexual transformation and the surgical treatment of flat feet, sublaxation of the foot, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratoses. Sugical treatment for gynecomastia, treatment of hyprehidosis, sclerotherapy for treatment of varicose veins of lower extremity, and treatment of talengiectatic dermal veins.

HOSPICE SERVICES

Services based on an approved treatment plan when life expectancy is six (6) months or less.

In-Network	100% Coverage after you meet the annual deductible

Exclusions: Physician visits, volunteer and housekeeping services, spiritual and bereavement counseling, non-palliative chemo or radiation therapy.

INFERTILITY SERVICES

Limited to basic health care services.

In-Network	100% Coverage after you meet the annual deductible

Excludes: Infertility drugs

URGENT CARE FACILITY

In-Network	$100 Co-pay per visit, which co-pays are limited to the deductible under the Plan

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HOME HEALTH CARE SERVICES

Medical treatment provided in the home on a part-time or intermittent basis including visits by a licensed health care professional, including a nurse, therapist, or home health aid for skilled nursing or therapy services.

In-Network	100% Coverage after you meet the annual deductible, subject to an annual 100 visit limit

Excludes: Dietician and homemaker services, food or home delivered meals, custodial care, home or outpatient hemodialysis services, maintenance therapy, prenatal care, private duty nursing, personal comfort items, physician charges, helpful environmental materials, Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting home health care provider. Services provided by a member of the patient's immediate family. Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors and services related to outside, occupational and social activities, manipulation therapies provided in the home.

EMERGENCY ROOM SERVICES

Services in an emergency room.

In-Network	$200 Co-pay waived if admitted, and 100% Coverage after you meet the annual deductible

Excludes: Care that is not emergency care.

EMERGENCY TRANSPORTATION/AMBULANCE

Transportation from home, scene of an accident or medical emergency to a hospital; between hospitals and between a hospital and a skilled nursing facility, from a hospital or skilled nursing facility to a patient's home.

In-Network	100% Coverage after you meet the annual deductible

Excludes: Non-covered services for ambulance including but not limited to trips to a physician's office or clinic, morgue or funeral home.

INPATIENT HOSPITAL SERVICES (E.G., HOSPITAL STAY)

Facility billed services while in an inpatient facility, such as room and board, nursing and ancillary services and supplies.

In-Network	100% Coverage after you meet the annual deductible

Exclusions: Oral surgery that is dental in origin, such as, but not limited to removal of impacted wisdom teeth, reversal of voluntary sterilization, radial keratotomy, keraplasty, Lasik and other surgical procedures to correct refractive defects, surgeries for sexual dysfunction, surgeries or services for sexual transformation and the surgical treatment of flat feet, sublaxation of the foot, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratosis. Surgical treatment for gynecomastia, treatment of hyprebidosis, sclerotherapy for treatment of varicose veins of the lower extremity, and treatment of talengietatic dermal veins.

INPATIENT PHYSICIAN AND SURGICAL SERVICES

Facility billed services while in an inpatient facility, such as room and board, nursing and ancillary services and supplies, limited to one visit per day per physician or other professional provider.

In-Network	100% Coverage after you meet the annual deductible

Exclusions: Oral surgery that is dental in origin, such as, but not limited to, removal of impacted wisdom teeth, reversal of voluntary sterilization, radial keratotomy, keraplasty, Lasik and other surgical procedures to correct refractive defects, surgeries for sexual dysfunction, surgeries or services for sexual transformation, and the surgical treatment of flat feet, sublaxation of the foot, strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratosis. Surgical treatment for gynecomastia, treatment of hyprehidosis, sclerotherapy for treatment of varicose veins of lower extremity, treatment of talengiectatic dermal veins. Staff consultations required by hospital rules, consultation requested by the patient, routine radiological or cardiographic consultations, telephone consultations, EKG transmittal via phone are also excluded from coverage under the plan.

SKILLED NURSING FACILITY (LIMITED TO 100 DAYS PER CALENDAR YEAR)

Coverage includes items and services provided as an inpatient in a skilled nursing bed or a skilled nursing facility accommodations, rehabilitative services, drugs, biological and supplies furnished for use in the skilled nursing facility and other medical necessary services and supplies.

In-Network 100% Coverage after you meet the annual deductible

Excludes: Custodial, ambulatory, rest, residential or part-time care in a skilled facility or any other facility except as rendered as part of hospice care.

PRENATAL AND POSTNATAL CARE

Maternity care, maternity-related check-ups and delivery of the baby in the hospital.

In-Network 100% Coverage after you meet the annual deductible

Exclusion(s) would include services related to surrogacy if the member is not the surrogate.

DELIVERY AND ALL INPATIENT SERVICES FOR MATERNITY CARE

Maternity care, maternity-related checkups and delivery of the baby in the hospital. 48 hour minimum length of stay for vaginal delivery, 96 hour minimum length of stay for cesarean delivery.

In-Network 100% Coverage after you meet the annual deductible

Excluded: Services related to surrogacy of member is not the surrogate.

MENTAL/BEHAVIORAL HEALTH OUTPATIENT SERVICES

Outpatient mental health treatment.

In-Network $45 Co-pay per office visit

Excludes: Custodial or domiciliary care, supervised living or halfway houses, residential treatment, room and board charges unless the treatment provided meets medical necessity criteria for inpatient admission for patient's condition(s). Services or care provided or billed by a school, halfway house, custodial care center for the developmentally disabled, residential programs for drug and alcohol or outward bound programs even if psychotherapy is included. Services related to non-compliance of care if the member ends treatment for substance abuse against the medical advice of the provider, marital and sexual counseling/therapy, wilderness camps.

MENTAL/BEHAVIORAL HEALTH INPATIENT SERVICES

Inpatient treatment for non-biologically based mental illnesses to include partial day mental health services, substance abuse services and intensive outpatient programs. Biologically based mental illness is covered the same as any other medical service.

In-Network 100% Coverage after you meet the annual deductible

Excludes: Custodial or domiciliary care, supervised living or halfway houses, residential treatment, room and board charges unless the treatment provided meets medical necessity criteria for inpatient admission for the patient's condition(s). Services or care provided or billed by a school, halfway hose, custodial care center for the developmentally disabled, residential programs for drug and alcohol or outward bound programs even if psychotherapy is included. Services related to non-compliance of care if the member ends treatment for substance abuse against the medical advice of the provider, marital and sexual counseling/therapy, wilderness camps.

SUBSTANCE ABUSE DISORDER OUTPATIENT SERVICES

Outpatient substance abuse treatment.

In-Network 100% Coverage after you meet the annual deductible

Excludes: Custodial or domiciliary care, supervised living or halfway houses, residential treatment, room and board charges unless the treatment provided meets the medical necessity criteria for inpatient admission for the patient's condition(s). Services or care provided or billed by a school, halfway house, custodial care center for the developmentally disabled, residential programs for drug and alcohol or outward bound programs even if psychotherapy is included. Services related to non-compliance of care if the member ends treatment for substance abuse against the medical advice of the provider, marital and sexual counseling/therapy, wilderness camps.

SUBSTANCE ABUSE INPATIENT SERVICES

Inpatient substance abuse treatment.

In-Network 100% Coverage after you meet the annual deductible

Excludes: Custodial or domiciliary care, supervised living or halfway houses, residential treatment, room and board charges unless the treatment provided meets medical necessity criteria for inpatient admission for the patient's condition(s). Services or care provided or billed by a school, halfway house, custodial care center for the developmentally disabled, residential programs for drug and alcohol or outward bound programs even if psychotherapy is included. Services related to non-compliant of care if the member ends treatment for substance abuse against the medical advice of the provider, marital and sexual counseling/therapy, wilderness camps.

OUTPATIENT REHABILITATION SERVICES

Separate 20 visit limit for physical, occupational and speech therapies.

In-Network 100% Coverage after you meet the annual deductible

Excludes: services for physical medicine and rehabilitation including admission to a hospital for physical therapy or long term rehabilitation in an inpatient setting.

DURABLE MEDICAL EQUIPMENT

Medical equipment, devices and supplies, prosthetics and appliances including cochlear implants and surgical bras following mastectomy.

In-Network 100% Coverage after you meet the annual deductible

Excludes: Items for person hygiene, environmental control, exercise equipment; Repairs and replacement due to misuse, malicious breakage, neglect, loss or stolen items. Does not include medical surgical supplies such as bandages, tape, arch supports, hot/cold packs, tub chair, dentures, dental appliances, stockings, heart implants, penile prosthesis, orthopedic shoes.

DIAGNOSTIC LAB, X-RAY AND IMAGING

In-Network

100% Coverage after you meet the annual deductible

PREVENTIVE CARE, SCREENING & IMMUNIZATION

Initial Mammography starting at 35, annual screening for cervical cancer, child health screenings and tests for diseases mental health and substance abuse. Vaccines and immunizations, well baby and child visits.

In-Network	100% Not subject to deductible

RADIATION THERAPY

In-Network	100% Coverage after you meet the annual deductible

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CHEMOTHERAPY

In-Network	100% Coverage after you meet the annual deductible

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INFUSION THERAPY

In-Network	100% Coverage after you meet the annual deductible

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RENAL DIALYSIS/HEMODIALYSIS

In-Network	100% Coverage after you meet the annual deductible

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ALLERGY TESTS

In-Network	100% Coverage after you meet the annual deductible

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INJECTABLE DRUGS AND OTHER DRUGS ADMINISTERED IN OUTPATIENT SETTINGS

In-Network	100% Coverage after you meet the annual deductible

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VISION CORRECTION AFTER SURGERY OR ACCIDENT

Prescription glasses or contact lenses when required as a result of surgery for the treatment of accidental injury.

In-Network	100% Coverage after you meet the annual deductible

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DIABETES EDUCATION AND CONTROL

Medical Supplies, equipment and education.

In-Network	100% Coverage after you meet the annual deductible

Excludes: Insulin pumps and supplies covered under DME benefit.

DENTAL SERVICES FOR INJURY OR ACCIDENT

Services resulting from an accidental injury when treatment is performed within 12 months of injury. Includes exam, x-ray, test and labs, oral surgery, prosthetic devices, reconstruction and anesthesia.

In-Network	100% Coverage after you meet the annual deductible

Exclusions: Damage due to biting or chewing is not covered.

PHYSICAL REHABILITATION FACILITIES

Includes coverage for day rehabilitation program services, subject to combined 60 day limit with inpatient services.

In-Network	100% Coverage after you meet the annual deductible

Excludes: Admission mainly for physical therapy or long-term inpatient rehabilitation.

PRESCRIPTION DRUG BENEFITS

80% coinsurance payment which limits your annual out of pocket expenses to $1,250 annually (for single coverage) or $2,500 for family coverage, not subject to the annual deductible.

Annual Out of Pocket Maximum
The annual out of pocket maximum under the Prescription Drug Benefit portion of this Plan will not be used to satisfy the Deductible under the medical benefits portion of this Plan. Out of Pocket maximums will not be met for expenses such as, penalties, legal fees or interest charged by your pharmacist, expenses related to non-covered prescription medications, deductibles paid under the Medical portion of this Plan, expenses incurred for prescription drugs not dispensed in compliance with the guidelines of the Prescription Drug Benefits otherwise provided under this Plan, expenses for prescription drugs purchased at non network pharmacies.

Transplant Benefits

This Plan provides coverage for Transplant care. Use of a Designated Transplant Facility is required in order for benefits to be paid under this Plan. A Designated Transplant Facility is a facility that must meet extensive criteria in the areas of patient outcomes to include patient and graft survival, patient satisfaction, Physician and program experience, program accreditations, and patient and caregiver education.

The Plan will pay for Covered Expenses incurred by a Covered Person at a Designated Transplant Facility for an illness or injury, subject to the Plan's annual Deductible. It will be the Covered Person's responsibility to obtain prior authorization for all transplant related services. If prior authorizations is not obtained, benefits may not be payable for such services. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended.

The Plan will pay for Approved Transplant Services only at a Designated Transplant Facility for Organ and Tissue Acquisition/Procurement and transplantation, if the Covered Person is the recipient. If a covered person requires a transplant, including bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition/Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition/Procurement. This includes the cost of donor testing, blood typing and evaluation to determine if the donor is a suitable match. The Plan will also provide donor services for donor related complications during the transplant period, if the recipient is a Covered Person under this Plan.

No travel expenses are covered under this Plan for the recipient of the transplant, however, if the non-covered living donor lives more than 50 miles from the transplant facility, the Plan will pay for travel and housing for a medically necessary period, which travel expenses would include (a) airfare, (b) tolls and parking fees, (c) gas/mileage, and reasonable lodging (not to exceed $50 per day) at or near the transplant facility.

Transplant Benefits under this Plan do not include:

- Expenses if the Covered Person donates an organ and/or tissue and the recipient is not covered under this Plan.
- Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services,
- Expenses for post-transplant complications of the donor, if the donor is not a Covered Person under this Plan,
- Transplants considered Experimental, Investigational or Unproven,
- Solid organ transplant in patients with carcinoma unless the carcinoma is in complete remission for five (5) years or considered cured. Exceptions, which will require additional review for Medical Necessity, include: diagnoses of squamous cell and basal cell carcinoma of the skin and hepatocellular carcinoma,
- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell) or allogeneic transplant (bone marrow or peripheral stem cell), for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehension Cancer Network (NCCN) compendium, and
- Expenses related to, or for, the purchase of any organ.

Retail and Mail Order Prescription Drug Coverage
The Retail and Mail Order Prescription Drug Benefit covers Medically Necessary drugs which may be lawfully dispensed only upon the written prescription of a Physician. The Retail benefit will cover up to a 60 day supply and the Mail Order benefit will up to a 90 day supply. Each Covered Person will receive a prescription drug identification card. When a Covered Person presents the card to a member pharmacy, the pharmacist will only charge the Covered Person the coinsurance amount for the prescription filled or refilled. Participating pharmacies have agreed with the Plan to charge Covered Persons reduced fees for covered prescription drugs.

Coverage for prescription drugs and the distribution thereof is subject to a formulary list of drugs administered by the pharmacy benefit manager under this Plan. Some drugs may be subject to prior authorization for medical necessity, as determined by the formulary list used and administered by the pharmacy benefit manager under this Plan. Plan participants should contact the pharmacy benefit manager using the telephone number found on the drug card issued in connection with coverage under this Plan for questions related to the formulary, prior authorization procedures or for more information. And, please remember that occasionally the formulary list of covered drugs changes with the development of new drugs, so be sure to refer to the list for updates.

No paper claims will be accepted under this portion of your benefit plan.

Utilization Management
Utilization Management is the process of evaluating whether services, supplies or treatments are Medically Necessary and are appropriate to help ensure cost-effective care. Utilization Management can determine Medical Necessity, shorten hospital confinements, improve the quality of care you receive and reduce costs for you and the Plan. This program includes certain Prior Authorization requirements.

The benefit amounts payable under the Schedule of Benefits may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons should call the phone number on the back of

the Plan Identification Care to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for fact gathering and independent medical review.

Please note that Covered Persons will not be penalized for failure to obtain Prior Authorization if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. At the same time, Covered Persons who received care on this basis must contact the Utilization Review Organizations as soon as possible (within 24 hours) of the first business day after receiving care or Hospital admittance.

As this Plan complies with the Newborns and Mothers Health Protection Act, the prior authorization is not required for Hospital or Birthing Center stays of 48 hours or less following a normal vaginal delivery of 96 hours or less following a Cesarean section. Prior Authorization for longer hospital stays may be required. Prior Authorization is the process of determining benefit coverage prior to a service being provided to a Covered Person. A determination is made based on Medical Necessity criteria for services, tests, or procedures that are appropriate and cost effective for the Covered Person.

Utilization Management means an assessment of the facility in which the treatment is being provided. It also includes a formal assessment of the effectiveness and appropriateness of health care services and treatment plans. These assessments can be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or a retrospective basis (following treatment).

Services that require a Prior Authorization would include:

- Inpatient hospital stays, including extended care facilities, and
- Organ and tissue transplants.

A penalty is imposed by the Plan where a Covered Person does not obtain Prior Authorization where one is required by the Plan. A penalty of $500 will be applied per admission if a Covered Person receives services without having obtained a Prior Authorization for either a hospital admission or organ and tissue transplant.

Even though a Covered Person requests a Prior Authorization before undergoing the procedure or being admitted to a hospital, it does not guarantee that this Plan will pay for the medical care. The Covered Person still needs to be eligible for coverage on the date that the service is provided and coverage under this Plan is still subject to any other provision for care described in this booklet.

NON-COVERED SERVICES OR ITEMS

Exclusions, including complications from excluded services are not considered covered benefits under this Plan and will not be considered for payment under the Plan.

1. Hospital and medical services, or items, that are not medically necessary and/or appropriate as determined by the plan. Non-medical treatment, including special education and training for dyslexia and global developmental delay.

2. Injury or illness caused or contributed to by international armed conflicts, hostile acts of foreign enemies, invasions, or war or acts of war, whether declared or undeclared, are not covered by this Plan.

3. Extraction of all teeth including wisdom teeth regardless of the cause and/or condition. Osteotomies of the maxilla or mandible (considered dental procedure) regardless of the cause or condition, whether congenital or acquired.

4. Custodial or domiciliary care, respite care, intermediate care, rest cures or other services primarily to assist in the activities of daily living and personal comfort items. Assistance with daily living activities.

5. Illness or bodily injury for which there is a medical payment or expense coverage provided or payable by another form of coverage, such as but not limited to auto coverage.

6. Services, supplies or treatments provided to the Covered Person before coverage was actually effective under this Plan, or after coverage ends, are not covered.

7. Biofeedback services, blood donor expenses, and blood pressure cuffs or monitors are not covered under this Plan.

8. Items or medical and hospital services deemed to be investigational or experimental by the Plan in conjunction with its specialty consultants, appropriate governmental agencies and other regulatory agencies as interpreted by the Plan. If medically acceptable and conventional techniques or treatment are available, new ones may not be covered. At such time as these new procedures, techniques or treatments become non-experimental or investigational and are medically necessary and appropriate, then they may be covered.

9. Chelation therapy, except in the treatment of conditions considered Medically Necessary, medically appropriate and not experimental or investigational for the medical condition for which the treatment is recognized.

10. If otherwise standard treatment items such as human tissues, anatomic structures and blood or blood derivatives are prohibited in the treatment of an individual based only by non-medical considerations (i.e., relating to religious restrictions or personal preferences) the alternative products used as substitutes are not a covered benefit.

11. Private rooms except when medically appropriate and authorized by the plan. Personal or comfort items and services (i.e., guest meals and lodging, radio, television, and phone).

12. Hospital or medical care for conditions that state or local law requires to be treated in a public facility.

13. Any injury or sickness to the extent any benefits, settlement, award or damages are received or payable (or could reasonably be expected to be received or payable if claim was made) by reason of Workers' Compensation, employer's liability or similar law or act. This provision applies even if you have waived your rights to Workers' Compensation, employer's liability or similar laws or acts.

14. Does not apply to essential benefits.

15. Reversal of voluntary sterilization and associated services and/or expenses.

16. Sex transformation surgery and associated services and/or expenses except when medically necessary and appropriate. Procedures, services and supplies related to sexual dysfunction, including but not limited to, penile implants.

17. Services not provided, arranged or authorized by your physician, except in an emergency or when allowed in this Certificate. Elective pre-surgery testing on an inpatient basis without the authorization of the Plan's Medical Director/s.

18. Physical, psychiatric, or psychological exams, testing, or treatments not otherwise covered by the Plan when such services are as follows:
    - Related to employment or school;
    - To obtain or maintain insurance;
    - Needed for marriage or adoption proceedings;
    - Related to judicial or administrative proceedings or orders;
    - Conducted for purposes of medical research;
    - To obtain or maintain a license or official document of any type; or
    - To participate in sports.

19. Elective termination of pregnancy (abortion), except when determined medically appropriate.

20. Therapy and related services for a patient showing no progress.

21. Acupressure**,** hypnosis, electrolysis, Christian Science treatment and autopsy. Lamaze classes and paternity testing, massage and vision therapy.

22. Liposuction, panniculectomies, abdominoplasty (i.e., surgical removal of fatty tissue), gastric stapling and gastroplasty or any other surgical treatment for morbid obesity.

23. Work hardening programs including functional capacity evaluations.

24. Coverage under this Plan is not provided for services received in connection with Marriage counseling, financial counseling, and or Family Planning.

25. Weight loss services and Fitness programs and associated expenses including; but not limited to, surgical procedures, wiring of the jaw, weight control programs, weight control drugs or products, nutritional products or supplements, screening for weight control programs and services of a similar nature are all excluded for reimbursement under this Plan.

26. Charges for service incurred in connection with Genetic Testing are also excluded for benefits under this Plan.

27. Charges for modifications to your home or property such as but not limited to escalators, elevators, saunas, steambaths, pools, hot tubs, whirlpools, or tanning equipment, wheelchair lifts, stair lifts or ramps are excluded for coverage under this Plan.

28. Safety devices used specifically for safety or to affect performance including sports-related activities.

29. Hepatitis B vaccine coverage limited to "direct exposure" defined as transmission that occurs through inadvertent percutaneous inoculation, mucosal absorption or sexual contact with a source currently infected with acute Hepatitis B virus. Vaccines when related to occupation or occupational, professional and educational requirements and dependent immunizations beyond their 21st birthday. Injections and immunizations required for travel outside the U.S. and associated with natural disasters (including Hepatitis A).

30. Health care services resulting from an action or omission for which a governmental entity operating a corrections facility or the governmental entity with which a law enforcement office is affiliated or liable.

31. Non-medical ancillary services and long-term rehabilitation services for the treatment of chemical dependency.

32. Physical exams or medical care required by court order or obtained in anticipation of judicial action.

33. Other limitations that are specifically stated in the Schedule of Benefits of this document.

34. Over the counter medications including but not limited to laxatives, antacids, nutritional supplements, vitamins, electrolytes, minerals, and vaginal yeast products are not covered for benefits under this Plan.

35. Any services for which the member has no legal obligation to pay in the absence of this or similar coverage.

36. Services received from, rendered or prescribed by a provider with the same legal residence as a covered person or who is a member of the covered person's family. This includes spouse, brothers, sister, parent or child. Services received or rendered by a provider to themselves.

37. Treatment in a state or federal hospital for military or service-related injuries or disabilities and/or services furnished, with or without charge, by any government agency or program, including incarceration, Medicare, military agencies, National Guard or Reserves.

38. Rehabilitation therapy that is primarily educational or cognitive in nature.

39. Non-medical services related to the treatment of Temporomandibular Joint Dysfunction (TMD), Craniomandibular Joint Dysfunction (CMD), and stylomandibular ligament including; but not limited to, braces, non-invasive conditions, experimental procedures, splints or other appliances.

40. Services, supplies, treatments, facilities or equipment which the Plan determines are not Medically Necessary for your care are not covered under this Plan. Additionally, the Plan excludes services, supplies, treatments, facilities or equipment which reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person.

41. Podiatrists performing procedures are limited by the Plan guidelines in accordance with experience, training, and certification.

42. Services that in the judgment of your physician are not medically appropriate or not required by accepted standards of medical practice or the Plan rules governing services.

43. Hearing exams unless there is a medical condition that requires such exam.

44. Megavitamin therapy, psychosurgery and nutritional based therapy.

45. Services performed after your physician has advised that further services are not medically appropriate or not covered services.

46. Homeopathic treatments.

47. Non-emergency, emergency or urgent care when traveling outside the U.S.

48. Private duty nurses are not covered under this Plan nor are items considered for personal comfort or convenience, such as but not limited to private rooms, television, telephone or guest trays.

49. Standby surgeon charges are excluded under this Plan.

50. Vision care is excluded for coverage under this Plan.

51. Infertility services. Services related to Cloning, In-vitro fertilization, gamete intra fallopian transfer and other ova transfer procedures/artificial insemination. Other types of artificial or surgical means of conception including drugs administered in connection with these procedures, diagnostic testing or treatment.

52. Long-term/custodial nursing home care.

53. Bariatric surgery regardless of the purpose for which it is proposed or performed. This includes Rouxen-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty (surgical procedures that decrease the size of the stomach) or gastric banding procedures. Complications directly related to bariatric surgery that result in an inpatient stay or an extended inpatient stay for the bariatric surgery. Directly related means that the inpatient stay or extended inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to including but not limited to: myocardial infarction, excessive nausea/vomiting, pneumonia and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

54. Hearing aids to include exams and fittings except for Cochlear implants.

55. Routine foot care. Foot care including the cutting or removal or corns and calluses. Nail cutting or debriding. Hygiene and preventive maintenance foot care including cleaning and soaking the feet.

56. Application of skin cream(s) in order to maintain skin tone. Other services that are performed when there is not a localized illness, injury or symptom involving the foot, cosmetic foot care.

57. No claims for the reimbursement of medical expenses, Medically Necessary or not, will be accepted if the date of the service was more than twelve (12) months prior to the date that the claim was first submitted to the Plan.

58. Cosmetic treatments and surgery that is cosmetic in nature is not covered for benefits under this Plan.

59. No coverage is provided under this Plan for illness or injury resulting from taking part in the commission of an assault or battery or any other similar action, or a felony.

60. No coverage for Dental care is provided under this Plan.

61. No coverage is provided for the preparation of medical reports or itemized bills from Providers.

62. Acupuncture. Services or supplies related to alternative or complementary medicine. Examples of services in this category include: acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies. Naturopathy, thermograph, orthomolecular therapy, contact reflux analysis, bioenergial synchronization technique (BEST), iridology study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervations therapy, electromagnetic therapy and neurofeedback.

63. Weight loss programs whether or not the member pursued under medical or physician supervision.

64. Alternative medicine services other than acupuncture. Services or supplies related to alternative or complementary medicine. Examples of services in this category include: acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies. Naturopathy, thermograph, orthomolecular therapy, contact reflux analysis, bioenergial synchronization technique (BEST), iridology study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervations therapy, electromagnetic therapy and neurofeedback.

Please note that this Plan does not limit you from seeking services from wherever you want. It does, however, limit reimbursements under this Plan to Network Providers. Further, if a medical expense is not a covered benefit, or is in some way subject to some limitation or exclusion, a Covered Person still has the freedom, right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

65. Services, supplies, medicines, treatments or facilities or equipment which the Plan determines are experimental, investigational, or unproven, including administrative services associated with the experimental, investigational or unproven treatments are not covered for benefits under the Plan.

66. Charges of a provider where the Covered Person failed to make an appointment.

67. Services provided to you or an eligible covered dependent, whether or not the services were considered medically necessary, where they were provided by a non-participating provider, chosen only for convenience.

DEFINITIONS

After Hours Care - services received in a Physician's office at times other than regularly scheduled office hours, including days when the office is normally closed (e.g., holidays or Sundays).

Agreement - the administrative services agreement between the TPA and your Employer. The Agreement includes the individual Enrollment Forms of the Card Holders, this Benefit Book, Schedules of Benefits and any Riders or addenda.

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.

Benefit Book - this document.

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

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

Birth Year - a 12 month rolling year beginning on the individual's birthdate.

Card Holder - an Eligible Employee or member of the Employer who has enrolled for coverage under the terms and conditions of the Plan and persons continuing coverage pursuant to COBRA or any other legally mandated continuation of coverage.

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

Claims Appeal – applies when you dispute a decision made by the TPA when considering coverage for a claim that you submitted under this Plan.

COBRA – refers to a federal law (the Consolidated Omnibus Reconciliation Act) concerning your rights to continue coverage under this Plan in certain cases where you would otherwise lose coverage.

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

Coinsurance Limit - a specified dollar amount of Coinsurance expense Incurred in a Benefit Period by a Covered Person for Covered Services received in connection with prescription drug coverage under this Plan.

Condition - an injury, ailment, disease, illness or disorder.

Contraceptives - oral, injectable, implantable or transdermal patches for birth control.

Contracting - the status of a Hospital or Other Facility Provider:

- that has an agreement with the Health Care Network or Health Care Network's parent company about payment for Covered Services; or
- designated by the Health Care Network or its parent as Contracting.

Coordination of Benefits – refers to rules used to determine how a person with coverage under two or more plans is reimbursed for covered medical expenses between the multiple plans.

Copayment – is the dollar amount that a Covered Person must pay to the provider each time certain services are received. Copayments do not apply toward satisfaction of Deductibles. Any copayments required of you when receiving medical services are described in the Schedule of Benefits.

Covered Charges - the Billed Charges for Covered Services, except that the Health Care Network reserves the right to limit the amount of Covered Charges for Covered Services provided by a Non-Contracting Institutional Provider to the Non-Contracting Amount determined as payable by the TPA.

Covered Person - the Card Holder, and if family coverage is in force, the Card Holder's Eligible Dependent(s).

Covered Service - a Provider's service or supply as described in the Health Care Benefits section of this Benefit Book for which the Plan will provide benefits, as listed in the Schedule of Benefits.

Creditable Coverage - coverage of an individual under any of the following:

- a Employer health plan, including church and governmental plans;
- health insurance coverage;
- Part A or Part B of Title XVIII of the Social Security Act (Medicare);
- the health plan for active military personnel, including TRICARE;
- the Indian Health Service or other tribal organization program;
- a state health benefits risk pool;
- the Federal Employees Health Benefits Program;
- a public health plan as defined in federal regulations;
- a health benefit plan under section 5 (c) of the Peace Corps Act; or
- any other plan that provides comprehensive hospital, medical and surgical services.

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

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

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

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

Deductible – is a dollar amount paid during a calendar year by the Covered Person before any Covered Expenses are paid by the Plan. A Deductible applies to each Covered Person up to a family Deductible limit. Each year, a new Deductible must be met. The Plan's Deductible is shown in the Schedule of Benefits.

Under this Plan, expenses for prescription drugs do not count toward meeting the Deductible. If you have family coverage under this Plan, any combination of covered family members can help meet the maximum annual family Deductible, up to each person's individual Deductible.

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.

Effective Date - 12:01 a.m. on the date when your coverage under the Plan begins, as determined by your Employer.

Emergency - an accidental traumatic bodily injury or other medical Condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:

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

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

Emergency Care - Covered Services that are furnished by a Provider within the Provider's license and as otherwise authorized by law that are needed to evaluate or Stabilize an individual in an Emergency.

Emergency Services - a medical screening examination as required by Federal Law that is within the capability of the Emergency Department of the Hospital, including ancillary services routinely available to the Emergency Department to evaluate an Emergency medical Condition; and further medical examination and treatment that are required to Stabilize an Emergency medical Condition and within the capabilities of the staff and facilities available at the Hospital, including any trauma or burn center at the Hospital.

Enrollment Form - a form you complete for yourself and your Eligible Dependents to be considered for coverage under the Plan.

Excess Charges - the amount of Billed Charges in excess of the covered Traditional Amount.

Experimental or Investigational Drug, Device, Medical Treatment or Procedure - a drug, device, medical treatment or procedure is Experimental or Investigational:

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

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written 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. Determination will be made by the Health Care Network at its sole discretion and will be final and conclusive, subject to any available appeal process.

External and Internal Review - Under the Affordable Care Act, consumers now have rights to appeal health plan decisions that might deny payment for services or coverage of treatment. Under the law, many health plans must meet basic standards for how to handle *internal appeals* and *external reviews*.

An internal appeal is a review by the health plan itself. You may file an *internal appeal* to ask your health plan to reconsider its decision to deny your:

- Request for approval to get a service or treatment (pre-authorization)
- Claim for payment for a service or treatment
- Application for health insurance coverage.

An external review is a review of the health plan's decision by an independent third party. Under the law, consumers now have rights to an external review. An external review is an easy way to appeal the health plan's denial.

Federally Eligible Individual -

- an individual who has had an 18 month period of Creditable Coverage with final coverage through a Employer plan, governmental plan or church plan. Coverage, after which there was a break of more than 63 days does not count in the period of Creditable Coverage. Creditable Coverage will be counted based on the standard method without regard to specific benefits;
- an individual who must apply within 63 days of the end of the termination date of your coverage under the Employer policy;
- an individual must not be eligible for coverage under a Employer health plan, Medicare or Medicaid;
- an individual must not have other health insurance coverage;
- an individual whose most recent prior coverage has not been terminated for nonpayment of premium or fraud; and
- an individual who elected COBRA coverage or Ohio extension of benefits coverage, after the individual has exhausted all such continuation coverage to become a Federally Eligible Individual. Termination for non-payment of premium does not constitute exhausting such coverage.

Formulary – A list of prescription drugs that includes both generic and name brand drugs covered under the Plan.

Full-time Student - an Eligible Dependent who is enrolled at an accredited institution of higher learning. It must be certified annually that the student meets the institution's requirements for full-time status.

Employer - the Employer or organization who enters into an Agreement with the Health Care Network for the Health Care Network and the TPA to provide administrative services for such employer's or organization's health plan.

Health Care Network – the network of health care providers that is offered by the Employer to plan participants using this Plan of benefits, as defined in this booklet**.**

Hospital - an Institution that meets the specifications of Chapter 3727 of the Ohio Revised Code, except for the requirement that such Institution be operated within the state of Ohio.

Identification Card – a card which identifies you as eligible for coverage under this Plan. Holding and presenting such card does not however guarantee that the medical service that you seek will be covered under this Plan.

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

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

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

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

Jefferson Health Plan – the non-profit partially self-insured health care program established as a Council of Governments under the Ohio Revised Code of which your Employer is a participating member.

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

Lesser Amount - for Contracting and Participating Providers, the Lesser Amount means the Lesser of the Negotiated Amount or the Covered Charges.

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

Medically Necessary (or Medical Necessity) - a service, supply and/or Prescription Drug that is required to diagnose or treat a Condition and which the Health Care Network and the TPA determines is:

- appropriate with regard to the standards of good medical practice and not Experimental or Investigational;
- clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for your Condition,
- not primarily for your convenience or the convenience of a health care Provider; and the most appropriate supply or level of service which can be safely provided to you. When applied to the care of an Inpatient, this means that your medical symptoms or Condition require that the services cannot be safely or adequately provided to you as an Outpatient. When applied to Prescription Drugs, this means the Prescription Drug is cost effective compared to alternative Prescription Drugs which will produce comparable effective clinical results.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of that service, treatment plan, supply, medicine, equipment or facility Medically Necessary.

Generally accepted standards of medical practice are standards that are based on credible scientific evidence published in peer review medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a casual relationship between the service or treatment and health outcomes.

If no credible evidence is available, then standards that are based on Physician specialty society recommendations of professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sold discretion.

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

Medicare Approved - the status of a Provider that is certified by the United States Department of Health and Human Services to receive payment under Medicare.

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.

Negotiated Amount - the amount the Provider has agreed with the Health Care Network to accept as payment in full for Covered Services.

The Negotiated Amount for Institutional Providers does not include adjustments and/or settlement due to prompt payment discounts, guaranteed discount corridor provisions, maximum charge increase limitation violations or any settlement, incentive, allowance or adjustment that does not accrue to a specific claim. The Negotiated Amount for Prescription Drugs does not include any share of formulary reimbursement savings, volume based credits or refunds or discount guarantees.

The Negotiated Amount for Contracting Institutional Providers may exceed the Covered Charges.

The Negotiated Amount for Participating Physicians and Other Professional Providers does not include any performance withhold adjustments.

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

Non-Contracting - the status of a Hospital or Other Facility Provider that does not meet the definition of a Contracting Institutional Provider.

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

Non-Participating - the status of a Physician or Other Professional Provider that does not have an agreement with the Health Care Network about payment for Covered Services.

Non-PPO Network Provider - a Contracting Hospital, Contracting Other Facility, Home Health Care, Agency or Hospice Provider which is not designated by the Health Care Network as a PPO Network Provider.

Office Visit - Office visits include medical visits or Outpatient consultations in a Physician's office or patient's residence. A Physician's office can be defined as a medical/office building, Outpatient department of a Hospital, freestanding clinic facility or a Hospital-based Outpatient clinic facility.

Other Facility Provider - the following Institutions which are licensed, when required, and where Covered Services are rendered which require compensation from their patients. Other than incidentally, these facilities are not used as offices or clinics for the private practice of a Physician or Other Professional Provider. The Plan will only provide benefits for services or supplies for which a charge is made. Only the following Institutions which are defined below are considered to be Other Facility Providers:

- Alcoholism Treatment Facility - a facility which mainly provides detoxification and/or rehabilitation treatment for Alcoholism.
- Ambulatory Surgical Facility - a facility with an organized staff of Physicians that has permanent facilities and equipment for the primary purpose of performing surgical procedures strictly on an Outpatient basis. Treatment must be provided by or under the supervision of a Physician and also includes nursing services.
- Day/Night Psychiatric Facility - a facility which is primarily engaged in providing diagnostic services and therapeutic services for the Outpatient treatment of Mental Illness. These services are provided through either a day or night treatment program.
- Dialysis Facility - a facility which mainly provides dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.
- Drug Abuse Treatment Facility - a facility which mainly provides detoxification and/or rehabilitation treatment for Drug Abuse.

- Home Health Care Agency - a facility which meets the specifications of Chapter 3701.88 of the Ohio Revised Code, except for the requirement that such Institution be operated within the state of Ohio and which provides nursing and other services as specified in the Home Health Care Services section of this Benefit Book. A Home Health Care Agency is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- Hospice Facility - a facility which provides supportive care for terminally ill patients as specified in the Hospice Services section of this Benefit Book.
- Psychiatric Facility - a facility which is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental Illness on an Outpatient basis.
- Psychiatric Hospital - a facility which is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental Illness on an Inpatient basis. Such services must be provided by or under the supervision of an organized staff of Physicians. Continuous nursing services must be provided under the supervision of a registered nurse.
- Skilled Nursing Facility - a facility which primarily provides 24-hour Inpatient Skilled Care and related services to patients requiring convalescent and rehabilitative care. Such care must be provided by either a registered nurse, licensed practical nurse or physical therapist performing under the supervision of a Physician.

Other Professional Provider - only the following persons or entities which are licensed as required:

- advanced nurse practitioner (A.N.P.);
- ambulance services;
- dentist;
- doctor of chiropractic medicine;
- durable medical equipment or prosthetic appliance vendor;
- laboratory (must be Medicare Approved);
- licensed independent social workers (L.I.S.W.);
- licensed practical nurse (L.P.N.);
- licensed professional clinical counselor;
- licensed professional counselor;
- licensed vocational nurse (L.V.N.);
- mechanotherapist (licensed or certified prior to November 3, 1975);
- nurse-midwife;
- occupational therapist;
- physical therapist;
- physician assistant;
- podiatrist;
- Psychologist;
- registered nurse (R.N.);
- registered nurse anesthetist; and
- Urgent Care Provider.

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

Participating - the status of a Physician or Other Professional Provider that has an agreement with the Health Care Network about payment for Covered Services.

Pharmacy Benefit Manager – is a TPA of prescription drug programs responsible for processing and paying drug claims under this Plan.

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

Plan - the program of health benefits coverage established by the Jefferson Health Plan for this Employer for its employees and their Eligible Dependents under this Plan. This Plan of Benefits coverage is defined by the Jefferson Health Plan and is not subject to changes brought about through the collective bargaining process and/or in any other manner negotiated by your Employer.

PPO Network Deductible - an amount, usually stated in dollars, for which you are responsible each Benefit Period before the Plan will start to provide benefits for services received from a PPO Network Provider.

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

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

Prescription Order - the request for medication by a Physician appropriately licensed to make such a request in the ordinary course of professional practice.

Prior Authorization - refers to the process of obtaining prior approval from the TPA or the third-party prescription drug vendor about the correctness, suitability, and coverage of a service or medication that allows a beneficiary to know in advance about whether a procedure, treatment, or service will be covered under his/her plan.

Professional - a Physician or Other Professional Provider.

Professional Charges - The cost of a Physician or Other Professional Provider's services before the application of the Negotiated Amount.

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

Psychologist - a Professional Provider who is a licensed Psychologist having either a doctorate in psychology or a minimum of five years of clinical experience. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

Residential Treatment Facility -A facility that provides care on a 24 hour a day, seven days a week, live-in basis for the evaluation and treatment of residents with psychiatric or chemical dependency disorders.

- The facility provides 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 meets 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.
- Residents do not require care in an acute or more intensive medical setting.

Rider - a document that amends or supplements your coverage.

Routine Services - Services not considered Medically Necessary.

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

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

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

Stabilize - the provision of medical treatment to you in an Emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your Condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you; or
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.
- Surgery -
- the performance of generally accepted operative and other invasive procedures;
- the correction of fractures and dislocations;
- usual and related preoperative and postoperative care; or
- other procedures as reasonably approved by the TPA.

Subrogation – is a legal term referring to the doctrine of equitable payment, which forms a wider part of a body of law known as unjust enrichment. Subrogation operates to prevent over-recovery in the case of a loss which might otherwise be covered by two policies.

TPA – refers to a third party administrator, which is the organization designated by your Employer to process and pay claims in accordance with the terms of this Plan.

Traditional Amount - the maximum amount determined and allowed by the Health Care Network for a Covered Service provided by a Physician or Other Professional Provider based on factors, including the following:

- the actual amount billed by a Provider for a given service
- Center for Medicare and Medicaid Services (CMS)'s Resource Based Relative Value Scale (RBRVS)
- other fee schedules
- input from Participating Physicians and wholesale prices (where applicable)
- geographic considerations; and
- other economic and statistical indicators and applicable conversion factors.

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

Urgent Care Provider - another Professional Provider that performs services for health problems that require immediate medical attention that are not Emergencies.

HOW TO APPLY FOR BENEFITS

Notice of Claim; Claim Forms
A claim must be filed for you to receive benefits. Many Providers will submit a claim for you; if you submit it yourself, you should use a claim form. In most cases, you can obtain a claim form from your Employer or Provider. If your Provider does not have a claim form, the Plan's TPA will send you one. Call or notify the Plan's TPA, in writing, within 20 days after receiving your first Covered Service, and the TPA will send you a form.

If you fail to receive a claim form within 15 days after you notify the Plan's TPA, you may send the TPA your bill or a written statement of the nature and extent of your loss; which should include all of the information necessary for the TPA needs to process your claim.

Proof of Loss
Proof of Loss is a claim for payment of health care services which has been submitted to the plan's TPA for processing with sufficient documentation to determine whether Covered Services have been provided to you. The TPA must receive a completed claim with the correct information. The TPA may require Provider's notes or other medical records before Proof of Loss is considered sufficient to determine benefit coverage. The TPA is not legally obligated to reimburse for Covered Services on behalf of the Plan unless written or electronically submitted proof that Covered Services have been given to you is received. Proof must be given within 90 days of your receiving Covered Services or as soon as is reasonably possible. No proof can be submitted later than one year after services have been received.

Time Limit for Filing Claims
No claims for benefits can be submitted to your TPA and considered for reimbursement under this Plan if filed more than 12 (twelve) months after you or your Eligible Dependent incurred the claim.

Covered Persons are responsible for ensuring that complete claims are submitted to the TPA.

HOW CLAIMS ARE PAID

The TPA, as the claims administrator, pays for benefits on behalf of the Plan for Covered Services through agreements with Contracting Institutional Providers and Participating Physicians and Other Professional Providers based on Negotiated Amounts. For Non-Contracting Institutional Providers, the TPA is not authorized to make payment, except where the claim was incurred in the course of an emergency.

Benefit Period Deductible
Each calendar year, you must pay the dollar amount that specified in the Schedule of Benefits as the Deductible applicable to medical services before the Plan will begin to provide benefits. This is the amount of expense that must be Incurred and paid by you for Covered Services related to medical care before the Plan starts to provide benefits. If a benefit is subject to a Deductible or a copayment under this Plan, only expenses for Covered Services under that benefit will satisfy the Deductible. To satisfy your Deductible, the Plan records must show that you have Incurred claims totaling the specified dollar amount, so submit copies of all your bills for Covered Services. Your Deductible accumulations do not necessarily occur in the same order that you receive services, but in the order in which The TPA receives and processes your claims. Copayments will apply to the Deductible. Deductibles and Copayments made by you for medical services received do not apply to the Coinsurance Limit. Under this Plan, the deductible does not apply to required prescription drugs you need.

This Schedule of Benefits specifies both a single Deductible and a family Deductible. The single Deductible is the amount each Covered Person must pay before the Plan begins to pay benefits, but the total amount that multiple family members must pay, where more than one person in a family is covered by this Plan, is limited to the family Deductible.

Coinsurance
Under this Plan, you are not required to pay an annual deductible in order for the Plan to reimburse you for necessary prescription drugs. The Plan will begin to pay benefits for necessary prescription drugs with the first drug you need each year under the Plan's coinsurance schedule. The amount of Coinsurance you have to pay for necessary prescription drugs is further limited to a maximum dollar amount each calendar year. After you have paid the maximum dollar amount of your coinsurance responsibilities in a calendar year, the Plan will pay 100% of the cost of necessary prescription drugs for the remainder of that calendar year.

Where a Coinsurance limit applies, the Schedule of Benefits specifies both a single Coinsurance Limit and a family Coinsurance Limit. The single limit is the amount each Covered Person must pay, but the family limit is the total amount the family must pay based on the respective limits.

Copayments
For some Covered Services, you may be responsible for paying a Copayment at the time services are delivered to you. Covered Services that require Copayments are counted as part of the Deductible requirements under this Plan. Any such Copayments are your responsibility, and they are not reimbursed by the Plan. Please refer to your Schedule of Benefits for specific Copayment amounts that may apply

Schedule of Benefits
The Deductible and Coinsurance Limits that apply will renew each calendar year. Some of the benefits offered in this Benefit Book have maximums.

The Schedule of Benefits shows your financial responsibility for Covered Services. The Plan covers the remaining liability for Covered Charges after you have paid the amounts indicated in the Schedule of Benefits, subject to benefit maximums and the TPA's Negotiated Amounts.

Your Financial Responsibilities

You are responsible for paying Non-Covered Charges and Billed Charges for all services and supplies after any benefit maximums have been reached. Your financial responsibilities include the Deductible amounts specified in the Schedule of Benefits, Copayments and Coinsurance. You are responsible for payment for services that are not Medically Necessary and for incidental charges.

For Covered Services rendered by Contracting Institutional Providers, Physicians and Other Professional Providers, the TPA will calculate your Deductible, Coinsurance, Copayment obligations and any applicable benefit maximum accumulations based on the Lesser Amount. Your financial responsibility to the Provider for Covered Services will also be based on the Lesser Amount. For Non-Participating Providers, this Plan will not make reimbursements and you will be responsible for all charges made by such Providers, except where such charges were incurred in the course of an emergency.

For Covered Services received from Contracting Institutional Providers and Participating Physicians and Other Professional Providers, the Provider has agreed not to bill for any amount of Covered Charges above the Negotiated Amount, except for services and supplies for which the Plan has no financial responsibility due to a benefit maximum.

For Covered Services rendered by Non-Contracting Institutional Providers, Physicians and Other Professional Providers, the TPA will calculate your Deductible and Coinsurance. You will be responsible for Charges over and above the amount established by the Plan as reimbursable for such services. You will always be responsible for Charges from Non-Contracting Providers where the service received was not provided in connection with an emergency. Payments made to Non-Contracting Providers will be subject to reimbursement schedules similar to those in place for Contracting Providers, which generally means that for covered emergency services, supplies or drugs associated charges will be reimbursed at no more than 125% of the Medicare allowable amount in place as of the date that the service, supply or drug was supplied in that geographical area. Where a diagnostic related group (DRG) methodology was used to bill for a service, this Plan will pay no more than amount that Medicare would reimburse the facility in that geographic area as of the date that the service was supplied, plus 100%.

Provider Status and Direction of Payment

The TPA has agreed to make payment directly to Contracting Institutional Providers and Participating Physicians and Other Professional Providers for Covered Services.

Some of the contracts with network Providers, including Institutional Providers, allow discounts, allowances, incentives, adjustments and settlements. These amounts are for the sole benefit of the Health Plan Network and/or the Employer, and the TPA and/or the Employer will retain any payments resulting therefrom; however, the Deductibles, Copayments, Coinsurance and benefit maximums, if applicable, will be calculated as described in this Benefit Book.

The choice of a Provider is yours. After a Provider performs a Covered Service, the TPA will not honor your request to withhold claim payment. The TPA, the Jefferson Health Plan and the Employer do not furnish Covered Services but only pay for Covered Services you receive from Providers. Neither the TPA, the Jefferson Health Plan nor the Employer is liable for any act or omission of any Provider. Neither the TPA, the Jefferson Health Plan nor the Employer have any responsibility for a Provider's failure or refusal to give Covered Services to you.

The Health Plan network has and retains the sole right to choose which Providers it will contract with, and on what terms, and to amend and terminate those contracts. The Health Plan network has and retains the sole right to designate Providers as Contracting and/or PPO Network.

You authorize the TPA to make payments directly to Providers who have performed Covered Services for you. The TPA also reserves the right to make payment directly to you. When this occurs, you must pay the Provider and neither the TPA, the Jefferson Health Plan nor the Employer are legally obligated to pay any

additional amounts. You cannot assign your right to receive payment to anyone else, nor can you authorize someone else to receive your payments for you, including your Provider.

If the TPA has incorrectly paid for services or it is later discovered that payment was made for services which are not considered Covered Services, then the TPA has the right to recover payment on behalf of the Employer, and you must repay this amount when requested.

Any reference to Providers as PPO Network, Non-PPO Network, Contracting, Non-Contracting, Participating or Non-Participating is not a statement about their abilities.

Pre-Authorization of Non-PPO Network Benefits
In some cases, the TPA may determine that certain Covered Services can only be provided by a Non-PPO Network Provider. If Covered Services provided by a Non-PPO Network Provider are pre-authorized by the TPA, benefits will be provided as if the Covered Services were provided by a PPO Network Provider.
To pre-authorize treatment by a Non-PPO Network Provider, your Physician must provide the TPA with:

- the proposed treatment plan for the Covered Services;
- the name and location of the proposed Non-PPO Network Provider;
- copies of your medical records, including diagnostic reports; and
- an explanation of why the Covered Services cannot be provided by a PPO Network Provider.

The TPA will determine whether the Covered Services can be provided by a PPO Network Provider and that determination will be final and conclusive. The TPA may elect to have you examined by a Physician of its choice and will pay for any required physical examinations. You and your Physician will be notified if Covered Services provided by a Non-PPO Network Provider will be covered as if they had been provided by a PPO Network Provider.

If you do not receive written pre-authorization for Covered Services, benefits will not be provided under this Plan.

Explanation of Benefits
After the TPA processes your claim, an Explanation of Benefits (EOB) is provided to you electronically or by mail. It lists Covered Services and non-covered services along with explanations for why services are not covered. It contains important amounts, appeal information and a telephone number if you have any questions.

Time of Payment of Claims
Benefits will be provided under this Benefit Book within 30 days after receipt of a completed claim. To have a payment or denial related to a claim reviewed, you must send a written request or call Customer Service at The TPA within 180 days of the claim determination.

Fraud
Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this Benefit Booklet. Please read those rules carefully and refer to Plan materials that you may receive, like COBRA notices.

Any action taken by a Covered Person to defraud the Plan will result in denial of the Covered Person's claim under the Plan and a termination from the Plan. Such action will also be subject to prosecution and punishment to the full extent under state and federal law.

Covered Persons should always:

- File accurate claims,
- Review the Explanation of Benefits (EOB) form to ensure proper payment based on a reasonable knowledge of the expense,
- Refuse to allow another person to file a claim under your Plan,
- Provide complete and accurate information on claim forms and answer all questions accurately and to the fullest extent possible, and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

Covered Persons who know or suspect any illegal activity should immediately notify the TPA.

BENEFIT DETERMINATION FOR CLAIMS

Urgent Care Claims
An **Urgent Care Claim** is a claim for Medical Care or treatment where applying the timeframes for non-urgent care could:

- seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
- in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Determination of ***urgent*** can be made by (a) an individual acting on behalf of the Plan and applying the judgment of a prudent lay person who possesses an average knowledge of medicine, or (b) any Physician with a knowledge of the claimant's medical condition who can determine that a claim involves urgent care.
If you file an Urgent Care Claim in accordance with the TPA's claim procedures and all of the required information is received, the TPA will notify you of its benefit determination, whether adverse or not, as soon as possible but not later than 72 hours after the TPA's receipt of the claim.

If you do not follow the TPA's procedures, or the TPA does not receive all of the information necessary to make a benefit determination, the TPA will notify you within 24 hours of receipt of the Urgent Care Claim of the specific deficiencies. You will have 48 hours to provide the requested information. Once the TPA receives the requested information, you will be notified of the benefit determination as soon as possible, but not later than 48 hours after receipt of the information.

The TPA 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
A Concurrent Care Claim is any claim for ongoing treatment, including a plan's approval for a number of treatments. The decision is adverse if the Plan decides to reduce or terminate benefits for the ongoing treatment (unless it's due to a health plan amendment or plan termination).

A request for an extension to an ongoing course of treatment must be filed in accordance with the TPA's claim procedures and must be made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. The TPA will notify you of any benefit determination concerning the request to extend the course of treatment within 24 hours after its receipt of the claim.

If the TPA reduces or terminates a course of treatment before the end of the course previously approved, the reduction or termination is considered an adverse benefit determination. The TPA 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.

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

If you file a Pre-Service Claim in accordance with the TPA's claim procedures and all of the required information is received, the TPA will notify you of its benefit determination within 15 days after receipt of the claim. The TPA may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of the TPA. The TPA 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 TPA will notify you, in writing, within the initial 15 day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

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

If you file a Post-Service Claim in accordance with the TPA's claim procedures and all of the required information is received, the TPA will notify you of its benefit determination within 30 days after receipt of the claim. The TPA may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of the TPA. The TPA 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 TPA will notify you, in writing, within the initial 15 day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

Benefit Determination Notices
You will receive notice of a benefit determination orally, as allowed, or in writing. All notices of a denial of benefits will include the following:

- the specific reason for the denial;
- reference to the specific plan provision on which the denial is based;
- a description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;
- a description of the TPA's appeal procedures, applicable timeframes, including the expedited appeal process, if applicable;
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the benefit determination, then that information will be provided free of charge upon written request; and
- if the claim was denied based on Medical Necessity or Experimental treatment or a similar exclusion or limit, then an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your circumstances will be provided free of charge upon request.

FILING A COMPLAINT

If you have a complaint, please call or write to Customer Service at the telephone number or address listed on the front of your Explanation of Benefits (EOB) form and/or identification card. To expedite the processing of an inquiry, the Card Holder 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 TPA Customer Service representative will review the claim for correctness in processing. If the claim was processed according to terms of the Plan, the Customer Service representative will telephone the Card Holder with the response. If attempts to telephone the Card Holder are unsuccessful, a letter will be sent explaining how the claim was processed. If an adjustment to the claim is required, the Card Holder will receive a check, Explanation of Benefits or letter explaining the revised decision.

Quality of Care issues are addressed by our Quality Improvement Department or committee.
If you are not satisfied with the results, you may continue to pursue the matter through the appeal process.

FILING AN APPEAL

Expedited Review Process
A request for an expedited review must be certified by your Provider that your Condition could, without immediate medical attention, result in any of the following:

- jeopardy to your life or health, or your ability to regain maximum function, or with respect to a pregnant woman, place the health of her unborn child in serious jeopardy; or
- in the opinion of a Physician with knowledge of your medical Condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The appeal does not need to be submitted in writing. You or your Physician should call the Care Management telephone number on your identification card as soon as possible.

Expedited reviews will be resolved within 72 hours after you have submitted the request, with a possibility of extending to five calendar days with good cause.

The expedited review process does not apply to prescheduled treatments, therapies, Surgeries or other procedures that do not require immediate action.

Filing an Appeal
If you are not satisfied with a benefit or Medical Necessity determination decision, you may file an appeal. No more than two appeals on one claim will be considered in accordance with the procedures explained below.

Enter Appeals directions and contact information here

You may appeal if your claim is denied because the TPA determined (1) the Services received or requested were not Covered Services or (2) the Services received or requested to be received were not Medically Necessary.

Your Right to an Independent Review for Non-Covered Services by the Ohio Department of Insurance
You have the right to request a review by the Ohio Department of Insurance in certain circumstances as described below. You may contact the Ohio Department of Insurance at the following address:

Ohio Department of Insurance Consumer Services Division
50 W. Town Street, Third Floor - Suite 300 Columbus, Ohio 43215-4186

If the TPA denied, reduced or terminated coverage for a health care benefit because the TPA determined that the benefit was not covered under your Benefit Book, you have the right to request a review by the Ohio Department of Insurance. If the Ohio Department of Insurance reviews your case and cannot make a determination because it requires resolution of a medical issue, the Department will notify the Plan and the Plan will initiate an external review as described below. If the Department of Insurance reviews your case and

determines that the health service is a covered benefit, the Plan must either cover the service or allow you the opportunity of an external review.

First Level Mandatory Appeal for Medical Necessity Denial
The Plan offers all Card Holders a first level mandatory appeal. You must complete this first level of appeal before any additional action is taken.

First level mandatory appeals related to a claim decision must be filed within 180 days from your receipt of the notice of denial of benefits. All requests for appeal may be made by submitting an electronic form, by calling Customer Service or in writing as described above.

Under the appeal process, there will be a full and fair review of the claim. The internal appeal process is a review of your appeal by an Appeals Coordinator, a Physician consultant and/or other licensed health care professional. The appeal will take into account all comments, documents, medical records and other information submitted by you and the Provider relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. All determinations of Medical Necessity that are based in whole or in part on a medical judgment, are made by health care professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment. The health care professionals who review the appeal will not have made any prior decisions about your care and will not be a subordinate of the professional who made the initial determination on your claim.
You may submit written comments, documents, records and other information relating to the claim being appealed. These documents should be submitted by you at the time you send in your request for an appeal. Upon written request, you may have reasonable access to and copies of documents, records and other information used to make the decision on your claim for benefits that you are appealing.
The appeal procedures are as follows:

- **Urgent Care Appeal -** You, your authorized representative or your Provider may request an appeal for urgent care. Urgent care claim appeals are typically those claims for Medical Care or treatment where withholding immediate treatment could seriously jeopardize the life or health of a patient or a patient's unborn child, or could affect the ability of the patient to regain maximum functions. The appeal must be decided with 72 hours of the request.

- **Pre-Service Claim Appeal -** You, your authorized representative or your Provider may request a pre-service claim appeal. Pre-service claim appeals are those requested in advance of obtaining Medical Care for approval of a benefit, as it relates to the terms of the plan Benefit Book. The pre-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of denial.

- **Post Service Claim Appeal -** You, your authorized representative or your Provider may request a post-service claim appeal. Post-service claim appeals are those requested for payment or reimbursement of the cost for Medical Care that has already been provided. As with pre-service claims, the post-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of the denial.

All notices of a denial of benefit will include the following:

- the specific reason for the denial;
- reference to the specific plan provision on which the denial is based.
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the determination, then that information will be provided free of charge upon written request;
- if the claim was denied based on a Medical Necessity or Experimental treatment or similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination applying the terms of the Plan to your circumstances will be provided free of charge upon request; and

- upon specific written request from you, provide the identification of the medical or vocational expert whose advice was obtained on behalf of the TPA in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

If your claim is denied for Medical Necessity at the first level mandatory appeal, then depending on the type of plan you have and the type of claim, there are two different Second Level Voluntary Appeal Processes. You will be eligible for either the Second Level External Review Process established by the Ohio Department of Insurance OR the Second Level Voluntary Internal Review Process.

Second Level External Review Process by the Ohio Department of Insurance for Medical Necessity Denial

In accordance with state law, the TPA has also established an external review process to examine coverage decisions under certain circumstances. You may be eligible to have a decision reviewed by the external review process if you meet the following criteria:

- The TPA has denied, reduced, or terminated coverage for what would be a covered health care service except for the fact that the TPA determined that the service is not Medically Necessary;
- the proposed service, plus any ancillary services and follow-up care, will cost you $500.00 or more if it is not covered; and
- you have exhausted the mandatory internal appeal process. You are NOT entitled to External Review if:
  - ✓ The Ohio Department of Insurance determined that the health care service is not a Covered Service under your Benefit Book; or
  - ✓ You have already had an external review for the same adverse determination and no new pertinent clinical information has been submitted.

External Reviews will be conducted by independent review organizations accredited by the Ohio Department of Insurance. You will not be required to pay for any part of the cost of the external review. The Plan is required by law to provide to the independent review organization conducting the review, a copy of the records that are relevant to your medical Condition and the external review.

The request for External Review must be made within 180 days from your receipt of the notice of denial from the first-level, internal appeal.

External Review for Non-Urgent Care Claims Appeals

A request for an external review for a non-expedited or non-urgent claim must be in writing and should be addressed to the TPA's Member Appeals Unit at the address listed above. It can be made by you or your Provider. Your Provider may not, however, request an external review without your prior written consent. A request must be accompanied by written certification from your Provider that the proposed service, plus any ancillary services and follow-up care, will cost you $500 or more if the proposed service is not covered by the Plan.

The review panel will issue a written decision within 30 days after you have submitted the request. This written decision will include a description of your Condition and the main reasons for the decision, including an explanation of the clinical rationale for the decision. The Plan will provide coverage determined by the written decision to be Medically Necessary subject to other terms, limitations and conditions of your Benefit Book.

External Review for Urgent Care Claim Appeals

A request for an external review for Urgent or Expedited claims may be requested orally or electronically with a written confirmation not later than five days after the request is submitted. A request for an expedited review should be made by contacting the Care Management Department at the number on the back of your identification card. It can be made by you or your Provider. Your Provider, may not, however, request an external review without your prior written consent.

A request for an expedited review must be certified by your Provider that your Condition could, without immediate medical attention, result in any of the following:

- serious jeopardy to your life or health or your ability to regain maximum function or, with respect to a pregnant woman, place the health of her unborn child in serious jeopardy; or
- in the opinion of a Physician with knowledge of your medical Condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The review panel will issue a written decision within seven calendar days after you have submitted the request. This written decision will include a description of your Condition and the main reasons for the decision, including an explanation of the clinical rationale for the decision. The Plan will provide coverage determined by the written decision to be Medically Necessary subject to other terms, limitations and conditions of your Benefit Book.

External Review Process for Terminal Conditions

If you have a terminal Condition, you are eligible to have an external review if you meet all of the following criteria:

- you have a terminal Condition that, according to the current diagnosis of your Physician, has a high probability of causing death within two years; and
- your Physician certifies that one of the following situations applies to your terminal Condition:
  - ✓ standard therapies have not been effective in improving your Condition;
  - ✓ standard therapies are not medically appropriate for you;
  - ✓ no standard therapy, covered by the Plan, is more beneficial than a therapy recommended by your Physician or requested by you; and
- your Physician has recommended a drug, device, procedure, or other therapy that your Physician certifies, in writing, is likely to be more beneficial to you, in the Physician's opinion, than standard therapies, or you have requested a therapy found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same Condition; and
- you have been denied coverage by the TPA for the drug, device, procedure or other recommended or requested therapy and have exhausted all internal appeals; and
- the drug, device, procedure or other recommended or requested therapy would be a Covered Service except for the TPA's determination that the drug, device, procedure or other therapy is Experimental or Investigational.

You must request the review in writing unless your Physician determines that the therapy would be significantly less effective if not started immediately. You will not be required to pay for any part of the cost of the external review. The review panel will issue a written decision within seven calendar days after you have submitted the request. This written decision will include a description of your Condition and the main reasons for the decision, including an explanation of the clinical rationale for the decision. The Plan will provide coverage determined by the written decision to be Medically Necessary subject to other terms, limitations and conditions of your Benefit Book.

Second Level Voluntary Internal Appeal

Unless your Employer requires you to use an alternative dispute resolution procedure, if your first level mandatory appeal is denied, and you do not qualify for an External Review by the Ohio Department of Insurance, because the cost to you is less than $500, then you have the option of a voluntary second level appeal by the TPA. All requests for appeal may be made by calling Customer Service or writing to the Member Appeals Department. You should submit additional written comments, documents, records, dental X-rays, photographs and other information that were not submitted for the first level of appeal.

The voluntary second level of appeal may be requested at the conclusion of the first level mandatory appeal. The request for the voluntary second level of appeal must be received by the TPA within 60 days from the

receipt of the first appeal decision. The TPA will complete its review of the voluntary second level appeal within 30 days from receipt of the request.

The voluntary second level of appeal provides a full and fair review of the claim. There will be a review of your appeal by an appeals coordinator, a Physician consultant and/or other licensed health care professional. The appeal will take into account all comments, documents, records and other information submitted by you and the Provider relating to the claim, without regard to whether such information was submitted or considered in the first level mandatory appeal. All determinations of Medical Necessity, that are based in whole or in part on medical judgment, are made by health care professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment. The health care professionals who review the appeal will not have made any prior decisions about your care and will not be a subordinate of the professional who made the initial determination of your appeal.

CLAIM REVIEW

Consent to Release Medical Information - Denial of Coverage
You consent to the release of medical information to the TPA, to the Jefferson Health Plan and to the Plan when you enroll and/or sign an Enrollment Form.

When you present your identification card for Covered Services, you are also giving your consent to release medical information to the TPA and to the Jefferson Health Plan. The TPA has the right to refuse to reimburse for Covered Services if you refuse to consent to the release of any medical information.

Right to Review Claims
When a claim is submitted, the TPA will review the claim to ensure that the service was Medically Necessary and that all other conditions for coverage are satisfied. The fact that a Provider may recommend or prescribe treatment does not mean that it is automatically a Covered Service.

Physical Examination
The Plan may require that you have one or more physical examinations at its expense. These examinations will help to determine what benefits will be covered, especially when there are questions concerning services you have previously received and for which you have submitted claims. These examinations will not have any effect on your status as a Covered Person or your eligibility.

LEGAL ACTIONS

No action, at law or in equity, shall be brought against the TPA, the Jefferson Health Plan or the Plan to recover benefits within 60 days after the TPA receives written proof in accordance with this Benefit Book 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 in the Proof of Loss section.

COORDINATION OF BENEFITS

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one plan. It does not apply, however, in the case of Prescription drug benefits. The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the total Covered Expenses incurred.

The order of benefit determination rules determine the order in which each plan will pay a claim for benefits. The plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total Allowable expense.

In no case will this Plan, as a Secondary Plan, reimburse to you in combination with the reimbursement you may receive from any other plan under which you have coverage, more than the amount you would have received under this Plan alone had this been your only coverage.

This Plan will coordinate benefits with the following types of medical plans:

- Group health plans, health insuring corporation contracts (HIC), closed panel and other types of employer plans, whether insured or self-insured
- Hospital indemnity benefits in excess of $200 per day,
- Specified disease policies,
- Foreign health care coverage,
- Medical care components of group long-term care contracts, such as skilled nursing care,
- Medical benefits under group or individual motor policies,
- Medical benefits under homeowner's policies,
- Medicare or other governmental benefits, as permitted by law.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a paid benefit.

The Plan does not include and coordinate benefits with hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan .

When This Plan is Primary, it determines payment for its benefits first before those of any other Plan without considering any other plan's benefits. When this Plan is Secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits received by the covered individual in

total do not exceed 100% of the amount that would have been paid under this Plan had other coverage not been available. When medical payments are available under a motor vehicle policy, this Plan shall always be considered secondary.

The following are examples of expenses that are not covered under this Plan:

- The difference between the cost of a semi-private Hospital room and a private Hospital room.
- If a person is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not considered eligible for reimbursement under this Plan.
- If a person is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
- If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
- The amount of any benefit reduction by the Primary plan because a Covered Person has failed to comply with the plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

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

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

- The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.
- A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in an Employer that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

- A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is Secondary to that other plan.
- Each plan determines its order of benefits using the first of the following rules that apply:
  - ✓ Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is the Primary plan and the

plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent, and Primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other plan is the Primary plan.

- ✓ Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan, the order of benefits is determined as follows:
  1. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
     - The plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
     - If both parents have the same birthday, the plan that has covered the parent the longest is the Primary plan.
     - However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
  2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
     - If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is Primary. This rule applies to plan years commencing after the plan is given notice of the court decree;
     - If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;
     - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) above shall determine the order of benefits; or
     - If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
       - The plan covering the Custodial parent;
       - The plan covering the spouse of the Custodial parent;
       - The plan covering the non-custodial parent; and then
       - The plan covering the spouse of the non-custodial parent.
  3. For a dependent child covered under more than one plan of individuals who are <u>not</u> the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

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

- COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits,

this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits.

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

- In no case where this Plan is determined to be the Secondary plan by any of the rules described above, will this Plan (as a Secondary payer) pay more in combination with any other plan's payments than it would have paid had this Plan been the Primary plan.

Effect On The Benefits Of This Plan

- When this Plan is secondary, it will reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total that would have been paid by this Plan had it been the only Plan providing coverage to the plan participant. In determining the amount to be paid for any claim, this Plan as a Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and subtract from that amount any reimbursement made by the Primary plan to determine the reimbursement under this Plan. The Secondary plan will thus reduce its payment by the amount that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all plans for the claim do not exceed the amount that would have otherwise been paid by this Plan alone had other coverage not be available. In addition, this Plan as a Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

- If a Covered Person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB shall not apply between that plan and other Closed panel plans.

- In no case will this Plan, as a Secondary Plan, reimburse to you in combination with the reimbursement you may receive from any other plan under which you have coverage, more than the amount you would have received under this Plan alone had this been your only coverage.

Right To Receive And Release Needed Information

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

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, the TPA may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The TPA will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

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

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting Customer Service at the telephone number or address listed on the front of your Explanation of Benefits (EOB) form and/or identification card. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at http://insurance.ohio.gov.

RIGHT OF SUBROGATION AND REIMBURSEMENT

Subrogation
The Plan reserves the right of subrogation. This means that, to the extent the Plan provides or pays benefits or expenses for Covered Services, the Plan assumes your legal rights to recover the value of those benefits or expenses from any person, entity, organization or insurer, including your own insurer and any under insured or uninsured coverage, that may be legally obligated to pay you for the value of those benefits or expenses. The amount of the Plan's subrogation rights shall equal the total amount paid by the Plan for the benefits or expenses for Covered Services. The Plan's right of subrogation shall have priority over yours or anyone else's rights until the Plan recovers the total amount the Plan paid for Covered Services. The Plan's right of subrogation for the total amount the Plan paid for Covered Services is absolute and applies whether or not you receive, or are entitled to receive, a full or partial recovery or whether or not you are "made whole" by reason of any recovery from any other person or entity. This provision is intended to and does reject and supersede the "make-whole" rule, which rule might otherwise require that you be "made whole" before the Plan may be entitled to assert its right of subrogation.

Reimbursement
The Plan also reserves the right of reimbursement. This means that, to the extent the Plan provides or pays benefits or expenses for Covered Services, you must repay the Plan any amounts recovered by suit, claim, settlement or otherwise, from any third party or his insurer and any under insured or uninsured coverage, as well as from any other person, entity, organization or insurer, including your own insurer, from which you receive payments (even if such payments are not designated as payments of medical expenses). The amount of the Plan's reimbursement rights shall equal the total amount paid by the Plan for the benefits or expenses for Covered Services. The Plan's right of reimbursement shall have priority over yours or anyone else's rights until the Plan recovers the total amount the Plan paid for Covered Services. The Plan's right of reimbursement for the total amount the Plan paid for Covered Services is absolute and applies whether or not you receive, or are entitled to receive, a full or partial recovery or whether or not you are "made whole" by reason of any recovery from any other person or entity. This provision is intended to and does reject and supersede the "make whole" rule, which rule might otherwise require that you be "made whole" before the Plan may be entitled to assert its right of reimbursement.

Your Duties
- You must provide the Plan or its designee any information requested by the Plan or its designee within five (5) days of the request.
- You must notify the Plan or its designee promptly of how, when and where an accident or incident resulting in personal injury to you occurred and all information regarding the parties involved.
- You must cooperate with the Plan or its designee in the investigation, settlement and protection of the Plan's rights.
- You must send the Plan or its designee copies of any police report, notices or other papers received in connection with an accident or incident resulting in personal injury to you.
- You must not settle or compromise any claims unless the Plan or its designee is notified in writing at least thirty (30) days before such settlement or compromise and the Plan or its designee agrees to it in writing.

Discretionary Authority
The TPA and/or its designated recovery service agent, if assigned, shall have discretionary authority to interpret and construct the terms and conditions of the Subrogation and Reimbursement provisions and make determination or construction which is not arbitrary and capricious. The TPA's determination will be final and conclusive.

CHANGES IN BENEFITS OR PROVISIONS

The benefits provided by this coverage may be changed at any time. It is your Employer's responsibility to notify you when these changes go into effect. If you are receiving Covered Services under this Benefit Book at the time your revised benefits become effective, the Plan will continue to provide benefits for these services only if they continue to be Covered Services under the revised benefits.

TERMINATION OF COVERAGE

How and When Your Coverage Stops
Your coverage under the terms and conditions, as described in this Benefit Book, stops:

Employee Coverage Ends

- On the date under the terms and conditions of the Plan, as described in this Benefit Book, that a Covered Person stops being an Eligible Dependent or if coverage is extended by your Employer for Full-time Student status, on the date the Full-time Student status ends. You are responsible for notifying your Employer immediately of any change to the eligibility status of a Full-time Student.
- The end of the period for which your last contribution is made, if you fail to make any required contribution towards the cost of this coverage when due, the date that this Plan is canceled or ended, or the last day of the month in which you tell the Plan to cancel your coverage if you decide to voluntarily cancel the coverage.
- The last day of the month in which your employment ends.
- Immediately upon notice if:
  - ✓ a Covered Person allows a non-Covered Person to use his/her identification card to obtain or attempt to obtain benefits; or
  - ✓ a Covered Person materially misrepresents a material fact provided to the Employer or The TPA or commits fraud or forgery.

Dependent Coverage Ends

- On the date under the terms and conditions of the Plan, as described in this Benefit Book, that a Covered Person stops being an Eligible Dependent or if coverage is extended by your Employer for Full-time Student status, on the date the Full-time Student status ends. You are responsible for notifying your Employer immediately of any change to the eligibility status of a Full-time Student.
- On the date that a Card Holder becomes ineligible.
- The end of the period for which your last contribution is made, if you fail to make any required contribution towards the cost of this coverage when due, the date that this Plan is canceled or ended, or the last day of the month in which you tell the Plan to cancel your coverage if you decide to voluntarily cancel the coverage.
- The last day of the month in which your dependent child attains the limiting age for coverage under this Plan, or the day of the month in which your dependent child no longer qualifies as a full time student, unless failure to attend is due to illness or injury.
- The last day of the month in which your dependent child no longer is deemed to be totally disabled under the terms of the Plan.
- The date that dependent coverage is no longer offered under this Plan.
- The last day of the month in which you tell the Plan to cancel your dependent's coverage if you are voluntarily canceling it while still remaining an eligible employee.
- The last day of the month in which your dependent becomes covered as an employee under this Plan.
- Immediately upon notice if:
  - a Covered Person allows a non-Covered Person to use his/her identification card to obtain or attempt to obtain benefits; or
  - a Covered Person materially misrepresents a material fact provided to the Employer or The TPA or commits fraud or forgery.

Certificate of Creditable Coverage
If any Covered Person's coverage would end and the Agreement is still in effect, you and your covered Eligible Dependents will receive a certificate of Creditable Coverage that shows your period of coverage under the Plan.

Federal Continuation Provisions - COBRA
If any Covered Person's Employer coverage would otherwise end as described above and your employer's health plan is still in effect, you and your Eligible Dependents may be eligible for continuation of benefits

under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA is a federal law that allows Covered Persons to continue coverage under specified circumstances where such Employer coverage would otherwise be lost. To continue coverage, you or your Eligible Dependents must apply for continuation coverage and pay the required premium before the deadline for payment. COBRA coverage can extend for 18, 29 or 36 months, depending on the particular "qualifying event" which gave rise to COBRA.

When You Are Eligible for COBRA
If you are a Card Holder and active employee covered under your Employer's health plan, you have the right to choose this continuation coverage if you lose your Employer health coverage because of reduction in your hours of employment or termination of employment (for reasons other than gross misconduct on your part) or at the end of a leave under the Family and Medical Leave Act.

In the case of an active employee, or Eligible Dependent of a Card Holder covered by the Plan, he or she has the right to continuation coverage if Employer health coverage under the Plan is lost for any of the following reasons:

- the death of the Card Holder;
- the termination of the Card Holder's employment (for reasons other than gross misconduct) or reduction in the Card Holder's hours of employment;
- the Card Holder's divorce or legal separation;
- the Card Holder becomes entitled (that is, covered) under Medicare;
- the dependent ceases to be an "Eligible Dependent;" or
- the Card Holder is retired and the Card Holder's Employer files for reorganization under Chapter 11 of the Bankruptcy Code.

Notice Requirements
Under COBRA, the Card Holder or Eligible Dependent has the responsibility to inform the Employer of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of any such event. If notice is not received within that 60-day period, the dependent will not be entitled to choose continuation coverage. When the Employer is notified that one of these events has happened, the Employer will, in turn, have 14 days to notify the effected family members of their right to choose continuation coverage. Under COBRA, you have 60 days from the date coverage would be lost because of one of the events described above or the date of receipt of notice, if later, to inform your Employer of your election of continuation coverage.

If you do not choose continuation coverage within the 60-day election period, your Employer health coverage will end as of the date of the qualifying event.

If you do choose continuation coverage, your Employer is required to provide coverage that is identical to the coverage provided by the Employer to similarly situated active employees and dependents. This means that if the coverage for similarly situated Covered Persons is modified, your coverage will be modified.

How Long COBRA Coverage Will Continue
COBRA requires that you be offered the opportunity to maintain continuation coverage for 18 months if you lost coverage under the Plan due to the Card Holder's termination (for reasons other than gross misconduct) or reduction in work hours. A Card Holder's covered Eligible Dependents are required to be offered the opportunity to maintain continuation coverage for 36 months if coverage is lost under the Plan because of an event other than the Card Holder's termination or reduction in work hours.

If, during an 18-month period of coverage continuation, another event takes place that would also entitle a qualified beneficiary (other than the Card Holder) to their own continuation coverage for up to 36 months from the date of entitlement (for example, the former Card Holder dies, is divorced or legally separated, becomes entitled to Medicare or the dependent ceased to be an Eligible Dependent under the Plan), the continuation coverage may be extended for the affected qualified beneficiary. However, in no case will any period of continuation coverage be more than 36 months.

If you are a former employee and you have a newborn or adopted child while you are on COBRA continuation and you enroll the new child for coverage, the new child will be considered a "qualified beneficiary." This gives the child additional rights such as the right to continue COBRA benefits even if you die during the COBRA period. Also, this gives the right to an additional 18-month coverage if a second qualifying event occurs during the initial 18-month COBRA period following your termination or retirement. If you are entitled to 18 months of continuation coverage and if the Social Security Administration determines that you were disabled within 60 days of the qualifying event, you are eligible for an additional 11 months of continuation coverage after the expiration of the 18-month period. To qualify for this additional period of coverage, you must notify the Employer within 60 days after becoming eligible for COBRA or receiving a disability determination from the Social Security Administration, whichever is later. Such notice must be given before the end of the initial 18 months of continuation coverage. If the individual entitled to the disability extension has non-disabled family members who are qualified beneficiaries and have COBRA coverage, those non-disabled beneficiaries will also be entitled to this 11-month disability extension. During the additional 11 months of continuation coverage, the premium for that coverage may be no more than 150% of the coverage cost during the preceding 18 months.

The law also provides that your continuation coverage may be terminated for any of the following reasons:

- your Employer no longer provides Employer health coverage to any of its employees;
- the premium for your continuation coverage is not paid in a timely fashion;
- you first become, after the date of election, covered under another Employer health plan (unless that other Plan contains an exclusion or limitation with respect to any preexisting Condition affecting you or a covered dependent); or
- you first become, after the date of election, entitled (that is covered) under Medicare.

Additional Information
An Eligible Dependent who is a qualified beneficiary is entitled to elect continuation of coverage even if the Card Holder does not make that election. At subsequent open enrollments, an Eligible Dependent may elect a different coverage from the coverage the Card Holder elects.

You do not have to provide proof of insurability to obtain continuation coverage under this Plan. However, under COBRA, you will have to pay the full cost of coverage for your continuation coverage, plus a 2% administrative fee. You will have an initial grace period of 45 days (starting with the date you choose continuation coverage) to pay any premiums then due; after that initial 45-day grace period, you will have a grace period of 30 days to pay any subsequent premiums.

It is your Employer's responsibility to advise you of your COBRA rights and to provide you with the required documents to complete upon the qualifying event.

Continuation of Coverage During Military Service
If you go on active duty in the U.S. armed forces, you will cease to be covered under the regular Employer health plan as of the end of the month in which you enter active military service. However, you have the following rights to continue coverage:

- If your military leave period is less than 31 days, you have the right to continue medical coverage for yourself and dependents who were covered under the Employer medical plan for up to 31 days, at a cost of not more than the cost for a similarly situated active employee.
- If the military leave period is more than 31 days, you are entitled to continue health coverage for yourself and your dependents who were covered under the Employer medical plan under the United States Employment and Reemployment Rights Act (USERRA). You may continue coverage under this Act for up to 24 months (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); at 102% of the cost of the coverage. This continuation

right is concurrent with any right to continue coverage under COBRA. USERRA coverage will end earlier if one of the following events takes place:

- ✓ A premium payment is not made within the required time;
- ✓ You fail to report to work or to apply for reemployment within the time required under USERRA following the completion of your service in the uniformed services; or
- ✓ You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Benefits After Termination of Coverage
If you are an Inpatient of a Hospital or Skilled Nursing Facility on the day your coverage stops, benefits end on the day your coverage stops.

Federally Eligible Individuals
In addition, you need to be advised of what qualifies you to meet the requirements of a Federally Eligible Individual. Special non-Employer plans are available to Federally Eligible Individuals. A Federally Eligible Individual is an individual who meets the following requirements:

- an individual must have an 18 month period of Creditable Coverage, with final coverage through a Employer health plan, including church and governmental plans; health insurance coverage; Part A or Part B of Title XVIII of the Social Security Act (Medicare); the health plan for active military personnel, including TRICARE; the Indian Health Service or other tribal organization program; a state health benefits risk pool; the Federal Employees Health Benefits Program; a public health plan as defined in federal regulations; a health benefit plan under section 5 (c) of the Peace Corps Act; or any other plan which provides comprehensive hospital, medical and surgical services. Coverage after which there was a break of more than 63 days does not count in the period of Creditable Coverage. Creditable Coverage will be counted based on the standard method, without regard to specific benefits.
- an individual must enroll within 63 days of the termination date of your coverage under the Employer policy coverage;
- an individual must not be eligible for coverage under a Employer health plan, Medicare or Medicaid;
- an individual must not have other health insurance coverage;
- an individual whose most recent prior coverage has not been terminated for nonpayment of premium or fraud; and
- if the individual elected COBRA coverage or Ohio extension of coverage, the individual must exhaust all such continuation coverage to become a Federally Eligible Individual. Termination for nonpayment of premium does not constitute exhausting such coverage.

Plan Amendment and Termination
Your Employer fully intends to continue and maintain this Plan indefinitely, however, your Employer reserves the right to terminate or suspend the offering of this Plan at any time. Neither your Employer or any other person has any authority to make any written, or oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the terms of the Plan or the benefit booklet or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The TPA will provide written notice to Covered Persons within 60 days following the adopted formal action that makes a material reduction in the benefits of the Plan, or, in the alternative, may furnish such notice through your Employer.

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time that expenses are incurred, whether or not the Covered Person has received written notification of a change in the Plan from the TPA or the Employer.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses incurred before the Covered Person receives notice of termination. All claims incurred prior to termination, but not submitted to

either the TPA or the Employer within 75 days of the effective date of termination of this Plan due to bankruptcy will be excluded from any benefit consideration.

The Plan will assume that the Covered Person received written amendment or termination notification from the TPA five days after the notification letter was mailed.

No Contract of Employment
This Plan is not intended to be, and may not be construed as a contract of employment between any Covered Person and the Employer sponsoring this Plan.

PLAN INFORMATION

Plan Name	The Bronze Plan
Name and Address of Employer	
Name, Address and Phone Number of Claims Administrator	
Named Fiduciary	Your TPA
Employer Identification Number	
Type of Plan Provided	Self Funded Health and Welfare Plan providing Group Health Care benefits
Type of Plan Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract with an insurance company.
Name and Address of Agent for Legal Service of Process	
Funding of the Plan	Employer and Employee Contributions
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new employees and dependents, a benefit plan year begins on the individual's effective date under the Plan and runs through December 31 of the same benefit plan year.
Plan's Fiscal Year	July 1 through June 30
Compliance	It is intended that this Plan meet all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.
Claims are Processed by	