# BUCKEYE OHIO RISK MANAGEMENT ASSOCIATION (BORMA)

# CITY OF BOWLING GREEN

# EMPLOYEE BENEFIT PLAN

# PLAN DOCUMENT

Effective Date: January 1, 2006

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# FACTS ABOUT THE PLAN

**Name of Plan:**

Buckeye Risk Management Association (BORMA) City of Bowling Green Employee Benefit Plan

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

Buckeye Risk Management Association (BORMA)
City of Bowling Green
304 N. Church Street
Bowling Green, Ohio 43402
419-354-6208

**Group Number:**

172

**Type of Plan:**

Welfare Benefit Plan: medical, dental, prescription drug benefits

**Type of Administration:**

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

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

Buckeye Risk Management Association (BORMA)
City of Bowling Green
304 N. Church Street
Bowling Green, Ohio 43402
419-354-6208

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

**Eligibility Requirements:**

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

*Eligibility, Enrollment and Effective Date of Coverage*

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

*Schedule of Benefits*
*Pre-Existing Conditions*
*Termination of Coverage*
*Plan Exclusions*

**Source of Plan Contributions:**

Contributions for ***Plan*** expenses are obtained from the ***employer*** and from covered ***employees***. The ***employer*** evaluates the costs of the ***Plan*** based on projected ***Plan*** expenses and determines the amount to be contributed by the ***employer*** and the amount to be contributed by the covered ***employees***. Contributions by the covered ***employees*** are deducted from their pay on a pre-tax basis as authorized by the ***employee*** on the enrollment form or other applicable forms.

**Funding Method:**

The ***employer*** will maintain a trust for the receipt of money and property to fund the ***Plan***, for the management and investment of such funds, and for the payment of ***Plan*** benefits and expenses from such funds.

The ***employer*** shall deliver, from time to time to the Trust, amounts of money and property as shall be necessary to provide the Trust with sufficient funds to pay all ***Plan*** benefits and reasonable expenses of administering the ***Plan*** as the same shall be due and payable. The ***employer*** may provide for all or any part of such funding by insurance issued by a company duly qualified to issue insurance for such purpose and may pay the premiums, therefore, directly or by funds deposited in the Trust.

All funds received by the Trust and all earnings of the Trust shall be applied toward payment of ***Plan*** benefits and reasonable expenses of administration of the ***Plan*** except to the extent otherwise provided by the ***Plan*** documents. The ***employer*** may appoint an investment manager or managers to manage (including the power to acquire and dispose of) any assets of the ***Plan***.

Any fiduciary, employee, agent representative, or other person performing services to or for the ***Plan*** shall be entitled to reasonable compensation for services rendered and for the reimbursement of expenses properly and actually incurred, unless such person is the ***employer*** or already receives full-time pay from the ***employer***.

***Covered persons*** shall look only to the funds in the Trust for payment of ***Plan*** benefits and expenses.

**Ending Date of Plan Year:**

December 31

**Procedures for Filing Claims:**

For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled, *Medical/Dental Claim Filing Procedure.*

The designated ***claims processor*** is:

CoreSource, Inc.
5200 Upper Metro Place, Suite 300
Dublin, Ohio 43017-5378

# SCHEDULE OF BENEFITS

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

*MEDICAL BENEFITS*

| | | |
|---|---|---|
| **Maximum Benefit Per Covered Person While Covered By This Plan For:** | | |
| Medical | $2,000,000 | |
| Hospice Care, Inpatient and Outpatient Combined | 26 weeks | |
| Temporomandibular Joint Dysfunction (TMJ) and Orthognathic Disorders | $3,000 | |
| Diabetic Education/Consultation | 1 Program | |
| **Maximum Benefit Per Covered Person Per Calendar Year For:** | | |
| Extended Care Facility | 120 Days | |
| Home Health Care | 60 Visits | |
| Accident Expense Benefit | $300 | |
| Well Child Care | $300 | |
| Routine Preventive Care | $300 | |
| Routine Pap Smear | 1 Test | |
| Routine Mammogram | 1 Mammogram | |
| | ***Preferred Provider*** | ***Nonpreferred Provider*** |
| **Deductible Per Calendar Year:** | | |
| Individual Deductible (Per Person) | $100 | $300 |
| Family Deductible (Aggregate) | $300 | $900 |
| **Out-of-Pocket Expense Limit Per Calendar Year: (includes deductible)** | | |
| Individual (Per Person) | $300 | $900 |
| Family (Aggregate) | $900 | $2,700 |

Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit.

Amounts applied toward satisfaction of the ***preferred provider*** deductible and out-of-pocket expense limit may also be applied toward satisfaction of the ***nonpreferred provider*** deductible and out-of-pocket expense limit and vice versa.

**Coinsurance:**

The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by a ***covered person*** during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the ***Plan*** pays one hundred percent (100%) of ***covered expenses*** for the remainder of the calendar year or until the ***maximum benefit*** has been reached. Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit,* for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance***.

| BENEFIT DESCRIPTION | ***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***) | ***Nonpreferred Provider*** (% of ***customary and reasonable amount***) |
|---|---|---|
| **Inpatient Hospital** | 90% | 70% |
| **Preadmission Testing** | 90% | 70% |
| **Outpatient Surgery/Ambulatory Surgical Center** | 90% | 70% |
| **Emergency Room Services** | 90% | 90% |
| **Non-Emergency Use of the Emergency Room** | 90% | 70% |
| **Immediate Care Center** | 90% | 70% |
| **Accident Expense Benefit**<br>Limitation: $300 ***maximum benefit*** per calendar year for ***inpatient*** and ***outpatient*** expenses when initial ***accident*** care is rendered within seventy-two (72) hours | 100%* | 100%* |
| **Physician's Services** | | |
| Office Visit | 100%*<br>after $15 copay | 70% |
| Inpatient Visit | 90% | 70% |
| Surgery - Physician's Office | 90% | 70% |
| Surgery - Other | 90% | 70% |
| Anesthesiology | 90% | 70% |
| Pathology | 90% | 70% |
| Radiology | 90% | 70% |
| **Diagnostic X-rays & Lab** | | |
| Inpatient or Outpatient | 90% | 70% |

* **Deductible Waived**

| BENEFIT DESCRIPTION | ***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***) | ***Nonpreferred Provider*** (% of ***customary and reasonable amount***) |
|---|---|---|
| **Second Surgical Opinion** | 90% | 70% |
| **Extended Care Facility**<br>Limitation: 120 days ***maximum benefit*** per calendar year | 90% | 70% |
| **Home Health Care**<br>Limitation: 60 visits ***maximum benefit*** per calendar year | 90% | 70% |
| **Hospice Care**<br>Limitation: 26 weeks ***maximum benefit*** for inpatient and outpatient combined while covered by this ***Plan*** | 90% | 70% |
| **Durable Medical Equipment** | 90% | 70% |
| **Prostheses** | 90% | 70% |
| **Orthotics** | 90% | 70% |
| **Well Child Care**<br>Limitation: $300 ***maximum benefit*** per calendar year | 100%* | 100%* |
| **Routine Preventive Care**<br>Limitation: $300 ***maximum benefit*** per calendar year | 100%* | 100%* |
| **Immunizations** | 100%* | 100%* |
| **Routine Pap Smear**<br>Limitation: One (1) test ***maximum benefit*** per calendar year | 100%* | 100%* |
| **Routine Mammograms**<br>Limitation: One (1) mammogram ***maximum benefit*** per calendar year | 100%* | 100%* |
| **Mental & Nervous Disorders and Chemical Dependency Care** | | |
| Inpatient Services | 90% | 70% |
| Outpatient Services | 90% | 70% |
| Electro-Convulsive therapy | 90% | 70% |

* **Deductible Waived**

| BENEFIT DESCRIPTION | ***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***) | ***Nonpreferred Provider*** (% of ***customary and reasonable amount***) |
|---|---|---|
| **Therapy Services (Physical, Speech, Occupational, etc.)** | 90% | 70% |
| **Birthing Facility** | 90% | 70% |
| **Ambulance Services** | 90% | 70% |
| **Private Duty Nursing** | 90% | 70% |
| **Chiropractic Care** | 90% | 70% |
| **Podiatry Services** | 90% | 70% |
| **Prescription Drugs** dispensed in a ***physician's*** office | 90% | 70% |
| **Diabetic Education/Consultation**<br>Limitation: One (1) program following the initial diagnosis Program must be billed by a ***hospital*** | 90% | 70% |
| **All Other Covered Expenses** | 90% | 70% |

* **Deductible Waived**

Refer to *Medical Expense Benefit* for complete details.

*PRESCRIPTION DRUG PROGRAM*

| **Pharmacy Option** | |
|---|---|
| Prescription Drug Card | 100% after ***copay*** |
| ***Copay*** | Generic: $5 ***copay*** |
| | Single Source Brand Name: $15 ***copay*** |
| | Multiple Source Brand Name: $30 ***copay*** |
| Limitation: 30 day supply | |
| If the ***covered person*** purchases a brand name drug when the ***physician*** has indicated a ***generic drug*** can be dispensed, the ***covered person*** will be required to pay the difference between the cost of the ***generic drug*** and the brand name requested, plus the usual ***copay***. | |
| **Mail Order Option** | |
| Mail Order Prescription | 100% after ***copay*** |
| ***Copay*** | Generic: $5 ***copay*** |
| | Single Source Brand Name: $15 ***copay*** |
| | Multiple Source Brand Name: $30 ***copay*** |
| Limitation: 90 day supply | |
| If the ***covered person*** purchases a brand name drug when the ***physician*** has indicated a ***generic drug*** can be dispensed, the ***covered person*** will be required to pay the difference between the cost of the ***generic drug*** and the brand name requested, plus the usual ***copay***. | |

Refer to *Prescription Drug Program* for complete details.

## *DENTAL BENEFITS*

| | |
|---|---|
| **Calendar Year Deductible:** | |
| Individual | $25 |
| Family (Aggregate) | $50 |
| The deductible is waived for diagnostic & preventive dental services and orthodontia | |
| **Maximum Benefit Per Covered Person:** | |
| Preventive, Basic and Major Dental services per calendar year (other than Orthodontics) | $1,500 |
| Orthodontic services while covered by this ***Plan*** | $1,000 |
| **Percentage of Customary and Reasonable Amount Payable For:** | |
| Diagnostic & Preventive Dental Services | 100% |
| Basic Dental Services | 80% |
| Major Dental Services | 50% |
| Orthodontic Services | 50% |

Refer to *Dental Expense Benefit* for complete details.

# PREFERRED PROVIDER OR NONPREFERRED PROVIDER

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

## *PREFERRED PROVIDER*

A ***preferred provider*** is a ***physician***, ***hospital*** or ancillary service provider which has an agreement in effect with the ***Preferred Provider Organization*** (PPO) to accept a reduced rate for services rendered to ***covered persons***. This is known as the ***negotiated rate***. The ***preferred provider*** cannot bill the ***covered person*** for any amount in excess of the ***negotiated rate***.

## *NONPREFERRED PROVIDER*

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

## *REFERRALS*

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

## *EXCEPTIONS*

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

1. ***Emergency*** treatment rendered at a ***nonpreferred provider facility*** or at a ***preferred provider facility*** by a ***nonpreferred provider*** emergency room ***physician***. If the ***covered person*** is admitted to the ***hospital*** on an ***emergency*** basis, ***covered expenses*** shall be payable at the ***preferred provider*** level only if the patient's medical condition prevents his transfer to a ***preferred provider***.

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

3. ***Covered persons*** who do not have access to ***preferred providers*** within thirty-five (35) miles of their place of residence, or for ***emergency*** treatment rendered while traveling out-of-area.

4. Treatment rendered at a ***facility*** of the Uniformed Services.

# MEDICAL EXPENSE BENEFIT

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

## COPAY

The ***copay*** is the amount payable by the ***covered person*** for certain services, supplies or treatment rendered by a ***preferred provider***. The service and applicable ***copay*** are shown on the *Schedule of Benefits*. The ***covered person*** selects a ***preferred provider*** and pays the ***preferred provider*** the ***copay***. The ***Plan*** pays the remaining ***covered expenses*** at the ***negotiated rate***. The ***copay*** must be paid each time a treatment or service is rendered.

The ***copay*** will not be applied toward the following:

1. The calendar year deductible.
2. The maximum out-of-pocket expense limit.
3. The deductible carry-over.
4. The common accident deductible.
5. The multiple birth deductible.

## DEDUCTIBLES

*Individual Deductible*

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

*Family Deductible*

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

*Common Accident*

If two or more covered members of a family are ***injured*** in the same ***accident*** and, as a result of that ***accident***, incur ***covered expenses***, only one (1) individual deductible amount will be deducted from the total ***covered expenses*** of all covered family members related to the ***accident*** for the remainder of the calendar year.

*Deductible Carry-Over*

Amounts ***incurred*** during October, November and December and applied toward the deductible of any ***covered person***, will also be applied to the deductible of that ***covered person*** in the next calendar year. Deductible carry-over does not apply to family deductibles.

*Multiple Birth Deductible*

When two (2) or more ***dependents*** are born in a multiple birth, only one (1) individual deductible will be taken from the total ***covered expenses incurred*** in a calendar year for those ***dependents*** if the ***covered expenses*** are ***incurred*** in the same calendar year as the birth and are due to:

1. Premature birth; or

2. Abnormal congenital conditions; or

3. ***Injury*** which is received at birth or ***illness*** which starts not more than thirty (30) days after birth.

# *COINSURANCE*

The ***Plan*** pays a specified percentage of ***covered expenses*** at the ***customary and reasonable amount*** for ***nonpreferred providers***, or the percentage of the ***negotiated rate*** for ***preferred providers***. That percentage is specified on the *Schedule of Benefits*. For ***nonpreferred providers***, the ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and one hundred percent (100%) of the billed amount. The ***covered person's*** portion of the ***coinsurance*** represents the out-of-pocket expense limit.

# *OUT-OF-POCKET EXPENSE LIMIT*

After the ***covered person*** has ***incurred*** an amount equal to the out-of-pocket expense limit listed on the *Schedule of Benefits* for ***covered expenses***, the ***Plan*** will begin to pay one hundred percent (100%) of ***covered expenses*** for the remainder of the calendar year.

After a covered family has ***incurred*** a combined amount equal to the family out-of-pocket expense limit shown on the *Schedule of Benefits*, the ***Plan*** will pay one hundred percent (100%) of ***covered expenses*** for all covered family members for the remainder of the calendar year.

*Out-of-Pocket Expense Limit Exclusions*

The following items do not apply toward satisfaction of the calendar year out-of-pocket expense limit and will not be payable at one hundred percent (100%) even if the out-of-pocket expense limit has been satisfied:

1. Expenses for services, supplies and treatments not covered by this ***Plan***, to include charges in excess of the ***customary and reasonable amount*** or ***negotiated rate***, as applicable.

2. ***Copays***.

3. Expenses for services, supplies and ***outpatient*** treatment of ***mental and nervous disorders*** and ***chemical dependency***.

4. Expenses ***incurred*** as a result of failure to obtain pre-certification.

## MAXIMUM BENEFIT

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

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

## HOSPITAL/AMBULATORY SURGICAL FACILITY

***Inpatient hospital*** admissions are subject to pre-certification. Failure to obtain pre-certification will result in a reduction of benefits as specified in the *Medical/Dental Claim Filing Procedure* section of this document.

***Covered expenses*** shall include:

1. ***Room and board*** for treatment in a ***hospital***, including ***intensive care units***, cardiac care units and similar ***medically necessary*** accommodations. ***Covered expenses*** for ***room and board*** shall be limited to the ***hospital's semiprivate*** rate. ***Covered expenses*** for ***intensive care*** or cardiac care units shall be the ***customary and reasonable amount*** for ***nonpreferred providers*** and the percentage of the ***negotiated rate*** for ***preferred providers***. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the ***covered person***.

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

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

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

4. Charges for pre-admission testing (x-rays and lab tests) performed within seven (7) days prior to a ***hospital*** admission which are related to the condition which is necessitating the ***confinement***. Such tests shall be payable even if they result in additional medical treatment prior to ***confinement*** or if they show that ***hospital confinement*** is not ***medically necessary***. Such tests shall not be payable if the same tests are performed again after the ***covered person*** has been admitted.

## FACILITY PROVIDERS

Services provided by a ***facility*** provider are covered if such services would have been covered if performed in a ***hospital*** or ***ambulatory surgical facility***.

## AMBULANCE SERVICES

***Covered expenses*** shall include:

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

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

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

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

## EMERGENCY ROOM SERVICES

Coverage for emergency room treatment shall be paid in accordance with the *Schedule of Benefits* provided the condition meets the definition of ***emergency*** herein. Emergency room treatment for conditions that do not meet the definition of ***emergency*** will be considered non-***emergency*** use of the emergency room and will be subject to the additional ***coinsurance*** as shown on the *Schedule of Benefits*.

***Emergency*** medical or ***accident*** care must begin within seventy-two (72) hours of the ***injury*** or the onset of the ***emergency***.

## IMMEDIATE CARE CENTER

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

## ACCIDENT EXPENSE BENEFIT

Initial treatment within seventy-two (72) hours of an accidental ***injury*** will be payable subject to the ***maximum benefit*** as specified on the *Schedule of Benefits*. ***Covered expenses*** include:

1. ***Hospital*** services and supplies.

2. Services rendered by a ***physician***, surgeon or ***dentist***.

3. Services of a Registered Nurse.

4. Drugs and dressings.

5. Braces, crutches, (initial) prosthetics, or ***durable medical equipment***.

6. Necessary transportation by ambulance.

When the ***accident*** expense benefit has been exhausted, any deductible, ***coinsurance*** and out-of-pocket expense limits will apply for ***covered expenses*** as shown on the *Schedule of Benefits*.

## *PHYSICIAN SERVICES*

***Covered expenses*** shall include:

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

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

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

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

3. Surgical assistance provided by a ***physician*** if it is determined that the condition of the ***covered person*** or the type of surgical procedure requires such assistance.

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

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

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

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

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

## *SECOND SURGICAL OPINION*

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

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

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

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

## *DIAGNOSTIC SERVICES AND SUPPLIES*

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

## *TRANSPLANT*

Transplant procedures are subject to pre-certification. Failure to obtain pre-certification will result in a reduction of benefits for the ***hospital confinement*** as specified in the *Medical/Dental Claim Filing Procedure* section of this document.

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

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

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

3. Expenses ***incurred*** within three (3) months of and related to the transplant by the donor who is not ordinarily covered under this ***Plan*** according to eligibility requirements will be ***covered expenses*** to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this ***Plan***. The donor's expense shall be applied to the recipient's ***maximum benefit***. In no event will benefits be payable in excess of the ***maximum benefit*** still available to the recipient.

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

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

## *PREGNANCY*

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

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

## *BIRTHING CENTER*

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

## *STERILIZATION*

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

## *INFERTILITY SERVICES*

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

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

## *NEWBORN CARE*

The ***Plan*** shall cover newborn care for a sick or well newborn child while the mother is confined for delivery as part of the mother's claim (one deductible and one coinsurance), whether or not the newborn child is enrolled for coverage.

Such care shall include, but is not limited to:

1. ***Physician*** services
2. ***Hospital*** services
3. Circumcision

## *WELL CHILD CARE*

***Covered expenses*** shall include the following preventive care services rendered to a covered ***dependent*** child: routine pediatric examinations for a reason other than to diagnose an ***injury*** or ***illness***; laboratory and other tests given in connection with pediatric examinations, subject to the ***maximum benefit*** specified on the *Schedule of Benefits*.

## *ROUTINE PREVENTIVE CARE*

***Covered expenses*** shall include the following routine services and supplies which are not required due to ***illness*** or ***injury***: physical check-up, gynecological examination, prostate examination and prostate specific antigen (PSA) test and routine testing, etc. Routine preventive care is subject to the ***maximum benefit*** as specified on the *Schedule of Benefits*.

## *IMMUNIZATIONS*

***Covered expenses*** shall include routine and ***medically necessary*** immunizations for all ***covered persons***.

## *ROUTINE PAP SMEAR*

***Covered expenses*** shall include one (1) routine Papanicolaou test (pap smear) per calendar year as specified on the *Schedule of Benefits*.

## *ROUTINE MAMMOGRAMS*

***Covered expenses*** shall include one (1) routine mammogram per calendar year as specified on the *Schedule of Benefits*.

## *THERAPY SERVICES*

Therapy services must be ordered by a ***physician*** to aid restoration of normal function lost due to ***illness*** or ***injury***.

***Covered expenses*** shall include:

1. Services of a ***professional provider*** for physical therapy, occupational therapy or respiratory therapy.
2. Radiation therapy and chemotherapy.
3. Dialysis therapy or treatment.
4. Infusion therapy.

Speech therapy is a ***covered expense*** provided that the services received are to restore speech loss or correct impairment due to a birth defect, injury or illness.

## *EXTENDED CARE FACILITY*

***Extended care facility confinement*** is subject to pre-certification. Failure to obtain pre-certification shall result in a reduction of benefits as specified in the *Medical/Dental Claim Filing Procedure* section of this document.

***Extended care facility*** services, supplies and treatments shall be a ***covered expense*** provided:

1. The ***covered person*** was first confined to a ***hospital*** for at least three (3) consecutive days;
2. The attending ***physician*** recommends extended care ***confinement*** for a convalescence from a condition which caused that ***hospital confinement***, or a related condition;
3. The extended care ***confinement*** begins within fourteen (14) days after discharge from that ***hospital confinement***, or within fourteen (14) days after a related extended care ***confinement***; and
4. The ***covered person*** is under a ***physician's*** continuous care and the ***physician*** certifies that the ***covered person*** must have twenty-four (24) hours-per-day nursing care.

***Covered expenses*** shall include:

1. ***Room and board*** (including regular daily services, supplies and treatments furnished by the ***extended care facility***) limited to the ***facility's*** average ***semiprivate*** room rate or fifty (50%) percent of the most common ***semiprivate*** room rate of the ***hospital*** in which the patient was most recently confined; and
2. Other services, supplies and treatment ordered by a ***physician*** and furnished by the ***extended care facility*** for ***inpatient*** medical care.

***Extended care facility*** benefits are subject to the ***maximum benefit*** specified on the *Schedule of Benefits*.

## *HOME HEALTH CARE*

Home health care enables the ***covered person*** to receive treatment in his home for an ***illness*** or ***injury*** instead of being confined in a ***hospital*** or ***extended care facility***. ***Covered expenses*** shall include the following services and supplies provided by a ***home health care agency***:

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

2. Physical, respiratory, occupational or speech therapy;

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

4. Medical social service consultations;

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

***Covered expenses*** shall be subject to the ***maximum benefit*** specified on the *Schedule of Benefits*.

A visit by a member of a home health care team and four (4) hours of ***home health aide service*** will each be considered one (1) home health care visit.

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

Private duty nursing during a period in which the ***covered person*** is receiving home health care services is not covered.

## *HOSPICE CARE*

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

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

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

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

***Covered expenses*** shall include:

1. ***Confinement*** in a ***hospice*** to include ancillary charges and ***room and board***.

2. Services, supplies and treatment provided by a ***hospice*** to a ***covered person*** in a home setting.

3. ***Physician*** services and/or nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse.

4. Physical therapy, occupational therapy, speech therapy or respiratory therapy.

5. Nutrition services to include nutritional advice by a registered dietitian, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be ***medically necessary***.

6. Counseling services provided through the ***hospice***.

7. Homemaker services.

Bereavement counseling as a supportive service to ***covered persons*** in the terminally ill ***covered person's*** immediate family. Benefits will be payable up to the ***maximum benefit*** specified on the *Schedule of Benefits*, provided:

a. On the date immediately before death, the terminally ill person was covered under the ***Plan*** and receiving ***hospice*** care benefits; and

b. Services are ***incurred*** by the ***covered person*** within three (3) months of the terminally ill person's death.

***Hospice*** benefits are limited to the ***maximum benefit*** as stated on the *Schedule of Benefits*.

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

## *DURABLE MEDICAL EQUIPMENT*

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

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

## *PROSTHESES*

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

## *ORTHOTICS*

Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a ***covered expense***. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, orthotics that can be legally purchased without a written prescription and other supportive devices for the feet shall not be covered. Replacement will be covered only after five (5) years from the date of original placement, unless a physiological change in the patient's condition necessitates earlier replacement.

## *DENTAL SERVICES*

***Covered expenses*** shall include repair of sound natural teeth or surrounding tissue provided it is the result of an ***injury***. Damage to the teeth as a result of chewing or biting shall not be considered an ***injury*** under this benefit.

***Covered expenses*** shall include charges for oral surgery such as closed or open reduction of fractures or dislocations of the jaw, and incision or excision of cysts and tumors of the mouth.

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

## *TEMPOROMANDIBULAR JOINT DYSFUNCTION*

Surgical and nonsurgical treatment of temporomandibular joint dysfunction (TMJ) or myofascial pain syndrome shall be a ***covered expense***. The ***maximum benefit*** payable for diagnosis and treatment of TMJ or myofascial pain syndrome per ***covered person*** is specified on the *Schedule of Benefits*. This limitation shall apply whether treatment is provided by a ***hospital***, ***physician***, ***dentist***, physical therapist or oral surgeon.

## *ORTHOGNATHIC DISORDERS*

Surgical and nonsurgical treatment of orthognathic disorders shall be a ***covered expense***. The ***maximum benefit*** payable for diagnosis and treatment of orthognathic disorders per ***covered person*** is specified on the *Schedule of Benefits*. This limitation shall apply whether treatment is provided by a ***hospital***, ***physician***, ***dentist***, physical therapist or oral surgeon.

## *SPECIAL EQUIPMENT AND SUPPLIES*

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

## *COSMETIC/RECONSTRUCTIVE SURGERY*

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

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

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

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

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

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

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

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

1. reconstruction of a surgically removed breast; and

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

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

## *MENTAL & NERVOUS DISORDERS AND CHEMICAL DEPENDENCY CARE*

***Covered expenses*** for ***inpatient*** and ***outpatient*** treatment, services or supplies for the treatment of ***mental and nervous disorders*** and ***chemical dependency***.

*Inpatient or Partial Confinement*

Subject to the pre-certification provisions of the ***Plan***, the ***Plan*** will pay the applicable ***coinsurance***, as shown on the *Schedule of Benefits*, for ***confinement*** in a ***hospital*** or ***treatment center*** for treatment, services and supplies related to the treatment of ***mental and nervous disorders*** and ***chemical dependency***.

***Covered expenses*** shall include:

1. ***Inpatient hospital confinement***;

2. Individual psychotherapy;

3. Group psychotherapy;

4. Psychological testing;

5. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same ***professional provider***.

*Outpatient*

The ***Plan*** will pay the applicable ***coinsurance***, as shown on the *Schedule of Benefits*, for ***outpatient*** treatment, services and supplies related to the treatment of ***mental and nervous disorders*** and ***chemical dependency***.

Covered expenses shall include:

1. Treatment in subacute treatment centers;

2. Treatment in a half way house or day ***facility***;

3. Expanded ***outpatient*** treatment;

4. Periodic office visits.

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

"Subacute treatment" means treatment received at a ***facility*** which may or may not be equipped or licensed to treat medical ***emergencies***, but which maintains close ties with acute care ***facilities***. Skilled professional therapists practice in these ***facilities***, and ***physician*** and Registered Nurses are available on call. Therapy is available for recovering chemically dependent patients and those with mental health problems requiring some medical management.

"Day treatment" means a structured program of therapy and activities which requires that the patient attend sessions and return to their own living arrangement at night. Day treatment programs are offered by ***hospitals***, freestanding subacute ***facilities*** and mental health clinics.

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

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

## *PRESCRIPTION DRUGS*

The application of ***copays*** under the *Prescription Drug Program* shall not be considered a ***covered expense*** under the *Medical Expense Benefit*.

Prescription drugs dispensed in a provider's office shall be considered a ***covered expense*** under this *Medical Expense Benefit*.

## *PODIATRY SERVICES*

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

## *PRIVATE DUTY NURSING*

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

## *CHIROPRACTIC CARE*

***Covered expenses*** include initial consultation, x-rays and treatment.

## *PATIENT EDUCATION*

***Covered expenses*** shall include ***medically necessary*** patient education programs including, but not limited to ostomy care and diabetic education. The diabetic education must be billed by a ***hospital*** and is limited as specified on the *Schedule of Benefits*.

## *SURCHARGES*

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

## *SURGICAL TREATMENT OF MORBID OBESITY*

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

## *OUTPATIENT CARDIAC/PULMONARY REHABILITATION PROGRAMS*

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

## *SLEEP DISORDERS*

***Covered expenses*** shall include charges for sleep studies and treatment of sleep apnea and other sleep disorders, including charges for sleep apnea monitors.

# MEDICAL EXCLUSIONS

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

1. Charges for ***pre-existing conditions*** as specified in *Pre-Existing Conditions* and *Certificates of Coverage*.

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

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

4. Charges for birth control services, supplies or devices.

5. Charges for services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

6. Charges for treatment or surgery for sexual dysfunction or inadequacies unless related to ***injury*** or organic ***illness***.

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

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

9. Charges for biofeedback therapy.

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

11. Charges for marriage, career or legal counseling.

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

13. Charges for routine vision examinations and eye refractions; vision therapy (orthoptics); eyeglasses or contact lenses, except as specified herein; dispensing optician's services.

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

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

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

17. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements.

18. Charges for prescription drug ***copays*** applicable to the *Prescription Drug Program*.

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

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

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

22. Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and ***hospital confinements*** for weight reduction programs.

23. Charges for services, supplies and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches.

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

25. Charges related to acupuncture treatment.

26. Charges for treatment to alter vertical dimension or to restore abraded dentition.

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

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

29. Charges for wigs, artificial hairpieces, artificial hair transplants, or any drug - prescription or otherwise - used to eliminate baldness or stimulate hair growth.

30. Charges for expenses related to hypnosis.

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

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

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

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

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

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

37. Charges for holistic medicines or providers of naturopathy.

38. Charges for or related to the following types of treatment:

    a. primal therapy;

    b. rolfing;

    c. psychodrama;

    d. megavitamin therapy;

    e. visual perceptual training.

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

40. Charges for exercise programs for treatment of any condition.

41. Charges for orthotics that can legally be purchased without a written prescription.

42. Charges for private duty nursing services during a period in which the ***covered person*** is receiving home health care services.

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

# PRESCRIPTION DRUG PROGRAM

## *PHARMACY OPTION*

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

## *PHARMACY OPTION COPAY*

The ***copay*** is applied to each covered pharmacy drug charge and is shown on the *Schedule of Benefits*. The ***copay*** amount is not a ***covered expense*** under the *Medical Expense Benefit*. Any one prescription is limited to a thirty (30) day supply.

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

## *MAIL ORDER OPTION*

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

## *MAIL ORDER OPTION COPAY*

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

## *COVERED PRESCRIPTION DRUGS*

1. Drugs prescribed by a ***physician*** that require a prescription either by federal or state law, including injectables, except drugs excluded by the ***Plan***.

2. Compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.

3. Insulin, insulin needles and syringes, glucose monitors and diabetic supplies.

4. Allergy serums.

5. Oral contraceptives, regardless of the reason prescribed.

6. Drugs used in the treatment of erectile dysfunction (limited to 24 tablets per ninety (90) days).

7. Any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a ***qualified prescriber***.

## *LIMITS TO THIS BENEFIT*

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

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

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

## *EXPENSES NOT COVERED*

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

2. Devices of any type, even though such devices may require a prescription. These include, but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.

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

4. A drug or medicine labeled: "Caution - limited by federal law to ***investigational*** use."

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

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

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

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

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

10. A charge for hypodermic syringes and/or needles, except for diabetes.

11. A charge for prescription drugs for smoking cessation purposes, including smoking deterrent patches.

12. A charge for infertility medication.

13. A charge for contraceptive devices.

14. A charge for legend vitamins.

15. A charge for minerals.

16. A charge for fluoride supplements.

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

18. A charge for weight loss drugs.

19. A charge for non-legend drugs, other than as specifically listed herein.

20. A charge for Levonorgestrel (Norplant implants).

## *NOTICE OF AUTHORIZED REPRESENTATIVE*

The ***covered person*** may provide the ***plan administrator*** or their designee with a written authorization for an authorized representative to represent and act on behalf of a ***covered person*** and consent to release of information related to the ***covered person*** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Personnel Department.

## *APPEALING A DENIED POST-SERVICE PRESCRIPTION DRUG CLAIM*

The "***named fiduciary***" for purposes of an appeal of a denied Post-Service Prescription Drug Claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the ***claims processor***.

A ***covered person***, or the ***covered person's*** authorized representative, may request a review of a denied claim by making written request to the ***named fiduciary*** within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the ***covered person*** feels the claim should not have been denied.

The following describes the review process and rights of the ***covered person***:

1. The ***covered person*** has a right to submit documents, information and comments.

2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.

3. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.

4. The review by the ***named fiduciary*** will not afford deference to the original denial.

5. The ***named fiduciary*** will not be:

    a. The individual who originally denied the claim, nor

    b. Subordinate to the individual who originally denied the claim.

6. If original denial was, in whole or in part, based on medical judgment:

    a. The ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment; and

    b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:

        i. An individual who was consulted in connection with the original denial of the claim, nor

        ii. A subordinate of any other ***professional provider*** who was consulted in connection with the original denial.

7. If requested, the ***named fiduciary*** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

## ***NOTICE OF BENEFIT DETERMINATION ON A POST-SERVICE PRESCRIPTION DRUG CLAIM APPEAL***

The ***plan administrator*** or their designee shall provide the ***covered person*** (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the denial.
2. Reference to specific ***Plan*** provisions on which the denial is based.
3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
4. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
    a. A copy of that criterion, or
    b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
5. If the denial was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***Plan*** will supply either:
    a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or
    b. A statement that such explanation will be supplied free of charge, upon request.

# DENTAL EXPENSE BENEFIT

Subject to all the terms of the ***Plan***, the ***Plan*** will pay a dental benefit for covered dental expenses. The dental benefit is a percentage of the ***customary and reasonable amount*** for covered dental expenses, as shown on the *Schedule of Benefits*.

## *DEDUCTIBLE*

*Individual Deductible*

The individual deductible is the dollar amount of ***covered expense*** which each ***covered person*** must incur during each calendar year before the ***Plan*** pays applicable benefits. The individual deductible amount is shown on the *Schedule of Benefits*.

*Family Deductible*

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

*Deductible Carry-Over*

Amounts ***incurred*** during October, November and December and applied toward the deductible of any ***covered person***, will also be applied to the deductible of that ***covered person*** in the next calendar year. Deductible carry-over does not apply to family deductibles.

## *COINSURANCE*

The ***Plan*** pays a specified percentage of the ***customary and reasonable amount*** for ***covered expenses***. That percentage is listed on the *Schedule of Benefits*. The ***covered person*** is responsible for the difference.

## *MAXIMUM BENEFIT*

The maximum calendar year benefit payable on behalf of a ***covered person*** for covered dental expense is stated on the *Schedule of Benefits*. If the ***covered person's*** coverage under the ***Plan*** terminates and he subsequently returns to coverage under the ***Plan*** during the calendar year, the ***maximum benefit*** will be calculated on the sum of benefits paid by the ***Plan***.

The ***maximum benefit*** for orthodontic treatment while a ***covered person*** is covered by this ***Plan*** is also specified on the *Schedule of Benefits*. If the ***covered person*** receives more than one course of orthodontic treatment while covered by this ***Plan*** and if it can be clearly shown that any later course of treatment is not a part of a previous course of treatment, then the ***covered person*** will be entitled to a separate ***maximum benefit*** for each course of treatment.

## *ALTERNATIVE TREATMENT*

In the event the ***dentist*** recommends a particular course of treatment and a lower-cost alternative would be as effective, benefits shall be limited to the lower-cost alternative. Any balance remaining, as a result of the ***covered person's*** choice to obtain the higher-cost treatment will be the ***covered person's*** responsibility.

## *DENTAL INCURRED DATE*

A dental procedure will be deemed to have commenced on the date the covered dental expense is ***incurred***, except as follows:

1. For installation of a prosthesis other than a bridge or crown, on the date the impression was made;
2. For a crown, bridge or gold restoration, on the date the tooth or teeth are first prepared;
3. For endodontic treatment, on the date the pulp chamber is opened.

There are times when one overall charge is made for all or part of a course of treatment. In this case the ***claims processor*** will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be ***incurred*** as each visit or treatment is completed.

## *EXTENDED DENTAL BENEFITS*

For dentures or bridges, if a final impression for a denture has been taken, or tooth for a bridge has been prepared, before coverage under this ***Plan*** ends, then charges for the construction and/or insertion of such denture or bridge will be considered as eligible only to the extent that such construction or insertion procedures are performed within thirty-one (31) days after termination of coverage.

Charges for dental procedures, other than dentures or bridges, will be considered as eligible expenses if such procedures relate to a particular multiple-appointment dental procedure which had commenced before coverage ended, but only to the extent that such procedures are performed within thirty-one (31) days of termination of coverage.

## *COVERED DENTAL EXPENSES*

Subject to the limitations and exclusions, covered dental expenses shall include the necessary services, supplies, or treatment listed below and on the following pages. No dental benefit will be paid for any dental service, supply or treatment which is not on the following list of covered dental expenses.

*Class I Diagnostic and Preventive Dental Services*

1. Routine oral examination: Initial or periodic, limited to once per six (6) consecutive month period.
2. Prophylaxis: Scaling and cleaning of teeth, limited to once per six (6) consecutive month period.
3. Dental x-rays as follows:
    a. Supplementary bite-wing x-rays, limited to once per six (6) consecutive month period.
    b. Panorex or full mouth series, limited to once during any thirty-six (36) consecutive month period.
    c. Other dental x-rays necessary for the diagnosis of a specific condition requiring treatment.
4. Topical application of fluoride for ***dependent*** children through the age of fourteen (14), limited to once during any six (6) consecutive month period.
5. Space maintainers, fixed appliance (not made of precious metals), designed to preserve the space between teeth caused by the premature loss of a primary tooth (also called a baby tooth) including all adjustments within six (6) months of installation, limited to ***dependent*** children through the age of eighteen (18). This does not include space maintainers used in orthodontics to create a space between teeth.
6. ***Emergency*** palliative treatment primarily for relief of dental pain, not cure. Only paid as a separate benefit when no other treatment (except x-rays) is rendered during the visit.

*Class II  Basic Dental Services*

1. Sedative fillings, covered as a separate procedure only if no other service (except x-rays) is rendered during the visit.

2. Restorations (fillings) to restore teeth to normal function, using amalgam, silicate, acrylic, synthetic, and composite filling materials to restore teeth broken down by decay or ***injury***.

3. Pin retention when part of the restoration instead of gold or crown retention.

4. Periodontics as follows:

    a. Gingivectomy/gingivoplasty, gingival curettage, gingival flap procedure or mucogingival surgery.
    b. Scaling and root planing limited to twice per quadrant in any calendar year.
    c. Pedicle and free soft tissue grafts, and vestibuloplasty.
    d. Occlusal adjustment, excluding charges for TMJ.
    e. Excision of pericoronal gingiva.
    f. Periodontal prophylaxis limited to once per six (6) consecutive month period with proof of previous periodontal treatment.
    g. Osseous surgery.

5. Endodontics as follows:

    a. Direct pulp capping.
    b. Pulpotomy.
    c. Root canal therapy.
    d. Apicoectomy.
    e. Hemisection.
    f. Retrograde fillings.

6. Oral surgery, including customary postoperative treatment furnished in connection with oral surgery, as follows:

    a. Simple extraction of one (1) or more teeth.
    b. Surgical extraction of erupted teeth and of soft tissue, partially bony, and completely bony impacted teeth.
    c. Extraction of tooth root.
    d. Incision and drainage of a tumor or a cyst.
    e. Alveolectomy, alveoloplasty, and frenectomy.
    f. Exostosis or hyperplastic tissue and excision of oral tissue for biopsy.
    g. Re-implantation or transplantation of a natural tooth.
    h. General anesthesia, only when provided in conjunction with a surgical procedure.

7. Specialist consultations and specialty examinations provided the ***covered person*** has been referred by a general ***dentist***.  These consultations and examinations are not restricted to the limitations for routine oral exams.

8. Topical application of sealant to permanent posterior teeth.

*Class III Major Dental Services*

1. Post and core on permanent teeth only.

2. Plastic or stainless steel crowns will be covered for primary teeth only and the five (5) year limitation, as noted below will not be applied.

3. Gold Inlays and Onlays: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have elapsed since the last placement.

4. Porcelain Restorations: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have elapsed since the last placement.

5. Crowns: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have lapsed since the last placement. Crowns used to treat temporomandibular joint dysfunction will not be covered.

6. Initial installation of fixed bridge (including abutments) to replace one (1) or more natural teeth.

7. Removable bridge, partial or complete dentures to replace one (1) or more natural teeth.

8. Replacement of or addition of teeth to an existing removable denture (full or partial) or fixed bridgework as follows:

    a. Replacement or addition of teeth is made necessary by the extraction of natural teeth;

    b. Replacement is necessary to correct Temporomandibular Joint disturbances caused by existing denture or bridgework when the prosthesis cannot be economically modified to correct the condition;

    c. Replacement is necessary when an immediate temporary denture was inserted shortly following extraction of teeth and cannot be economically modified to the final shape required;

    d. The existing denture or bridgework was installed at least five (5) years prior to its replacement and the existing denture or bridgework cannot be made serviceable.

9. Complete dentures.

10. Repairs and adjustments to full or partial dentures.

11. Relining of present dentures, but only if they were installed more than six (6) months earlier and if they have not been relined during the past twelve (12) months.

12. Rebasing of present dentures, but only if they were installed more than six (6) months earlier and if they have not been rebased during the past thirty-six (36) months.

13. Denture adjustment once per twelve (12) consecutive months, only if done more than six (6) months after the initial insertion of the denture.

14. Repair or recementing of crowns, inlays, onlays or bridgework.

*Class IV  Orthodontic Services*

1. Any dental expense furnished in connection with the orthodontic treatment.

2. Surgical exposure of impacted or unerupted teeth in connection with orthodontic treatment, including routine x-rays, local anesthetics, and post-surgical care.

3. Active appliances, including diagnostic services, the treatment plan, the fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.

4. Comprehensive full-banded and bracketed orthodontic treatment.

5. Fixed or cemented appliance to control harmful habits.

## *DENTAL EXCLUSIONS*

In addition to the *Plan Exclusions*, no benefit will be provided under this ***Plan*** for dental expenses ***incurred*** by a ***covered person*** for the following:

1. Charges for any device ordered while the individual was covered under this ***Plan*** and not delivered or installed within thirty (30) days after termination of coverage.

2. Replacement of lost, missing or stolen appliances or prosthetic devices or duplicate appliances or prosthetic devices.

3. Charges for all services, supplies and treatment related to dental implants.

4. Any procedure which began before the date the ***covered person's*** dental coverage started, to include a service which is:

    a. An appliance, or modification of an appliance, for which an impression was made before such person became covered, or

    b. A crown, bridge or gold restoration, for which a tooth was prepared before such person became covered, or

    c. Root canal therapy, for which the pulp chamber was opened before such person became covered.

    X-rays and prophylaxis shall not be deemed to start a dental procedure.

5. Services, supplies or treatment that is cosmetic in nature, including charges for personalization or characterization of dentures.  Veneers or coverings placed on teeth except when used to return the tooth to normal form and function are considered cosmetic in nature.

6. Surgical services with respect to congenital or developmental malformations.  These conditions include:  cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis, and anodontia.

7. Appliances, restoration or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion or attrition, except as provided under *Orthodontic Services*.

8. A service not furnished by a ***dentist***, except:

   a. Services performed by a licensed dental hygienist under a ***dentist's*** supervision;

   b. X-rays ordered by a ***dentist***; and

   c. Denturist.

9. Charges for over-dentures, including related root canal therapy and supportive restorations.

10. Replacement of a prosthetic which in the ***dentist's*** opinion can be repaired or does not need replacement.

11. Fixed prosthetics and/or partials for children through the age of fifteen (15). An allowance will be made for a temporary acrylic partial.

12. A posterior fixed prosthetic appliance when done in connection with a removable appliance in the same arch.

13. Charges in excess of the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.

14. Charges resulting from changing from one ***dentist*** to another while receiving treatment, or resulting from receiving care from more than one ***dentist*** for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one ***dentist*** had performed all the required dental services.

15. Porcelain, gold, porcelain veneer, acrylic veneer, and precious metal crowns over primary teeth for children through the age of fifteen (15). An allowance will be made for an acrylic crown.

16. Charges for precision attachments, semi-precision attachments.

17. Charges for instruction in dental plaque control, dental hygienics, or nutritional counseling.

18. Charges for services or supplies related to diagnosis of, or treatment of temporomandibular joint syndrome, by whatever name called.

19. Charges for adjustments of new dentures within six (6) months of installation.

20. Charges for infection control (OSHA fees).

21. Charges for behavior management.

22. Any procedure not listed under *Covered Dental Expenses*.

# PLAN EXCLUSIONS

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

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

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

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

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

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

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

7. Charges in connection with any ***illness*** or ***injury*** of the ***covered person*** resulting from or occurring during commission or attempted commission of a criminal battery or felony by the ***covered person***.

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

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

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

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

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

13. Charges for services, supplies or treatment rendered by any individual who is a ***close relative*** of the ***covered person*** or who resides in the same household as the ***covered person***.

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

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

16. Claims not submitted within the ***Plan's*** filing limit deadlines as specified in the section, *Medical/Dental Claim Filing Procedure*.

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

18. If the primary plan provides coverage through the services of an HMO and the ***covered person*** chooses not to use the HMO, this ***Plan*** will not pay for any charges disallowed by the primary plan due to failure to utilize the HMO.

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

20. Benefits which are payable under any one section of this ***Plan*** shall not be payable as a benefit under any other section of this ***Plan***. For example, if a benefit is eligible under both the *Medical Expense Benefit* section and the *Dental Expense Benefit* section, and is paid under the *Medical Expense Benefit*, the remaining balance will **<u>not</u>** be paid under the *Dental Expense Benefit*.

# ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

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

## *EMPLOYEE ELIGIBILITY*

All ***full-time*** or permanent ***part-time employees*** regularly scheduled to work at least forty (40) hours per work week for ***full-time*** or at least twenty (20) hours, but less than forty (40) hours per work week, for permanent ***part-time*** shall be eligible to enroll for coverage under this ***Plan***. This does not include temporary or seasonal ***employees***.

***Full-time employees*** are eligible to enroll for medical, prescription drug and dental benefits. Permanent ***part-time employees*** are eligible to enroll for medical and prescription benefits only.

## *EMPLOYEE ENROLLMENT*

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

## *EMPLOYEE(S) EFFECTIVE DATE*

Eligible ***employees***, as described in *Employee Eligibility*, are covered under the ***Plan*** on the first day of the month following completion of thirty (30) days of employment, provided the ***employee*** has enrolled for coverage as described in *Employee Enrollment*. If the ***employee*** enrolls for coverage within thirty-one (31) days of the first day of the month following thirty (30) days of employment, coverage will be effective on the date of enrollment.

## *DEPENDENT(S) ELIGIBILITY*

The following describes ***dependent*** eligibility requirements. The ***employer*** will require proof of ***dependent*** status.

1. The term "spouse" means the spouse of the ***employee*** under a legally valid existing marriage with a person of the opposite sex, unless court ordered separation exists.

2. The term "child" means the ***employee's*** natural child, stepchild, legally adopted child, foster child, provided:

   a. The child is less than nineteen (19) years of age (end of calendar year in which $19^{th}$ birthday occurs), and qualifies as a tax dependent under IRC Section 152 (amounts received under accident and health plans), and;

   b. The child is unmarried, and;

   c. The child is principally dependent upon the ***employee*** for support and maintenance, and;

   d. The child is listed as an exemption on the most current Federal Income Tax Return, and;

   e. The child is not regularly employed by one or more employers on a full-time basis, exclusive of scheduled vacation periods.

3. An eligible child shall also include any other child of an ***employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan***, even if the child is not residing in the ***employee's*** household. Such child shall be referred to as an ***alternate recipient***. ***Alternate recipients*** are eligible for coverage regardless of whether the ***employee*** elects coverage for himself. An application for enrollment must be submitted to the ***employer*** for coverage under this ***Plan***. The ***employer/plan administrator*** shall establish written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under the ***Plan*** pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the ***employer/plan administrator*** shall determine whether such order is a Qualified Medical Child Support Order (QMCSO), as defined in Section 609 of ERISA, or a National Medical Support Notice (NMSN), as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.

   The ***employer/plan administrator*** reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency.

4. Adopted children, who are less than eighteen (18) years of age at the time of adoption, shall be considered eligible from the date the child is ***placed for adoption***.

5. Upon written notice to the ***employer***, a child who has reached his or her nineteenth (19th) birthday (end of calendar year) and is principally dependent upon the ***employee*** for support and maintenance and is listed as an exemption on the most current Federal Income Tax Return, may also be included herein as an eligible ***dependent*** until the child's twenty-fourth (24th) birthday, provided such child is unmarried, qualifies as a tax dependent under IRC Section 152 (amounts received under accident and health plans) and is a ***full-time student*** or ***part-time student*** (during each of at least five (5) calendar months in a tax year) in a secondary school, accredited college, university or institution of higher learning and is not regularly employed by one or more employers on a full-time basis, exclusive of scheduled vacation periods. It is the ***employee's*** responsibility to provide the ***claims processor*** with proof of ***full-time*** or ***part-time student status*** for each semester. The ***employee*** must notify the ***employer*** when the ***dependent*** is no longer a ***full-time student*** or ***part-time student***.

6. A child who is unmarried, incapable of self-sustaining employment, and dependent upon the ***employee*** for support due to a mental and/or physical disability, and who was covered under the ***Plan*** prior to reaching age nineteen (19) (end of calendar year) or due to other loss of ***dependent's*** eligibility and who lives with the ***employee***, will remain eligible for coverage under this ***Plan*** beyond the date coverage would otherwise be lost.

   Proof of incapacitation must be provided within thirty-one (31) days of the child's loss of eligibility and thereafter as requested by the ***employer*** or ***claims processor***, but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

   a. Cessation of the mental and/or physical disability;

   b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Every eligible ***employee*** may enroll eligible ***dependents***. However, if both the husband and wife are ***employees***, they may choose to have one covered as the ***employee***, and the spouse covered as the ***dependent*** of the ***employee***, or they may choose to have both covered as ***employees***. An ***employee*** cannot be covered as an ***employee*** and a ***dependent***. Eligible children may be enrolled as ***dependents*** of one spouse, but not both.

## *DEPENDENT ENROLLMENT*

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

## *DEPENDENT(S) EFFECTIVE DATE*

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

1. The date the ***employee's*** coverage becomes effective.

2. The date the ***dependent*** is acquired, provided any required contributions are made and the ***employee*** has applied for ***dependent*** coverage within thirty-one (31) days of the date acquired.

3. Newborn children will be considered a ***dependent*** under this ***Plan*** during the period of ***hospital confinement*** immediately following birth. For coverage under the ***Plan*** for the newborn beyond that date, the ***employee*** must submit an application for enrollment within thirty-one (31) days of birth.

4. Coverage for a newly adopted or to be adopted child shall be effective on the date the child is ***placed for adoption***.

## *SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)*

An ***employee*** or ***dependent*** who did not enroll for coverage under this ***Plan*** because he was covered under other group coverage or had health insurance coverage at the time he was initially eligible for coverage under this ***Plan***, may request a special enrollment period if he is no longer eligible for the other coverage. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

1. Termination of the other coverage (including exhaustion of COBRA benefits)

2. Cessation of employer contributions toward the other coverage

3. Legal separation or divorce

4. Termination of other employment or reduction in number of hours of other employment

5. Death of ***dependent*** or spouse

6. Cessation of other coverage because ***employee*** or ***dependent*** no longer resides or works in the service area and no other benefit package is available to the individual

7. Cessation of ***dependent*** status under other coverage and ***dependent*** is otherwise eligible under ***employee's Plan***

8. A claim that would exceed the other coverage's lifetime limit is ***incurred***. The lifetime limit is all-inclusive and means that no further benefits are payable under the other coverage because the specific total benefit pay out lifetime maximum has been reached under the other coverage. The right for special enrollment continues for thirty (30) days after the date the claim is denied under the other coverage

The end of any extended benefits period, which has been provided due to any of the above, will also be considered a loss of eligibility.

However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage).

The ***employee*** or ***dependent*** must request the special enrollment and enroll no later than thirty-one (31) days from the date of loss of other coverage.

The ***effective date*** of coverage as the result of a special enrollment shall be the date of loss of other coverage.

## *SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)*

An ***employee*** who is not covered under the ***Plan***, but who acquires a new ***dependent*** may request a special enrollment period. For the purposes of this provision, the acquisition of a new ***dependent*** includes:

- marriage
- birth of a ***dependent*** child
- adoption or ***placement for adoption*** of a ***dependent*** child

The ***employee*** must request the special enrollment within thirty-one (31) days of the acquisition of the ***dependent***.

The ***effective date*** of coverage as the result of a special enrollment shall be:

1. in the case of marriage, the date of such marriage;

2. in the case of a ***dependent's*** birth, the date of such birth;

3. in the case of adoption or ***placement for adoption***, the date of such adoption or ***placement for adoption***.

Coverage will be effective for the ***dependents***, and for the ***employee*** if the ***employee*** is eligible to be enrolled under this ***Plan*** but failed to enroll during a previous enrollment period, as follows:

1. When coverage is requested to add a newborn, adopted child or child ***placed for adoption***, coverage will be offered to the ***employee***, eligible spouse, and all other eligible ***dependents*** in addition to the newly acquired child. Coverage will become effective for the ***employee***, spouse and all other eligible ***dependents*** in addition to the newly acquired child retroactive to the date of birth, adoption or ***placement for adoption***.

2. When coverage is requested to add ***dependents*** acquired due to marriage, coverage will be offered to the ***employee***, spouse and all other eligible ***dependents*** acquired as a result of the marriage. Coverage will become effective for the ***employee***, spouse and all other eligible ***dependents*** acquired as a result of the marriage retroactive to the date of the marriage.

## *OPEN ENROLLMENT*

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

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

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

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

1. Change in family status. A change in family status shall include only:

   a. Change in ***employee's*** legal marital status;

   b. Change in number of ***dependents***;

   c. Termination or commencement of employment by the ***employee***, spouse or ***dependent***;

   d. Change in work schedule;

   e. ***Dependent*** satisfies (or ceases to satisfy) ***dependent*** eligibility requirements;

   f. Change in residence or worksite of ***employee***, spouse or ***dependent***.

2. Change in the cost of coverage under the ***employer's*** group medical plan.

3. Cessation of required contributions.

4. Taking or returning from a ***leave of absence*** under the Family and Medical Leave Act of 1993.

5. Significant change in the health coverage of the ***employee*** or spouse attributable to the spouse's employment.

6. A Special Enrollment Period as mandated by the Health Insurance Portability and Accountability Act of 1996.

7. A court order, judgment or decree.

8. Entitlement to ***Medicare*** or Medicaid.

9. A COBRA qualifying event.

# PRE-EXISTING CONDITIONS

A ***pre-existing condition*** is an ***illness*** or ***injury*** which existed within ninety (90) days before the ***covered person's enrollment date*** for coverage under this ***Plan***. An ***illness*** or ***injury*** is considered to have existed when the ***covered person***:

1. Sought or received professional advice for that ***illness*** or ***injury***, or

2. Received medical care or treatment for that ***illness*** or ***injury***, or

3. Received medical supplies, drugs, or medicines for that ***illness*** or ***injury***.

Benefits will be provided for ***pre-existing conditions*** after the completion of a period of twelve (12) months from the ***covered person's enrollment date*** for coverage under this ***Plan***. The ***enrollment date*** shall mean the first day of any applicable service waiting period or the date of hire or, in the case of a Special Enrollment Period or Open Enrollment Period, the date the enrollment form is executed.

This ***pre-existing condition*** limitation shall not apply to a child born to or ***placed for adoption*** under the Special Enrollment provisions of the ***Plan*** for ***dependent*** acquisitions, or to ***pregnancy*** under any circumstances.

Pre-certification from the ***Health Care Management Organization*** does not constitute ***Plan*** liability for any ***pre-existing condition*** charges during this ***pre-existing condition*** limitation period.

The ***covered person*** has a right to appeal the determination of coverage for ***pre-existing conditions***. Refer to the *Medical/Dental Claim Filing Procedure* section of this document.

For the purpose of determining whether this ***pre-existing condition*** provision of the ***Plan*** will be applied to claims for any individual, the ***plan administrator*** will look not only to the period of time the individual has been covered under this ***Plan***, but also to any period of previous creditable coverage the individual has earned. Creditable coverage shall include, but is not limited to, coverage the individual may have had under a prior employer's benefit plan or COBRA, individual or group insurance, ***Medicare*** or Medicaid, a state risk pool, or CHAMPUS/TRICARE. Other types of coverage may also be considered creditable coverage. However, creditable coverage will only be applied to this ***Plan's pre-existing condition*** time periods if there has been no break in coverage of the individual for sixty-three (63) days or more. If there has been a break in coverage of sixty-three (63) days or more, the ***plan administrator*** will not apply previous coverage towards this ***Plan's pre-existing condition*** limitation. Waiting periods for coverage do not count as a break in coverage.

It is the ***employee's*** responsibility to provide the ***plan administrator*** with evidence of creditable coverage. Such evidence may be in the form of a Certificate of Coverage or in any other form acceptable to the ***plan administrator***.

However, this limitation does not apply to the first $1,000 of such expenses.

# TERMINATION OF COVERAGE

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

## *TERMINATION OF EMPLOYEE COVERAGE*

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

## *TERMINATION OF DEPENDENT(S) COVERAGE*

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health plan.
2. The date the ***employee's*** coverage terminates. However, if the ***employee*** remains eligible for the ***Plan***, but elects to discontinue coverage, coverage may be extended for ***alternate recipients***.
3. The date such person ceases to meet the eligibility requirements of the ***Plan***.
4. The date the ***employee*** ceases to make any required contributions on the ***dependent's*** behalf.
5. The end of the calendar year in which a child has reached his or her nineteenth ($19^{th}$) birthday and fails to meet the ***full-time*** or ***part-time student*** criteria.
6. Cessation of ***full-time*** or ***part-time student status*** for ***dependent*** children age nineteen (19) or older shall terminate coverage on the earliest of the following dates:
    a. The last day of the month in which the ***dependent*** is no longer a ***full-time*** or ***part-time student***.
    b. The last day of the month the school reconvenes after school vacation, if the ***dependent*** fails to meet the ***full-time*** or ***part-time student*** criteria.
    c. The last day of the month in which graduation occurs.
    d. The date the ***dependent*** reaches the ***full-time*** or ***part-time student status*** age as stated in *Dependent(s) Eligibility*.
7. The date the ***dependent*** becomes a full-time, active member of the armed forces of any country.
8. The date the ***Plan*** discontinues ***dependent*** coverage for any and all ***dependents***.

## *LEAVE OF ABSENCE*

Coverage may be continued for a limited time in accordance with the City of Bowling Green policies.

## *FAMILY AND MEDICAL LEAVE ACT (FMLA)*

Coverage under this ***Plan*** during a period of Family and Medical Leave Act ***leave of absence*** shall be in accordance with the City of Bowling Green policies.

## *EMPLOYEE REINSTATEMENT*

An ***employee*** who returns to work following an unapproved ***leave of absence***, ***layoff***, or termination of employment will be considered a new ***employee*** for purposes of eligibility and will be subject to all eligibility requirements, including all requirements relating to the ***effective date*** of coverage and the ***pre-existing condition*** limitations.

Coverage under this ***Plan*** during a period while an ***employee*** is either on or is returning from an approved unpaid ***leave of absence*** shall be in accordance with City of Bowling Green policies. If an ***employee*** fails to pay for medical and/or dental coverage in accordance with City policy while on an approved, unpaid ***leave of absence*** upon returning to work the ***employee*** will be considered a new ***employee*** for eligibility and will be subject to all eligibility requirements.

## *CERTIFICATES OF COVERAGE*

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

# CONTINUATION OF COVERAGE

In order to comply with federal regulations, this ***Plan*** includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Public Health Services Act. This continuation of coverage may be commonly referred to as "COBRA coverage" or "continuation coverage."

The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes medical, prescription drug and dental benefits as provided under the ***Plan***.

## *QUALIFYING EVENTS*

Qualifying events are any one of the following events that would cause a ***covered person*** to lose coverage under this ***Plan*** or cause an increase in required contributions, even if such loss of coverage or increase in required contributions does not take effect immediately, and allow such person to continue coverage beyond the date described in *Termination of Coverage*:

1. Death of the ***employee***.

2. The ***employee's*** termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the ***Plan***. This event is referred to below as an "18-Month Qualifying Event."

3. Divorce or legal separation from the ***employee***.

4. The ***employee's*** entitlement to ***Medicare*** benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this ***Plan***.

5. A ***dependent*** child no longer meets the eligibility requirements of the ***Plan***.

6. The last day of leave under the Family and Medical Leave Act of 1993, or an earlier date on which the ***employee*** informs the ***employer*** that he or she will not be returning to work.

7. The call-up of an ***employee*** reservist to active duty.

## *NOTIFICATION REQUIREMENTS*

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered ***employee***, or a child's loss of ***dependent*** status, the ***employee*** or ***dependent*** must submit a completed Qualifying Event Notification form to the ***plan administrator*** (or its designee) within sixty (60) days of the latest of:

   a. The date of the event;

   b. The date on which coverage under this ***Plan*** is or would be lost as a result of that event; or

   c. The date on which the ***employee*** or ***dependent*** is furnished with a copy of this Plan Document.

   A copy of the Qualifying Event Notification form is available from the ***plan administrator*** (or its designee). In addition, the ***employee*** or ***dependent*** may be required to promptly provide any supporting documentation as may be reasonably requested for purposes of verification. Failure to provide such notice

and any requested supporting documentation will result in the person forfeiting their rights to continuation of coverage under this provision.

Within fourteen (14) days of the receipt of a properly completed Qualifying Event Notification, the ***plan administrator*** (or its designee) will notify the ***employee*** or ***dependent*** of his rights to continuation of coverage, and what process is required to elect continuation of coverage. This notice is referred to below as "Election Notice."

2. When eligibility for continuation of coverage results from any qualifying event under this ***Plan*** other than the ones described in Paragraph 1 above, the ***employer*** must notify the ***plan administrator*** (or its designee) not later than thirty (30) days after the date on which the ***employee*** or ***dependent*** loses coverage under the ***Plan*** due to the qualifying event. Within fourteen (14) days of the receipt of the notice of the qualifying event, the ***plan administrator*** (or its designee) will furnish the Election Notice to the ***employee*** or ***dependent***.

3. In the event it is determined that an individual seeking continuation of coverage (or extension of continuation coverage) is not entitled to such coverage, the ***plan administrator*** (or its designee) will provide to such individual an explanation as to why the individual is not entitled to continuation coverage. This notice is referred to here as the "Non-Eligibility Notice." The Non-Eligibility Notice will be furnished in accordance with the same time frame as applicable to the furnishing of the Election Notice.

4. In the event an Election Notice is furnished, the eligible ***employee*** or ***dependent*** has sixty (60) days to decide whether to elect continued coverage. Each person who is described in the Election Notice and was covered under the ***Plan*** on the day before the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the ***employee*** or ***dependent*** chooses to have continuation coverage, he must advise the ***plan administrator*** (or its designee) of this choice by returning to the ***plan administrator*** (or its designee) a properly completed Election Notice not later than the last day of the sixty (60) day period. If the Election Notice is mailed to the ***plan administrator*** (or its designee), it must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the later of the following:

   a. The date coverage under the ***Plan*** would otherwise end; or

   b. The date the person receives the Election Notice from the ***plan administrator*** (or its designee).

5. Within forty-five (45) days after the date the person notifies the ***plan administrator*** (or its designee) that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continuation coverage are to be made monthly, and are due in advance, on the first day each month.

## *COST OF COVERAGE*

1. The ***Plan*** requires that ***covered persons*** pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. Except for the initial payment (see above), payments must be remitted to the ***plan administrator*** (or its designee) by or before the first day of each month during the continuation period. The payment must be remitted on a timely basis in order to maintain the coverage in force.

2. For a person originally covered as an ***employee*** or as a spouse, the cost of coverage is the amount applicable to an ***employee*** if coverage is continued for himself alone. For a person originally covered as a child and continuing coverage independent of the family unit, the cost of coverage is the amount applicable to an ***employee***.

## *WHEN CONTINUATION COVERAGE BEGINS*

When continuation coverage is elected and the initial payment is made within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for ***dependents*** acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the ***Plan***.

## *FAMILY MEMBERS ACQUIRED DURING CONTINUATION*

A spouse or ***dependent*** child newly acquired during continuation coverage is eligible to be enrolled as a ***dependent***. The standard enrollment provision of the ***Plan*** applies to enrollees during continuation coverage. A ***dependent*** acquired and enrolled after the original qualifying event, other than a child born to or ***placed for adoption*** with a covered ***employee*** during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

## *EXTENSION OF CONTINUATION COVERAGE*

1. In the event any of the following events occur during the period continuation coverage resulting from an 18-Month Qualifying Event, it is possible for a ***dependent's*** continuation coverage to be extended:

   a. Death of the ***employee***.

   b. Divorce or legal separation from the ***employee***.

   c. The child's loss of ***dependent*** status.

   Written notice of such event must be provided by submitting a completed Additional Extension Event Notification form to the ***plan administrator*** (or its designee) within sixty (60) days of the latest of:

   a. The date of that event;

   b. The date on which coverage under this ***Plan*** would be lost as a result of that event if the first qualifying event had not occurred; or

   c. The date on which the ***employee*** or ***dependent*** is furnished with a copy of this Plan Document.

   A copy of the Additional Extension Event Notification form is available from the ***plan administrator*** (or its designee). In addition, the ***dependent*** may be required to promptly provide any supporting documentation as may be reasonably required for purposes of verification. Failure to properly provide the Additional Extension Event Notification and any requested supporting documentation will result in the person forfeiting their rights to extend continuation coverage under this provision. In no event will any extension of continuation coverage extend beyond thirty-six (36) months from the later of the date of the first qualifying event or the date as of which continuation coverage began.

   Only a person covered prior to the original qualifying event or a child born to or ***placed for adoption*** with a covered ***employee*** during a period of COBRA coverage may be eligible to continue coverage through an extension of continuation coverage as described above. Any other ***dependent*** acquired during continuation coverage is not eligible to extend continuation coverage as described above.

2. A person who loses coverage on account of an 18-Month Qualifying Event may extend the maximum period of continuation coverage from eighteen (18) months to up to twenty-nine (29) months in the event both of the following occur:

a. That person (or another person who is entitled to continuation coverage on account of the same 18-Month Qualifying Event) is determined by the Social Security Administration, under Title II or Title XVI of the Social Security Act, to have been disabled before the sixtieth ($60^{th}$) day of continuation coverage; and

b. The disability status, as determined by the Social Security Administration, lasts at least until the end of the initial eighteen (18) month period of continuation coverage.

The disabled person (or his representative) must submit written proof of the Social Security Administration's disability determination to the ***plan administrator*** (or its designee) within the initial eighteen (18) month period of continuation coverage and no later than sixty (60) days after the latest of:

a. The date of the disability determination by the Social Security Administration;

b. The date of the 18-Month Qualifying Event;

c. The date on which the person loses (or would lose) coverage under this ***Plan*** as a result of the 18-Month Qualifying Event; or

d. The date on which the person is furnished with a copy of this Plan Document.

Should the disabled person fail to notify the ***plan administrator*** (or its designee) in writing within the time frame described above, the disabled person (and others entitled to disability extension on account of that person) will then be entitled to whatever period of continuation he or they would otherwise be entitled to, if any. The ***Plan*** may require that the individual pay one hundred and fifty percent (150%) of the cost of continuation coverage during the additional eleven (11) months of continuation coverage. In the event the Social Security Administration makes a final determination that the individual is no longer disabled, the individual must provide notice of that final determination no later than thirty (30) days after the later of:

a. The date of the final determination by the Social Security Administration; or

b. The date on which the individual is furnished with a copy of this Plan Document.

## *END OF CONTINUATION*

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months (or twenty-nine (29) months if continuation coverage is extended due to certain disability status as described above) from the date continuation began because of an 18-Month Qualifying Event or the last day of leave under the Family and Medical Leave Act of 1993.

2. Twenty-four (24) months from the date continuation began because of the call-up to military duty.

3. Thirty-six (36) months from the date continuation began for ***dependents*** whose coverage ended because of the death of the ***employee***, divorce or legal separation from the ***employee***, or the child's loss of ***dependent*** status.

4. The end of the period for which contributions are paid if the ***covered person*** fails to make a payment by the date specified by the ***plan administrator*** (or its designee). In the event continuation coverage is terminated for this reason, the individual will receive a notice describing the reason for the termination of coverage, the effective date of termination, and any rights the individual may have under this ***Plan*** or under applicable law to elect an alternative group or individual coverage, such as a conversion right. This notice is referred to below as an "Early Termination Notice."

5. The date coverage under this ***Plan*** ends and the ***employer*** offers no other group health benefit plan. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

6. The date the ***covered person*** first becomes entitled, after the date of the ***covered person's*** original election of continuation coverage, to ***Medicare*** benefits under Title XVIII of the Social Security Act. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

7. The date the ***covered person*** first becomes covered under any other employer's group health plan after the original date of the ***covered person's*** election of continuation coverage, but only if such group health plan does not have any exclusion or limitation that affects coverage of the ***covered person's pre-existing condition***. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

8. For the spouse or ***dependent*** child of a covered ***employee*** who becomes entitled to ***Medicare*** prior to the spouse's or ***dependent's*** election for continuation coverage, thirty-six (36) months from the date the covered ***employee*** becomes entitled to ***Medicare***.

## *SPECIAL RULES REGARDING NOTICES*

1. Any notice required in connection with continuation coverage under this ***Plan*** must, at minimum, contain sufficient information so that the ***plan administrator*** (or its designee) is able to determine from such notice the ***employee*** and ***dependent(s)*** (if any), the qualifying event or disability, and the date on which the qualifying event occurred.

2. In connection with continuation coverage under this ***Plan***, any notice required to be provided by any individual who is either the ***employee*** or a ***dependent*** with respect to the qualifying event may be provided by a representative acting on behalf of the ***employee*** or the ***dependent***, and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.

3. As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:

    a. A single notice addressed to both the ***employee*** and the spouse will be sufficient as to both individuals if, on the basis of the most recent information available to the ***Plan***, the spouse resides at the same location as the ***employee***; and

    b. A single notice to the ***employee*** or the spouse will be sufficient as to each ***dependent*** child of the ***employee*** if, on the basis of the most recent information available to the ***Plan***, the ***dependent*** child resides at the same location as the individual to whom such notice is provided.

## *PRE-EXISTING CONDITIONS*

In the event that a ***covered person*** becomes eligible for coverage under another employer-sponsored group health plan, and that group health plan has an applicable exclusion or limitation regarding coverage of the ***covered person's pre-existing condition***, the ***covered person's*** continuation coverage under the ***Plan*** will not be affected by enrollment under that other group health plan. This ***Plan*** shall be primary payer for the ***covered expenses*** that are excluded or limited under the other employer sponsored group health plan and secondary payer for all other expenses.

## *MILITARY MOBILIZATION*

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

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

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

1. Twenty-four (24) months beginning on the day that the leave commences, or

2. A period beginning on the day that the leave began and ending on the day after the ***employee*** fails to return to employment within the time allowed.

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

## *PLAN CONTACT INFORMATION*

Questions concerning this ***Plan***, including any available continuation coverage, can be directed to the ***plan administrator***.

## *ADDRESS CHANGES*

In order to help ensure the appropriate protection of rights and benefits under this ***Plan***, ***covered persons*** should keep the ***plan administrator*** (or its designee) informed of any changes to their current addresses.

# MEDICAL/DENTAL CLAIM FILING PROCEDURE

A "pre-service claim" is a claim for a ***Plan*** benefit that is subject to the prior certification rules, as described in the section, *Pre-Service Claim Procedure*. All other claims for ***Plan*** benefits are "post-service claims" and are subject to the rules described in the section, *Post-Service Claim Procedure.*

## POST-SERVICE CLAIM PROCEDURE

### *FILING A CLAIM*

1. A claim form is to be completed for each covered family member at the beginning of the calendar year and for each claim involving an ***injury***. Appropriate claim forms are available from the Personnel Department.

2. ***Preferred Provider Organization*** (PPO) claims should be submitted to the ***Preferred Provider Organization*** which is identified on the employee identification card and shown below:

   Medical Mutual of Ohio
   P. O. Box 94648
   Cleveland, OH 44101-4648

   All other claims should be submitted to the ***claims processor*** at the address noted below:

   CoreSource, Inc.
   P.O. Box 279
   Sheldon, IA 51201-0279

   The date of receipt will be the date the claim is received by the ***claims processor***.

3. All claims submitted for benefits must contain all of the following:

   a. Name of patient.
   b. Patient's date of birth.
   c. Name of ***employee***.
   d. Address of ***employee***.
   e. Name of ***employer*** and group number.
   f. Name, address and tax identification number of provider.
   g. ***Employee*** Social Security Number.
   h. Date of service.
   i. Diagnosis (applies to medical claims ONLY).
   j. Description of service and procedure number.
   k. Charge for service.
   l. The nature of the ***accident***, ***injury*** or ***illness*** being treated.

4. All claims not submitted within fifteen (15) months from the date the services were rendered will not be a ***covered expense*** and will be denied.

The ***covered person*** may ask the health care provider to submit the claim directly to the ***claims processor*** or to the ***Preferred Provider Organization*** as outlined above, or the ***covered person*** may submit the bill with a claim form. However, it is ultimately the ***covered person's*** responsibility to make sure the claim for benefits has been filed.

## *NOTICE OF AUTHORIZED REPRESENTATIVE*

The ***covered person*** may provide the ***plan administrator*** or their designee with a written authorization for an authorized representative to represent and act on behalf of a ***covered person*** and consent to the release of information related to the ***covered person*** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Personnel Department.

## *NOTICE OF CLAIM*

A claim for benefits should be submitted to the ***claims processor*** within ninety (90) calendar days after the occurrence or commencement of any services by the ***Plan***, or as soon thereafter as reasonably possible.

Failure to file a claim within the time provided shall not invalidate or reduce a claim for benefits if: (1) it was not reasonably possible to file a claim within that time; and (2) that such claim was furnished as soon as possible, but no later than fifteen (15) months after the loss occurs or commences, unless the claimant is legally incapacitated.

Notice given by or on behalf of a ***covered person*** or his beneficiary, if any, to the ***plan administrator*** or to any authorized agent of the ***Plan***, with information sufficient to identify the ***covered person***, shall be deemed notice of claim.

## *TIME FRAME FOR BENEFIT DETERMINATION*

After a completed claim has been submitted to the ***claims processor***, and no additional information is required, the ***claims processor*** will generally complete its determination of the claim within thirty (30) calendar days of receipt of the completed claim unless an extension is necessary due to circumstances beyond the ***Plan's*** control.

After a completed claim has been submitted to the ***claims processor***, and if additional information is needed for determination of the claim, the ***claims processor*** will provide the ***covered person*** (or authorized representative) with a notice detailing information needed. The notice will be provided within thirty (30) calendar days of receipt of the completed claim and will state the date as of which the ***Plan*** expects to make a decision. The ***covered person*** will have forty-five (45) calendar days to provide the information requested, and the ***Plan*** will complete its determination of the claim within fifteen (15) calendar days of receipt by the ***claims processor*** of the requested information. Failure to respond in a timely and complete manner will result in the denial of benefit payment.

## *NOTICE OF BENEFIT DENIAL*

If the claim for benefits is denied, the ***plan administrator*** or their designee shall provide the ***covered person*** or authorized representative with a written Notice of Benefit Denial within the time frames described immediately above.

The Notice of Benefit Denial shall include an explanation of the denial, including:

1. The specific reasons for the denial.

2. Reference to the ***Plan*** provisions on which the denial is based.

3. A description of any additional material or information needed and an explanation of why such material or information is necessary.

4. A description of the ***Plan's*** claim review procedure and applicable time limits.

5. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Denial will contain either:

   a. A copy of that criterion, or

   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

6. If denial was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***Plan*** will supply either:

   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or

   b. A statement that such explanation will be supplied free of charge, upon request.

## *APPEALING A DENIED POST-SERVICE CLAIM*

The "***named fiduciary***" for purposes of an appeal of a Post-Service Claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the ***claims processor***.

A ***covered person***, or the ***covered person's*** authorized representative, may request a review of a denied claim by making written request to the ***named fiduciary*** within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the ***covered person*** feels the claim should not have been denied.

The following describes the review process and rights of the ***covered person***:

1. The ***covered person*** has a right to submit documents, information and comments.

2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.

3. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.

4. The review by the ***named fiduciary*** will not afford deference to the original denial.

5. The ***named fiduciary*** will not be:

   a. The individual who originally denied the claim, nor

   b. Subordinate to the individual who originally denied the claim.

6. If original denial was, in whole or in part, based on medical judgment:

   a. The ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment; and

   b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:

      i. An individual who was consulted in connection with the original denial of the claim, nor

      ii. A subordinate of any other ***professional provider*** who was consulted in connection with the original denial.

7. If requested, the ***named fiduciary*** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

## *NOTICE OF BENEFIT DETERMINATION ON APPEAL*

The ***plan administrator*** or their designee shall provide the ***covered person*** (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the denial.

2. Reference to specific ***Plan*** provisions on which the denial is based.

3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.

4. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:

   a. A copy of that criterion, or

   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

5. If the denial was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***Plan*** will supply either:

   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or

   b. A statement that such explanation will be supplied free of charge, upon request.

## *RIGHT TO EXTERNAL REVIEW OF DENIED CLAIMS – POST SERVICE APPEAL* (Including reduction or termination of coverage)

Once the internal appeal process has been exhausted and the initial denial or reduction of benefits has been upheld, the ***covered person*** or authorized representative has the right to request a review by the Ohio Superintendent of Insurance.

1. The following conditions must be met by the ***covered person*** to request an external review through the Ohio Department of Insurance:

   a. The ***Plan*** has determined the service the ***covered person*** wants is not ***medically necessary***; and

   b. The ***covered person's professional provider*** documents that the service will cost the ***covered person*** more than $500 if not covered; and

   c. The ***covered person*** requests external review within 60 days of being notified about the ***Plan***'s appeal decision.

2. The ***covered person*** must submit a request for external review in writing (note process for expedited review below) within 60 days of Notice of Benefit Determination on Appeal to:

   Superintendent of Insurance<br>
   Consumer Services Division<br>
   Ohio Department of Insurance<br>
   2100 Stella Court<br>
   Columbus, OH 43215-1067

3. Once received, the Ohio Superintendent shall consider whether the service is a ***covered expense*** under the ***Plan***. The Ohio Superintendent will notify the ***covered person*** and the ***Plan*** of its determination or advise that it is not able to make a determination because of a medical issue.

4. If the Ohio Superintendent of Insurance determines that it is a ***covered expense***, the ***Plan*** must either pay the ***covered expense*** or allow the ***covered person*** an external review.

5. If the Ohio Superintendent determines it is not a ***covered expense***, the ***Plan*** is not required to offer an external review.

6. If the Ohio Superintendent cannot make a determination for the reason that a decision requires resolution of a medical issue, the ***Plan*** must allow an opportunity for an external review at its expense.

7. If review for ***medical necessity*** is required, the Ohio Superintendent will assign an Independent Review Organization (IRO) which has been accredited through the Ohio Department of Insurance.

8. A written decision will be issued not later than thirty days after the filing of the request for review. The IRO shall send a copy of its decision to the ***Plan*** and the ***covered person***.

## *EXPEDITED REVIEW*

If the ***covered person***'s condition requires expedited review, the review may be requested orally or by electronic means. Written confirmation of such request shall be submitted to the ***Plan*** not later than five days after the oral or electronic request is submitted. A decision will be made within seven days of receipt by IRO from when all necessary information is received. For expedited review, the ***covered person's professional provider*** must certify that the ***covered person's*** condition could, in the absence of immediate medical attention, resulting in any of the following:

1. Placing the health of the ***covered person*** or, with respect to a pregnant woman, the health of the ***covered person*** or the unborn child, in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

A written decision will be issued not later than seven days after the filing of the request for review. The IRO shall send a copy of its decision to the ***Plan*** and the ***covered person***.

## *EXTERNAL REVIEW FOR TERMINAL ILLNESS*

The ***Plan*** allows for an external review when:

1. The ***professional provider*** concludes the illness is likely to cause death within two years; AND
2. The ***professional provider*** gives written opinion that:
    a. Standard treatments have not helped OR

    b. Standard treatments are not medically appropriate OR

    c. No standard treatment works as well as some other treatment; AND

3. Coverage was denied because the ***Plan*** considered the ***professional provider's*** recommended treatment ***experimental***; AND

4. The ***Plan***'s internal appeal process has already denied coverage for the treatment.

## *FOREIGN CLAIMS*

In the event a ***covered person*** incurs a ***covered expense*** in a foreign country, the ***covered person*** shall be responsible for providing the following information to the ***claims processor*** before payment of any benefits due are payable.

1. The claim form, provider invoice and any documentation required to process the claim must be submitted in the English language.

2. The charges for services must be converted into U.S. dollars.

3. A current published conversion chart, validating the conversion from the foreign country's currency into U.S. dollars, must be submitted with the claim.

# PRE-SERVICE CLAIM PROCEDURE

## *HEALTH CARE MANAGEMENT*

***Health care management*** is the process of evaluating whether proposed services, supplies or treatments are ***medically necessary*** and appropriate to help ensure quality, cost-effective care.

Certification of ***medical necessity*** and appropriateness by the ***Health Care Management Organization*** does not establish eligibility under the ***Plan*** nor guarantee benefits.

## *FILING A PRE-CERTIFICATION CLAIM*

All ***inpatient*** admissions and partial hospitalizations are to be certified by the ***Health Care Management Organization***. For non-urgent care, the ***covered person*** or their authorized representative must call the ***Health Care Management Organization*** at least fifteen (15) calendar days prior to initiation of services. If the ***Health Care Management Organization*** is not called at least fifteen (15) calendar days prior to initiation of services for non-urgent care, benefits may be reduced. For ***urgent care***, the ***covered person*** or their authorized representative must call the ***Health Care Management Organization*** within forty-eight (48) hours or the next business day, whichever is later, after the initiation of services. Please note that if the ***covered person*** needs medical care that would be considered as ***urgent care***, then there is no requirement that the ***Plan*** be contacted for prior approval.

***Covered persons*** **shall contact the** ***Health Care Management Organization*** **by calling:**

**1-800-480-6658**

When a ***covered person*** (or authorized representative) calls the ***Health Care Management Organization***, he or she should be prepared to provide all of the following information:

1. ***Employee's*** name, address, phone number and Social Security Number.
2. ***Employer's*** name.
3. If not the ***employee***, the patient's name, address, phone number.
4. Admitting ***physician's*** name and phone number.
5. Name of ***facility***.
6. Date of admission or proposed date of admission.
7. Condition for which patient is being admitted.

*Group health plans generally may not, under federal law, restrict benefits for any* ***hospital*** *length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally*

*does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the* ***Plan*** *for prescribing a length of stay not in excess of the above periods.*

However, ***hospital*** maternity stays in excess of forty-eight (48) or ninety-six (96) hours as specified above must be precertified.

If the ***covered person*** (or authorized representative) fails to contact the ***Health Care Management Organization*** prior to the hospitalization and within the timelines detailed above, the amount the ***Plan*** may pay for ***covered expenses incurred*** shall be reduced by twenty percent (20%) to a maximum of $2,000 per calendar year. If the ***Health Care Management Organization*** declines to grant the full pre-certification requested, benefits for days not certified as ***medically necessary*** by the ***Health Care Management Organization*** shall be denied. (Refer to *Post-Service Claim Procedure* discussion above.)

## *NOTICE OF AUTHORIZED REPRESENTATIVE*

The ***covered person*** may provide the ***plan administrator*** or their designee with a written authorization for an authorized representative to represent and act on behalf of a ***covered person*** and consent to release of information related to the ***covered person*** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Personnel Department.

## *TIME FRAME FOR PRE-SERVICE CLAIM DETERMINATION*

1. In the event the ***Plan*** receives from the ***covered person*** (or authorized representative) a communication that fails to follow the pre-certification procedure as described above but communicates at least the name of the ***covered person***, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the ***covered person*** (or the authorized representative) will be orally notified (and in writing if requested), within five (5) calendar days of the failure of the proper procedure to be followed.

2. After a completed pre-certification request for non-urgent care has been submitted to the ***Plan***, and if no additional information is required, the ***Plan*** will generally complete its determination of the claim within a reasonable period of time, but no later than fifteen (15) calendar days from receipt of the request.

3. After a pre-certification request for non-urgent care has been submitted to the ***Plan***, and if an extension of time to make a decision is necessary due to circumstances beyond the control of the ***Plan***, the ***Plan*** will, within fifteen (15) calendar days from receipt of the request, provide the ***covered person*** (or authorized representative) with a notice detailing the circumstances and the date by which the ***Plan*** expects to render a decision. If the circumstances include a failure to submit necessary information, the notice will specifically describe the needed information. The ***covered person*** will have forty-five (45) calendar days to provide the information requested, and the ***Plan*** will complete its determination of the claim no later than fifteen (15) calendar days after receipt by the ***Plan*** of the requested information. Failure to respond in a timely and complete manner will result in a denial.

## ***CONCURRENT CARE CLAIMS***

If an extension beyond the original certification is required, the ***covered person*** (or authorized representative) shall call the ***Health Care Management Organization*** for continuation of certification.

1. If a ***covered person*** (or authorized representative) requests to extend a previously approved hospitalization or an ongoing course of treatment, and;

    a. The request involves non-urgent care, then the extension request must be processed within fifteen (15) calendar days after the request was received.

    b. The ***inpatient*** admission or ongoing course of treatment involves ***urgent care***, and

        i. The request is received at least twenty-four (24) hours before the scheduled end of a hospitalization or course of treatment, then the request must be ruled upon and the ***covered person*** (or authorized representative) notified as soon as possible taking into consideration medical exigencies but no later than twenty-four (24) hours after the request was received; or

        ii. The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment, then the request must be ruled upon and the ***covered person*** (or authorized representative) notified as soon as possible but no later than seventy-two (72) hours after the request was received; or.

        iii. The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment and additional information is required, the covered person (or authorized representative) will be notified within twenty-four (24) hours of requesting additional information. The ***covered person*** (or authorized representative) has forty-eight (48) hours to provide such information (may be oral unless written requested). Upon timely response, the ***covered person*** (or authorized representative) will be notified as soon as possible but no later than forty-eight (48) hours after receipt of additional information. Failure to submit requested information timely will result in a denial of such request.

If the ***Health Care Management Organization*** determines that the ***hospital*** stay or course of treatment should be shortened or terminated before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved, then the ***Health Care Management Organization*** shall:

1. Notify the ***covered person*** of the proposed change, and

2. Allow the ***covered person*** to file an appeal and obtain a decision, before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved.

If, at the end of a previously approved hospitalization or course of treatment, the ***Health Care Management Organization*** determines that continued ***confinement*** is no longer ***medically necessary***, additional days will not be certified. (Refer to *Appealing a Denied Pre-Service Claim* discussion below.)

## *NOTICE OF PRE-SERVICE CLAIM DENIAL*

If a pre-certification request is denied in whole or in part, the ***plan administrator*** or their designee shall provide the ***covered person*** (or authorized representative) with a written Notice of Pre-Service Denial within the time frames above.

The Notice of Pre-Service Denial shall include an explanation of the denial, including:

1. The specific reasons for the denial.
2. Reference to the ***Plan*** provisions on which the denial is based.
3. A description of any additional material or information needed and an explanation of why such material or information is necessary.
4. A description of the ***Plan's*** claim review procedure and applicable time limits.
5. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Denial will contain either:
    a. A copy of that criterion, or
    b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
6. If denial was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***Plan*** will supply either:
    a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
    b. A statement that such explanation will be supplied free of charge, upon request.

## *APPEALING A DENIED PRE-SERVICE CLAIM*

The "***named fiduciary***" for purposes of an appeal of a Pre-Service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the ***claims processor***.

A ***covered person*** (or authorized representative) may request a review of a denied claim by making a written request to the ***named fiduciary*** within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the ***covered person*** feels the claim should not have been denied. If the ***covered person*** (or authorized representative) wishes to appeal the denial when the services in question have already been rendered, such an appeal will be considered as a separate post-service claim. (Refer to *Post-Service Claim Procedure* discussion above.)

The following describes the review process and rights of the ***covered person***:

1. The ***covered person*** has a right to submit documents, information and comments.
2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
3. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.
4. The review by the ***named fiduciary*** will not afford deference to the original denial.

5. The ***named fiduciary*** will not be:

   a. The individual who originally denied the claim, nor

   b. Subordinate to the individual who originally denied the claim.

6. If original denial was, in whole or in part, based on medical judgment:

   a. The ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment.

   b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:

      i. An individual who was consulted in connection with the original denial of the claim, nor

      ii. A subordinate of any other ***professional provider*** who was consulted in connection with the original denial.

7. If requested, the ***named fiduciary*** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

## *NOTICE OF PRE-SERVICE DETERMINATION ON APPEAL*

The ***plan administrator*** or their designee shall provide the ***covered person*** (or authorized representative) with a written Notice of Appeal Decision as soon as possible, but not later than thirty (30) calendar days from receipt of the appeal (not applicable to urgent care claims).

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the decision, including:

1. The specific reasons for the denial.

2. Reference to specific ***Plan*** provisions on which the denial is based.

3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.

4. A statement that the ***covered person*** has the right to access, free of charge, information about the voluntary appeal process.

5. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:

   a. A copy of that criterion, or

   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

6. If the denial was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***Plan*** will supply either:

   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or

   b. A statement that such explanation will be supplied free of charge, upon request.

## *SECOND LEVEL VOLUNTARY APPEAL*

The ***Health Care Management Organization***, upon request by the ***covered person*** (or authorized representative) following a pre-service determination on appeal, will conduct a second level voluntary appeal. This appeal is comprised of a panel of three ***professional providers*** that were not consulted in connection with the original pre-service denial. The ***covered person's*** decision as to whether to submit a previously denied appeal to the voluntary appeal process will have no effect on the ***covered person's*** rights to any other benefits under the ***Plan***. There are no fees or costs imposed as a condition to use of the voluntary appeal process.

Upon receipt of the request to conduct a voluntary appeal, a determination will be made within thirty (30) calendar days. Notification of the outcome of the review will be communicated verbally and in writing.

With respect to pre-service claims, the ***Plan*** agrees not to later assert a defense of failure to exhaust available administrative remedies against a ***covered person*** who chooses not to make use of the voluntary appeal process.

With respect to pre-service claims, the ***Plan*** agrees that any statute of limitations or other defense based on timelines is tolled while the dispute is under submission to the voluntary appeal process.

Upon written request, more information about the voluntary appeal process is available, free of charge, from the ***Health Care Management Organization***.

## *RIGHT TO EXTERNAL REVIEW OF DENIED PRE-SERVICE CLAIM*

(Including reduction or termination of coverage)

Once the internal appeal process has been exhausted and the initial denial or reduction of benefits has been upheld, the ***covered person*** or authorized representative has the right to request a review by the Ohio Superintendent of Insurance.

1. The following conditions must be met for the ***covered person*** to request an external review through the Ohio Department of Insurance:

    a. The ***Plan*** has determined the service the ***covered person*** requested is not ***medically necessary***; and

    b. The ***covered person's professional provider*** documents that the service will cost the ***covered person*** more than $500 if not covered; and

    c. The ***covered person*** request external review within 60 days of being notified about the ***Plan***'s appeal decision

2. The ***covered person*** must submit request for external review in writing (note process for expedited review below) within 60 days of Notice of Benefit Determination on Appeal to:

    Superintendent of Insurance
    Consumer Services Division
    Ohio Department of Insurance
    2100 Stella Court
    Columbus, OH 43215-1067

3. Once received, the Ohio Superintendent shall consider whether the service is a ***covered expense*** under the ***Plan***. The Ohio Superintendent will notify the ***covered person*** and the ***Plan*** of its determination or advise that it is not able to make a determination because of a medical issue.

4. If the Ohio Superintendent of Insurance determines that it is a ***covered expense***, the ***Plan*** must either pay the ***covered expense*** or allow ***covered person*** an external review.

5. If the Ohio Superintendent determines it is not a ***covered expense***, the ***Plan*** is not required to offer an external review.

6. If the Ohio Superintendent cannot make a determination for the reason that a decision requires resolution of a medical issue, the ***Plan*** must allow an opportunity for an external review at its expense.

7. If review for ***medical necessity*** is required, the Ohio Superintendent will assign an Independent Review Organization (IRO) which has been accredited through the Ohio Department of Insurance.

8. A written decision will be issued not later than thirty days after the filing of the request for review. The IRO shall send a copy of its decision to the ***Plan*** and the ***covered person***.

## *EXPEDITED REVIEW*

If the ***covered person***'s condition require expedited review, the review may be requested orally or by electronic means. Written confirmation of such request shall be submitted to the ***Plan*** not later than five days after the oral or electronic request is submitted. A decision will be made within seven days of receipt by and IRO from when all necessary information is received. For expedited review, the ***covered person's professional provider*** must certify that the ***covered person's*** condition could, in the absence of immediate medical attention, result in any of the following:

1. Placing the health of the ***covered person*** or, with respect to a pregnant woman, the health of the ***covered person*** or the unborn child, in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

A written decision will be issued not later than seven days after the filing of the request for review. The Independent Review Organization shall send a copy of its decision to the ***Plan*** and the ***covered person***.

## *EXTERNAL REVIEW FOR TERMINAL ILLNESS*

The ***Plan*** allows for an external review when:

1. The ***professional provider*** concludes the illness is likely to cause death within two years; AND

2. The ***professional provider*** gives written opinion that:

    a. Standard treatments have not helped OR

    b. Standard treatments are not medically appropriate OR

    c. No standard treatment works as well as some other treatment; AND

3. Coverage was denied because the ***Plan*** considered the ***professional provider's*** recommended treatment ***experimental***; AND

4. The ***Plan***'s internal appeal process has already denied coverage for the treatment.

## *CASE MANAGEMENT*

In cases where the ***covered person's*** condition is expected to be or is of a serious nature, the ***Health Care Management Organization*** may arrange for review and/or case management services from a professional qualified to perform such services. The ***plan administrator*** shall have the right to alter or waive the normal provisions of this ***Plan*** when it is reasonable to expect a cost effective result without a sacrifice to the quality of care.

In addition, the ***Health Care Management Organization*** may recommend (or change) alternative methods of medical care or treatment, equipment or supplies that:

1. are not ***covered expenses*** under this ***Plan***; or

2. are ***covered expenses*** under this ***Plan*** but on a basis that differs from the alternative recommended by the ***Health Care Management Organization***.

The recommended alternatives will be considered as ***covered expenses*** under the ***Plan*** provided the expenses can be shown to be viable, ***medically necessary***, and are included in a written case management report or treatment plan proposed by the ***Health Care Management Organization.***

Case management will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that ***covered person*** or any other ***covered person***.

# COORDINATION OF BENEFITS

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

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

## *DEFINITIONS APPLICABLE TO THIS PROVISION*

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

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

This ***Plan*** is not eligible to be elected as primary coverage in lieu of automobile benefits. Payments from automobile insurance will always be primary and this ***Plan*** shall be secondary only.

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

"Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) do not include flexible spending accounts (FSA), health reimbursement accounts (HRA) or health savings account (HSA). Such Other Plan(s) may include, without limitation:

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

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

3. A licensed Health Maintenance Organization (HMO);

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

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

6. Group automobile insurance;

7. Individual automobile insurance coverage;

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

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

10. Labor/management trusteed, union welfare, employer organization, or employee benefit organization plans.

"This ***Plan***" shall mean that portion of the ***employer's Plan*** which provides benefits that are subject to this provision.

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

## *EFFECT ON BENEFITS*

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

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

## *ORDER OF BENEFIT DETERMINATION*

Each plan will make its claim payment according to the first applicable provision in the following list of provisions which determine the order of benefit payment:

1. No Coordination of Benefits Provision

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

2. Member/Dependent

   The plan which covers the claimant directly pays before a plan that covers the claimant as a ***dependent***.

3. Dependent Children of Parents not Separated or Divorced

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

4. Dependent Children of Separated or Divorced Parents

   When parents are separated or divorced, the birthday rule does not apply, instead:

   a. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent, if any, pays fourth.

   b. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody, if any, pays fourth.

5. Active/Inactive

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

6. Limited Continuation of Coverage

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

7. Longer/Shorter Length of Coverage

   If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

## *COORDINATION WITH MEDICARE*

Individuals may be eligible for ***Medicare*** Part A at no cost if they: (i) are age 65 or older, (ii) have been determined by the Social Security Administration to be disabled, or (iii) have end stage renal disease. Participation in ***Medicare*** Part B is available to all individuals who make application and pay the full cost of the coverage.

1. When an ***employee*** becomes entitled to ***Medicare*** coverage (due to age or disability) and is still actively at work, the ***employee*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

2. When a ***dependent*** becomes entitled to ***Medicare*** coverage (due to age or disability) and the ***employee*** is still actively at work, the ***dependent*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

3. If the ***employee*** and/or ***dependent*** is also enrolled in ***Medicare*** (due to age or disability), this ***Plan*** shall pay as the primary plan. If, however, the ***Medicare*** enrollment is due to end stage renal disease, the ***Plan***'s primary payment obligation will end at the end of the thirty (30) month "coordination period" as provided in ***Medicare*** law and regulations.

4. Notwithstanding Paragraphs 1 to 3 above, if the ***employer*** (including certain affiliated entities that are considered the same employer for this purpose) has fewer than one hundred (100) ***employees***, when a covered ***dependent*** becomes entitled to ***Medicare*** coverage due to ***total disability***, as determined by the Social Security Administration, and the ***employee*** is actively-at-work, ***Medicare*** will pay as the primary payer for claims of the ***dependent*** and this ***Plan*** will pay secondary.

5. If the ***employee*** and/or ***dependent*** elect to discontinue health coverage under this ***Plan*** and enroll under the ***Medicare*** program, no benefits will be paid under this ***Plan***. ***Medicare*** will be the only payor.

This section is subject to the terms of the ***Medicare*** laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

## *LIMITATIONS ON PAYMENTS*

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

## *RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION*

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

## *FACILITY OF BENEFIT PAYMENT*

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

## *AUTOMOBILE ACCIDENT BENEFITS*

The ***Plan's*** liability for expenses arising out of an automobile accident shall always be secondary to any automobile insurance, irrespective of the type of automobile insurance law that is in effect in the ***employee's*** state of residence. Currently, there are three (3) types of state automobile insurance laws.

1. No-fault automobile insurance laws
2. Financial responsibility laws
3. Other automobile liability insurance laws

No Fault Automobile Insurance Laws. In no event will the ***Plan*** pay any claim presented by or on behalf of an ***employee*** for lost wages or medical benefits that would have been payable under an automobile insurance policy but for an election made by the principal named insured under the automobile policy that reduced covered levels and/or subsequent premium. This is intended to exclude, as a ***covered expense***, lost wages or medical expenses arising from an automobile accident that are payable under an automobile insurance policy or that would have been payable under an automobile insurance policy but for such an election.

a. In the event an ***employee*** shall incur lost wages or medical expenses as a result of ***injuries*** sustained in an automobile accident while "covered by an automobile insurance policy," as an operator of the vehicle, as a passenger, or as a pedestrian, benefits will be further limited to medical expenses, that would in no event be payable under the automobile insurance; provided however that benefits payable due to a required deductible under the automobile insurance policy will be paid by the ***Plan*** up to the amount equal to that deductible.

b. For the purposes of this section the following people are deemed "covered by an automobile insurance policy."

    i. An owner or principal named insured individual under such policy.

    ii. A family member of an insured person for whom coverage is provided under the terms and conditions of the automobile insurance policy.

    iii. Any other person who, except for the existence of the ***Plan***, would be eligible for medical expense benefits under an automobile insurance policy.

Financial Responsibility Laws. The ***Plan*** will be secondary to any potentially applicable automobile insurance even if the state's "financial responsibility law" does not allow the ***Plan*** to be secondary.

Other Automobile Liability Insurance. If the state does not have a no-fault automobile insurance law nor a "financial responsibility" law, the ***Plan*** is secondary to automobile insurance coverage or to any other person or entity who caused the ***accident*** or who may be liable for the ***employee's*** lost wages or medical expenses pursuant to the general rule for *Subrogation.*

# SUBROGATION/REIMBURSEMENT

The ***Plan*** is designed to only pay ***covered expenses*** for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a ***covered person*** in a time of need, however, the ***Plan*** may pay ***covered expenses*** that may be or become the responsibility of another person, provided that the ***Plan*** later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the ***Plan***, as well as by applying for payment of ***covered expenses***, a ***covered person*** is subject to, and agrees to, the following terms and conditions with respect to the amount of ***covered expenses*** paid by the ***Plan***:

1. Assignment of Rights (Subrogation). The ***covered person*** automatically assigns to the ***Plan*** any rights the ***covered person*** may have to recover all or part of the same ***covered expenses*** from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts and health savings accounts), but limited to the amount of Reimbursable Payments made by the ***Plan***. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a ***covered person*** or paid to another for the benefit of the ***covered person***. This assignment applies on a first-dollar basis (*i.e.*, has priority over other rights), applies whether the funds paid to (or for the benefit of) the ***covered person*** constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the ***Plan*** to pursue any claim that the ***covered person*** may have, whether or not the ***covered person*** chooses to pursue that claim. By this assignment, the ***Plan's*** right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Equitable Lien and other Equitable Remedies. The ***Plan*** shall have an equitable lien against any rights the ***covered person*** may have to recover the same ***covered expenses*** from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the ***Plan***. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the ***Plan*** has paid ***covered expenses*** prior to a determination that the ***covered expenses*** arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

   This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the ***covered person***, the ***covered person's*** attorney, and/or a trust) as a result of an exercise of the ***covered person's*** rights of recovery (sometimes referred to as "proceeds"). The ***Plan*** shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the ***plan administrator***, the ***Plan*** may reduce any future ***covered expenses*** otherwise available to the ***covered person*** under the ***Plan*** by an amount up to the total amount of Reimbursable Payments made by the ***Plan*** that is subject to the equitable lien.

   This and any other provisions of the ***Plan*** concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court's decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002). The provisions of the ***Plan*** concerning subrogation, equitable liens and other equitable remedies are also intended to supercede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

3. Assisting in ***Plan's*** Reimbursement Activities. The ***covered person*** has an obligation to assist the ***Plan*** to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the ***covered person***, and to provide the ***Plan*** with any information concerning the ***covered person's*** other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or

entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the ***covered person***. The ***covered person*** is required to (a) cooperate fully in the ***Plan's*** (or any ***Plan*** fiduciary's) enforcement of the terms of the ***Plan***, including the exercise of the ***Plan's*** right to subrogation and reimbursement, whether against the ***covered person*** or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the ***Plan*** as a co-payee for the amount of the Reimbursable Payments and notifying the ***Plan***), (c) sign any document deemed by the ***plan administrator*** to be relevant to protecting the ***Plan's*** subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the ***plan administrator*** or ***claims processor*** to enforce the ***Plan***'s rights.

The ***plan administrator*** has delegated to the ***claims processor*** the right to perform ministerial functions required to assert the ***Plan's*** rights; however, the ***plan administrator*** shall retain discretionary authority with regard to asserting the ***Plan's*** recovery rights.

# GENERAL PROVISIONS

## *ADMINISTRATION OF THE PLAN*

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

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

## *APPLICABLE LAW*

Except to the extent preempted by the Employee Retirement Income Security Act of 1974 (ERISA) or other federal law, all provisions of the ***Plan*** shall be construed and administered in a manner consistent with the requirements under the laws of the State of Ohio.

## *ASSIGNMENT*

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

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

This ***Plan*** will pay benefits to the responsible party of an ***alternate recipient*** as designated in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

## *BENEFITS NOT TRANSFERABLE*

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

## *CLERICAL ERROR*

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

## *CONFORMITY WITH STATUTE(S)*

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

## *EFFECTIVE DATE OF THE PLAN*

The original ***effective date*** of this ***Plan*** was April 1, 1998. The ***effective date*** of the modifications contained herein is January 1, 2006.

## *FREE CHOICE OF HOSPITAL AND PHYSICIAN*

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

## *INCAPACITY*

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

## *INCONTESTABILITY*

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

## *LEGAL ACTIONS*

No action at law or in equity shall be brought to recover on the benefits from the ***Plan*** prior to the expiration of sixty (60) days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the ***Plan***. No such action shall be brought after the expiration of two (2) years from the date the expense was ***incurred***, or one (1) year from the date a completed claim was filed, whichever occurs first.

## *LIMITS ON LIABILITY*

Liability hereunder is limited to the services and benefits specified, and the ***employer*** shall not be liable for any obligation of the ***covered person incurred*** in excess thereof. The ***employer*** shall not be liable for the negligence, wrongful act, or omission of any ***physician***, ***professional provider***, ***hospital***, or other institution, or their employees, or any other person. The liability of the ***Plan*** shall be limited to the reasonable cost of ***covered expenses*** and shall not include any liability for suffering or general damages.

## *LOST DISTRIBUTEES*

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

## *MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS*

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

## *MISREPRESENTATION*

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

## *PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN*

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

## *PLAN IS NOT A CONTRACT*

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

## *PLAN MODIFICATION AND AMENDMENT*

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

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

## *PLAN TERMINATION*

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

Upon termination of this ***Plan***, all claims ***incurred*** prior to termination, but not submitted to either the ***employer*** or ***claims processor*** within three (3) months of the ***effective date*** of termination of this ***Plan***, will be excluded from any benefit consideration.

## *PRONOUNS*

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

## *RECOVERY FOR OVERPAYMENT*

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

## *STATUS CHANGE*

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

## *TIME EFFECTIVE*

The effective time with respect to any dates used in the ***Plan*** shall be 12:01 a.m. as may be legally in effect at the address of the ***plan administrator***.

## *WORKERS' COMPENSATION NOT AFFECTED*

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

# HIPAA PRIVACY

The following provisions are intended to comply with applicable ***Plan*** amendment requirements under Federal regulation implementing Section 264 of the Health Insurance Portability and Accountability Act of 1996 (***HIPAA***).

## *DISCLOSURE BY PLAN TO PLAN SPONSOR*

The ***Plan*** may take the following actions only upon receipt of a ***Plan*** amendment certification:

1. Disclose protected health information to the ***plan sponsor***.

2. Provide for or permit the disclosure of protected health information to the ***plan sponsor*** by a health insurance issuer or HMO with respect to the ***Plan***.

## *USE AND DISCLOSURE BY PLAN SPONSOR*

The ***plan sponsor*** may use or disclose protected health information received from the ***Plan*** to the extent not inconsistent with the provisions of this *HIPAA PRIVACY* Section or the ***privacy rule***.

## *OBLIGATIONS OF PLAN SPONSOR*

The ***plan sponsor*** shall have the following obligations:

1. Ensure that:

   a. Any agents (including a subcontractor) to whom it provides protected health information received from the ***Plan*** agree to the same restrictions and conditions that apply to the ***plan sponsor*** with respect to such information; and

   b. Adequate separation between the ***Plan*** and the ***plan sponsor*** is established in compliance with the requirement in 45 C.F.R. 164.504(f)(2)(iii).

2. Not use or further disclose protected health information received from the ***Plan***, other than as permitted or required by the ***Plan*** documents or as ***required by law***.

3. Not use or disclose protected health information received from the ***Plan***:

   a. For employment-related actions and decisions; or

   b. In connection with any other benefit or employee benefit plan of the ***plan sponsor***.

4. Report to the ***Plan*** any use or disclosure of the protected health information received from the ***Plan*** that is inconsistent with the use or disclosure provided for of which it becomes aware.

5. Make available protected health information received from the ***Plan***, as and to the extent required by the ***privacy rule***:

   a. For access to the individual;

   b. For amendment and incorporate any amendments to protected health information received from the ***Plan***; and

   c. To provide an accounting of disclosures.

6. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the ***Plan*** available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the ***Plan*** with the ***privacy rule***.

7. Return or destroy all protected health information received from the ***Plan*** that the ***plan sponsor*** still maintains in any form and retain no copies when no longer needed for the purpose for which the disclosure by the ***Plan*** was made, but if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

8. Provide protected health information only to those individuals, under the control of the ***plan sponsor*** who perform administrative functions for the ***Plan***; (*i.e.*, eligibility, enrollment, payroll deduction, benefit determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use protected health information for any reason other than for ***Plan*** administrative functions nor to release protected health information to an unauthorized individual.

9. Provide protected health information only to those entities required to receive the information in order to maintain the ***Plan*** (*i.e.*, claim administrator, case management vendor, pharmacy benefit manager, claim subrogation, vendor, claim auditor, network manager, stop-loss insurance carrier, insurance broker/consultant, and any other entity subcontracted to assist in administering the ***Plan***).

10. Provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision.

11. Reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the ***plan sponsor*** on behalf of the ***Plan***. Specifically, such safeguarding entails an obligation to:

    a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the ***plan sponsor*** creates, receives, maintains, or transmits on behalf of the ***Plan***;

    b. Ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

    c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

    d. Report to the ***Plan*** any security incident of which it becomes aware.

## *EXCEPTIONS*

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

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

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

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

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

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

3. Use or disclose protected health information:

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

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

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

# DEFINITIONS

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

***Accident***

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

***Alternate Recipient***

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

***Ambulatory Surgical Facility***

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

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

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

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

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

***Birthing Center***

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

***Chemical Dependency***

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

***Chiropractic Care***

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

***Claims Processor***

Refer to the *Facts About The Plan* section of this document.

***Close Relative***

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

***Coinsurance***

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

***Complications of Pregnancy***

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

1. Intra-abdominal surgery (but not elective Cesarean Section).
2. Ectopic ***pregnancy***.
3. Toxemia with convulsions (Eclampsia).
4. Pernicious vomiting (hyperemesis gravidarum).
5. Nephrosis.
6. Cardiac Decompensation.
7. Missed Abortion.
8. Miscarriage.

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

***Concurrent Care***

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

***Confinement***

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

***Copay***

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

***Cosmetic Surgery***

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

***Covered Expenses***

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

***Covered Person***

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

***Custodial Care***

Care provided primarily for maintenance of the ***covered person*** or which is designed essentially to assist the ***covered person*** in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an ***illness*** or ***injury***. ***Custodial care*** includes, but is not limited to: help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services shall be considered ***custodial care*** without regard to the provider by whom or by which they are prescribed, recommended or performed.

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

***Customary and Reasonable Amount***

The fee assessed by a provider of service for services, supplies or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is ***incurred*** and is comparable in severity and nature to the ***illness*** or ***injury***. Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill or experience. The ***customary and reasonable amount*** is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges. The percentage applicable to this ***Plan*** is 90% and is applied to CPT codes or HIAA Code Analysis using MDR or HIAA tables.

***Dentist***

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

***Dependent***

A ***dependent*** is:

1. The spouse of the ***employee*** under a legally valid existing marriage with a person of the opposite sex, unless court ordered separation exists.

2. The term "child" means the ***employee's*** natural child, stepchild, legally adopted child, foster child, provided:

    a. The child is less than nineteen (19) years of age (end of calendar year in which $19^{th}$ birthday occurs), and qualifies as a tax dependent under IRC Section 152 (amounts received under accident and health plans), and;

b. The child is unmarried, and;

c. The child is principally dependent upon the ***employee*** for support and maintenance, and;

d. The child is listed as an exemption on the most current Federal Income Tax Return, and;

e. The child is not regularly employed by one or more employers on a full-time basis, exclusive of scheduled vacation periods.

3. An eligible child shall also include any other child of an ***employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan***, even if the child is not residing in the ***employee's*** household. Such child shall be referred to as an ***alternate recipient***. ***Alternate recipients*** are eligible for coverage regardless of whether the ***employee*** elects coverage for himself. An application for enrollment must be submitted to the ***employer*** for coverage under this ***Plan***. The ***employer/plan administrator*** shall establish written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under the ***Plan*** pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the ***employer/plan administrator*** shall determine whether such order is a Qualified Medical Child Support Order (QMCSO), as defined in Section 609 of ERISA, or a National Medical Support Notice (NMSN), as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.

   The ***employer/plan administrator*** reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency.

4. Adopted children, who are less than eighteen (18) years of age at the time of adoption, shall be considered eligible from the date the child is ***placed for adoption***.

5. Upon written notice to the ***employer***, a child who has reached his or her nineteenth (19th) birthday (end of calendar year) and is principally dependent upon the ***employee*** for support and maintenance and is listed as an exemption on the most current Federal Income Tax Return, may also be included herein as an eligible ***dependent*** until the child's twenty-fourth (24th) birthday, provided such child is unmarried, qualifies as a tax dependent under IRC Section 152 (amounts received under accident and health plans) and is a ***full-time student*** or ***part-time student*** (during each of at least five (5) calendar months in a tax year) in a secondary school, accredited college, university or institution of higher learning and is not regularly employed by one or more employers on a full-time basis, exclusive of scheduled vacation periods. It is the ***employee's*** responsibility to provide the ***claims processor*** with proof of ***full-time*** or ***part-time student status*** for each semester. The ***employee*** must notify the ***employer*** when the ***dependent*** is no longer a ***full-time student***.

6. A child who is unmarried, incapable of self-sustaining employment, and dependent upon the ***employee*** for support due to a mental and/or physical disability, and who was covered under the ***Plan*** prior to reaching age nineteen (19) (end of calendar year) or due to other loss of ***dependent's*** eligibility and who lives with the ***employee***, will remain eligible for coverage under this ***Plan*** beyond the date coverage would otherwise be lost.

For further information regarding eligibility for ***dependents***, refer to the *Eligibility, Enrollment and Effective Date, Dependent Eligibility* section of this document.

***Durable Medical Equipment***

Medical equipment which:

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

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

***Effective Date***

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

***Emergency***

An accidental ***injury***, or the sudden onset of an ***illness*** where the symptoms are of such severity that the absence of immediate medical attention could reasonably result in:

1. Placing the ***covered person's*** life in jeopardy, or
2. Causing other serious medical consequences, or
3. Causing serious impairment to bodily functions, or
4. Causing serious dysfunction of any bodily organ or part.

***Employee***

A person directly involved in the regular business of and compensated for services, as reported on the individual's annual W-2 form, by the ***employer*** who meets the eligibility requirements as described in *Eligibility, Enrollment and Effective Date, Employee Eligibility*.

***Employer***

The ***employer*** is Buckeye Ohio Risk Management Association (BORMA) City of Bowling Green.

***Enrollment Date***

A ***covered person's enrollment date*** is the first day of any applicable service waiting period or the date of hire. For a ***covered person*** who enrolls in the ***Plan*** as the result of a Special Enrollment Period or as the result of late enrollment or open enrollment period, if available, the ***enrollment date*** is the first date of coverage.

***Experimental/Investigational***

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

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

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. If the drug, device, medical treatment or procedure, was not reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

3. If "reliable evidence" shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials, is in the research, ***experimental***, study or ***investigational*** arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis; or

4. If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

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

***Extended Care Facility***

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

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

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

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

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

5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of ***mental and nervous disorders***.

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

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

***Facility***

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

***Full-time***

***Employees*** who are regularly scheduled to work not less than forty (40) hours per work week.

***Full-time Student or Full-time Student Status***

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

***Generic Drug***

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

***Health Care Management***

A process of evaluating if services, supplies or treatment are ***medically necessary*** and appropriate to help ensure cost-effective care.

***Health Care Management Organization***

The individual or organization designated by the ***employer*** for the process of evaluating whether the service, supply, or treatment is ***medically necessary***. The ***Health Care Management Organization*** is CoreSource, Inc.

***Home Health Aide Services***

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

***Home Health Care Agency***

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

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.

2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one ***physician*** and at least one Registered Nurse. It must provide for full-time supervision of such services by a ***physician*** or Registered Nurse.

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

4. It has a full-time administrator.

5. It qualifies as a reimbursable service under ***Medicare***.

***Hospice***

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

1. It has obtained any required state or governmental Certificate of Need approval.
2. It provides service twenty-four (24) hours-per-day, seven (7) days a week.
3. It is under the direct supervision of a ***physician***.
4. It has a Nurse coordinator who is a Registered Nurse.
5. It has a social service coordinator who is licensed.
6. It is an agency that has as its primary purpose the provision of ***hospice*** services.
7. It has a full-time administrator.
8. It maintains written records of services provided to the ***covered person***.
9. It is licensed, if licensing is required.

***Hospital***

An institution which meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to ***hospitals***.
2. It is engaged primarily in providing medical care and treatment to ***ill*** and ***injured*** persons on an ***inpatient*** basis at the ***covered person's*** expense.
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an ***illness*** or ***injury***; and such treatment is provided by or under the supervision of a ***physician*** with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.
4. It qualifies as a ***hospital*** and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations. This condition may be waived in the case of ***emergency*** treatment in a ***hospital*** outside of the United States.
5. It must be approved by ***Medicare***. This condition may be waived in the case of ***emergency*** treatment in a ***hospital*** outside of the United States.

Under no circumstances will a ***hospital*** be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

***Hospital*** shall include a facility designed exclusively for physical rehabilitative services where the ***covered person*** received treatment as a result of an ***illness*** or ***injury***.

The term ***hospital***, when used in conjunction with ***inpatient confinement*** for ***mental and nervous disorders*** or ***chemical dependency***, will be deemed to include an institution which is licensed as a mental ***hospital*** or ***chemical dependency*** rehabilitation and/or detoxification ***facility*** by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

***Illness***

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

***Immediate Care Center***

A ***facility*** which is engaged primarily in providing minor emergency and episodic medical care and which has:

1. a board-certified ***physician***, a registered nurse (RN) and a registered x-ray technician in attendance at all times;

2. has x-ray and laboratory equipment and life support systems.

An ***immediate care center*** may include a clinic located at, operated in conjunction with, or which is part of a regular ***hospital***.

***Incurred or Incurred Date***

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

***Injury***

A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. ***Injury*** does not include ***illness*** or infection of a cut or wound.

***Inpatient***

A ***confinement*** of a ***covered person*** in a ***hospital***, ***hospice***, or ***extended care facility*** as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for ***room and board***.

***Intensive Care***

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

***Intensive Care Unit***

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

1. Facilities for special nursing care not available in regular rooms and wards of the ***hospital***;

2. Special life saving equipment which is immediately available at all times;

3. At least two beds for the accommodation of the critically ill; and

4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours-per-day.

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

***Layoff***

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

***Leave of Absence***

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

***Maximum Benefit***

Any one of the following, or any combination of the following:

1. The maximum amount paid by this ***Plan*** for any one ***covered person*** during the entire time he is covered by this ***Plan***.

2. The maximum amount paid by this ***Plan*** for any one ***covered person*** for a particular ***covered expense***. The maximum amount can be for:

   a. The entire time the ***covered person*** is covered under this ***Plan***, or

   b. A specified period of time, such as a calendar year.

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

   a. Treatments during a specified period of time, or

   b. Days of ***confinement***, or

   c. Visits by a ***home health care agency***.

***Medically Necessary (or Medical Necessity)***

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

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the ***covered person's illness*** or ***injury*** and which could not have been omitted without adversely affecting the ***covered person's*** condition or the quality of the care rendered; and

2. Supplied or performed in accordance with current standards of medical practice within the United States; and

3. Not primarily for the convenience of the ***covered person*** or the ***covered person's*** family or ***professional provider***; and

4. Is an appropriate supply or level of service that safely can be provided; and

5. Is recommended or approved by the attending ***professional provider***.

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

***Medicare***

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

***Mental and Nervous Disorder***

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM-IV (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

***Morbid Obesity***

A diagnosed condition in which the body weight is one hundred (100) pounds or more over the medically recommended weight in the most recent Metropolitan Life Insurance Company tables for a person of the same height, age and mobility as the ***covered person***, or having a BMI (body mass index) of forty (40) or higher, or having a BMI of thirty-five (35) in conjunction with any of the following co-morbidities: coronary artery disease, type II diabetes, clinically significant obstructive sleep apnea or medically refractory hypertension (blood pressure > 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management).

***Named Fiduciary for Post-Service Claim Appeals***

CoreSource, Inc.
5200 Upper Metro Place, Suite 300
Dublin, Ohio 43017-5378

***Named Fiduciary for Pre-Service Claim Appeals***

CoreSource, Inc.
5200 Upper Metro Place, Suite 300
Dublin, Ohio 43017-5378

***Negotiated Rate***

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

***Nonparticipating Pharmacy***

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

***Nonpreferred Provider***

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

***Nurse***

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

***Outpatient***

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

1. A ***hospital*** as other than an ***inpatient***;
2. A ***physician's*** office, laboratory or x-ray ***facility***; or
3. An ***ambulatory surgical facility***; and

The stay is less than twenty-three (23) consecutive hours.

***Partial Confinement***

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

1. Psychiatric services.
2. Treatment of ***mental and nervous disorders***.
3. ***Chemical dependency*** treatment.

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

***Participating Pharmacy***

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

***Part-time***

***Employees*** who are regularly scheduled to work at least twenty (20) hours per work week, but less than forty (40) hours per work week.

***Part-time Student or Part-time Student Status***

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

***Pharmacy Organization***

The ***pharmacy organization*** is Caremark.

***Physician***

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

***Placed For Adoption (Placement For Adoption)***

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

***Plan***

"***Plan***" refers to the benefits and provisions for payment of same as described herein. The ***Plan*** is the Buckeye Risk Management Association (BORMA) City of Bowling Green Employee Benefit Plan.

***Plan Administrator***

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

***Plan Sponsor***

The ***plan sponsor*** is Buckeye Risk Management Association (BORMA) City of Bowling Green.

***Plan Year End***

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

***Pre-existing Conditions***

An ***illness*** or ***injury*** which existed within ninety (90) days before the ***covered person's*** enrollment date for coverage under this ***Plan***. An ***illness*** or ***injury*** is considered to have existed when the ***covered person***:

1. Sought or received professional advice for that ***illness*** or ***injury***, or

2. Received medical care or treatment for that ***illness*** or ***injury***, or

3. Received medical supplies, drugs, or medicines for that ***illness*** or ***injury***.

***Preferred Provider***

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

***Preferred Provider Organization***

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

***Pregnancy***

The physical state which results in childbirth or miscarriage.

***Privacy Rule***

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

***Professional Provider***

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

Audiologist

Certified Addictions Counselor

Certified Registered Nurse Anesthetist

Chiropractor

Clinical Laboratory

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

Dental Hygienist

Dentist

Dietitian

Dispensing Optician

Midwife

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

Nurse Practitioner

Occupational Therapist

Optician

Optometrist

Physical Therapist

Physician

Physician's Assistant

Podiatrist

Psychologist

Respiratory Therapist

Speech Therapist

***Qualified Prescriber***

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

***Reconstructive Surgery***

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

***Relevant Information***

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

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

***Required By Law***

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

***Room and Board***

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

***Semiprivate***

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

***Total Disability or Totally Disabled***

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

***Treatment Center***

1. An institution which does not qualify as a ***hospital***, but which does provide a program of effective medical and therapeutic treatment for ***chemical dependency***, and
2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or
3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:
   a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
   b. It provides a program of treatment approved by the ***physician***.
   c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the ***covered person***.

d. It provides at least the following basic services:

   i. ***Room and board***

   ii. Evaluation and diagnosis

   iii. Counseling

   iv. Referral and orientation to specialized community resources.

***Urgent Care***

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

# AMENDMENT NO. 1
# FOR
# BUCKEYE OHIO RISK MANAGEMENT ASSOCIATION (BORMA)
# CITY OF BOWLING GREEN
# EMPLOYEE BENEFIT PLAN

I. The section "**ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE**" shall be amended as follows:

The subsection "**Employee Eligibility**" shall be deleted in its entirety and the following substituted therefore:

***EMPLOYEE ELIGIBILITY***

All ***full-time*** regularly scheduled to work at least forty (40) hours per work week shall be eligible to enroll for coverage under this ***Plan***.

All non-temporary ***part-time*** salaried or exempt hire ***employees*** shall be eligible to enroll for coverage under this ***Plan*** if their salary is based on 50% of the salary for a ***full-time*** hire into the same or similar position. All non-temporary ***part-time*** hourly ***employees*** who are hired to work a minimum of 1,250 hours per calendar year shall be eligible to enroll for coverage under this ***Plan***. This does not include temporary or seasonal ***employees***.

***Full-time employees*** are eligible to enroll for medical, prescription drug and dental benefits. Non-temporary ***part-time employees*** are eligible to enroll for medical and prescription benefits only.

II. The section "**DEFINITIONS**" shall be amended as follows:

The subsection "***Part-time***" shall be deleted in its entirety and the following substituted therefore:

***Part-time***

***Employees*** who meet the ***part-time*** eligibility requirements described in *Eligibility, Enrollment and Effective Date, Employee Eligibility*.

**Effective July 1, 2006**

**Received and accepted for Buckeye Ohio Risk Management Association (BORMA) – City of Bowling Green**

By: Barbara Ford

Title: Personnel Director

Date: June 26, 2006

**AMENDMENT NO. 2**
**FOR**
**BUCKEYE OHIO RISK MANAGEMENT ASSOCIATION (BORMA)**
**CITY OF BOWLING GREEN**
**EMPLOYEE BENEFIT PLAN**

The section "**TERMINATION OF COVERAGE**" shall be amended as follows:

The subsection "**Employee Reinstatement**" shall be deleted in its entirety and the following substituted therefore:

## *EMPLOYEE REINSTATEMENT*

An ***employee*** who returns to work following an unapproved ***leave of absence***, ***layoff***, or termination of employment will be considered a new ***employee*** for purposes of eligibility and will be subject to all eligibility requirements, including all requirements relating to the ***effective date*** of coverage and the ***pre-existing condition*** limitations.

***Employees*** and eligible ***dependents*** who lost coverage due to a disability leave under the Ohio Public Employees Retirement System or Ohio Police and Fire Pension Fund are eligible for reinstatement of coverage as follows:

1. The ***employee*** must submit the completed application for enrollment to the ***employer*** within thirty (30) days of rehire or return to work. If the application for enrollment is not submitted within thirty (30) days, the ***Plan's*** provisions for eligibility and application for enrollment shall apply.

2. Coverage shall be effective from the date the ***employee*** returns to work on a ***full-time*** or permanent ***part-time*** basis as described in *Employee Eligibility*. Prior benefits and limitations, such as deductible, ***maximum benefit***, ***pre-existing condition*** waiting period, shall be applied with no break in coverage.

Coverage under this ***Plan*** during a period while an ***employee*** is either on or is returning from an approved unpaid ***leave of absence*** shall be in accordance with City of Bowling Green policies. If an ***employee*** fails to pay for medical and/or dental coverage in accordance with City policy while on an approved, unpaid ***leave of absence*** upon returning to work the ***employee*** will be considered a new ***employee*** for eligibility and will be subject to all eligibility requirements.

**Effective March 1, 2007**

**Received and accepted for Buckeye Ohio Risk Management Association (BORMA) – City of Bowling Green**

By:

Title: Municipal Administrator

Date: 3/19/07

**AMENDMENT NO. 3**
**FOR**
**BUCKEYE OHIO RISK MANAGEMENT ASSOCIATION (BORMA)**
**CITY OF BOWLING GREEN**
**EMPLOYEE BENEFIT PLAN**

I. The section "**ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE**" shall be amended as follows:

The subsection "**Employee Eligibility**" shall be deleted in its entirety and the following substituted therefore:

## *EMPLOYEE ELIGIBILITY*

All ***full-time*** or permanent ***part-time employees*** regularly scheduled to work at least forty (40) hours per work week for ***full-time*** or at least twenty (20) hours, but less than forty (40) hours per work week, for permanent ***part-time*** shall be eligible to enroll for coverage under this ***Plan***. This does not include temporary or seasonal ***employees***.

***Full-time employees*** are eligible to enroll for medical, prescription drug and dental benefits. Permanent ***part-time employees*** are eligible to enroll for medical and prescription benefits only.

The mayor of the City of Bowling Green shall be eligible to enroll for medical, prescription drug and dental benefits as outlined in §33.23 of the codified ordinances of the City of Bowling Green. As used in this document, the term ***employee*** shall include the mayor of the City of Bowling Green.

II. The section "**TERMINATION OF COVERAGE**" shall be amended as follows:

Item #3 in the subsection "**Termination of Employee Coverage**" shall be deleted in its entirety and the following substituted therefore:

3. The last day of the month in which employment terminates, as defined by the ***employer's*** personnel policies. The last day of the month in which the mayor discontinues as mayor of the City of Bowling Green.

**Effective January 1, 2008**

**Received and accepted for Buckeye Ohio Risk Management Association (BORMA) – City of Bowling Green**

By: Barbara [signature]

Title: Personnel Director

Date: 10/8/07

**AMENDMENT NO. 4**
**FOR**
**BUCKEYE OHIO RISK MANAGEMENT ASSOCIATION (BORMA)**
**CITY OF BOWLING GREEN**
**EMPLOYEE BENEFIT PLAN**

I. Effective September 30, 2007, the section "**SCHEDULE OF BENEFITS**," shall be amended as follows:

In the subsection "**Medical Benefits**," the benefit for "**Mental & Nervous Disorders and Chemical Dependency Care**" shall be deleted in its entirety and the following substituted therefore:

| **BENEFIT DESCRIPTION** | ***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***) | ***Nonpreferred Provider*** (% of ***customary and reasonable amount***) |
|---|---|---|
| **Chemical Dependency Care and Mental & Nervous Disorders, Other Than Biologically Based Mental Illness (*biologically based mental illness* shall be covered as any other *covered expense* for a physical disease or disorder)** | | |
| Inpatient Services | 90% | 70% |
| Outpatient Services | 90% | 70% |
| Electro-Convulsive therapy | 90% | 70% |

II. Effective September 30, 2007, the section "**MEDICAL EXPENSE BENEFIT**" shall be amended as follows:

In the subsection "**Out-of-Pocket Expense Limit**," the information under the heading "**Out-of-Pocket Expense Limit Exclusions**" shall be deleted in its entirety and the following substituted therefore:

*Out-of-Pocket Expense Limit Exclusions*

The following items do not apply toward satisfaction of the calendar year out-of-pocket expense limit and will not be payable at one hundred percent (100%), even if the out-of-pocket expense limit has been satisfied:

1. Expenses for services, supplies and treatments not covered by this ***Plan***, to include charges in excess of the ***customary and reasonable amount*** or ***negotiated rate***, as applicable.
2. ***Copays***.
3. Expenses for services, supplies and ***outpatient*** treatment of ***chemical dependency*** and ***mental and nervous disorders***, other than ***biologically based mental illness***.
4. Expenses ***incurred*** as a result of failure to obtain pre-certification.

III. Effective September 30, 2007, the section "**MEDICAL EXPENSE BENEFIT**" shall be amended as follows:

The subsection "**Mental & Nervous Disorders and Chemical Dependency Care**" shall be deleted in its entirety and the following substituted therefore:

## *CHEMICAL DEPENDENCY CARE AND MENTAL & NERVOUS DISORDERS*

*Biologically Based Mental Illness*

Plans in the State of Ohio must provide benefits for the diagnosis and treatment of ***biologically based mental illnesses*** on the same terms and conditions as, with benefits no less extensive than, those provided under the ***Plan*** for the diagnosis and treatment of all other physical diseases and disorders. This includes ***inpatient hospital*** services, ***outpatient*** services, medication, ***maximum benefits*** while covered by the ***Plan***, copayments and deductibles (see the *Schedule of Benefits*).

***Biologically based mental illnesses*** means:

- Schizophrenia
- Schizoaffective disorder
- Major depressive disorder
- Bipolar disorder
- Paranoia and other psychotic disorders
- Obsessive-compulsive disorder
- Panic disorder

All as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

The ***biologically based mental illness*** must be clinically diagnosed by a licensed ***physician***, psychologist, professional clinical counselor, professional counselor, independent social worker or clinical nurse specialist with a mental health specialty. Treatment that is ***experimental*** or ***investigational*** is excluded from coverage.

*Inpatient or Partial Confinement*

Subject to the pre-certification provisions of the ***Plan***, the ***Plan*** will pay the applicable ***coinsurance***, as shown on the *Schedule of Benefits*, for ***confinement*** in a ***hospital*** or ***treatment center*** for treatment, services and supplies related to the treatment of ***chemical dependency*** and ***mental and nervous disorders***, other than ***biologically based mental illness***.

***Covered expenses*** shall include:

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

*Outpatient*

The ***Plan*** will pay the applicable ***coinsurance***, as shown on the *Schedule of Benefits*, for ***outpatient*** treatment, services and supplies related to the treatment of ***chemical dependency*** and ***mental and nervous disorders***, other than ***biologically based mental illness***.

Covered expenses shall include:

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

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

"Subacute treatment" means treatment received at a ***facility*** which may or may not be equipped or licensed to treat medical ***emergencies***, but which maintains close ties with acute care ***facilities***. Skilled professional therapists practice in these ***facilities***, and ***physician*** and Registered Nurses are available on call. Therapy is available for recovering chemically dependent patients and those with mental health problems requiring some medical management.

"Day treatment" means a structured program of therapy and activities which requires that the patient attend sessions and return to their own living arrangement at night. Day treatment programs are offered by ***hospitals***, freestanding subacute ***facilities*** and mental health clinics.

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

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

IV. Effective January 1, 2008, the section **"ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE"** shall be amended as follows:

The subsection **"Employee Eligibility"** shall be deleted in its entirety and the following substituted therefore:

## *EMPLOYEE ELIGIBILITY*

All ***full-time*** regularly scheduled to work at least forty (40) hours per work week shall be eligible to enroll for coverage under this ***Plan***.

All non-temporary ***part-time*** salaried or exempt hire ***employees*** shall be eligible to enroll for coverage under this ***Plan*** if their salary is based on 50% of the salary for a ***full-time*** hire into the same or similar position. All non-temporary ***part-time*** hourly ***employees*** who are hired to work a minimum of 1,250 hours per calendar year shall be eligible to enroll for coverage under this ***Plan***. This does not include temporary or seasonal ***employees***.

***Full-time employees*** are eligible to enroll for medical, prescription drug and dental benefits. Non-temporary ***part-time employees*** are eligible to enroll for medical and prescription benefits only.

The mayor of the City of Bowling Green shall be eligible to enroll for medical, prescription drug and dental benefits as outlined in §33.23 of the codified ordinances of the City of Bowling Green. As used in this document, the term ***employee*** shall include the mayor of the City of Bowling Green.

V. Effective January 1, 2008, the section "**ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE**" shall be amended as follows:

The subsection "**Employee(s) Effective Date**" shall be deleted in its entirety and the following substituted therefore:

## *EMPLOYEE(S) EFFECTIVE DATE*

Eligible ***employees***, as described in *Employee Eligibility*, are covered under the ***Plan*** on the first day of the month following the date of hire, provided the ***employee*** has enrolled for coverage as described in *Employee Enrollment*.

VI. Effective September 30, 2007, the section "**DEFINITIONS**" shall be amended as follows:

The following subsection shall be added:

***Biologically Based Mental Illness***

***Biologically based mental illnesses*** means:

- Schizophrenia
- Schizoaffective disorder
- Major depressive disorder
- Bipolar disorder
- Paranoia and other psychotic disorders
- Obsessive-compulsive disorder
- Panic disorder

All as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

**Received and accepted for Buckeye Ohio Risk Management Association (BORMA) – City of Bowling Green**

By:

Title: Municipal Administrator

Date: January 28, 2008

**AMENDMENT NO. 5**
**FOR**
**BUCKEYE OHIO RISK MANAGEMENT ASSOCIATION (BORMA)**
**CITY OF BOWLING GREEN**
**EMPLOYEE BENEFIT PLAN**

The section "**ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE**" shall be amended as follows:

The subsection "**Special Enrollment Period (Dependent Acquisition)**" shall be deleted in its entirety and the following substituted therefore:

## *SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)*

An ***employee*** who is currently covered or not covered under the ***Plan***, but who acquires a new ***dependent*** may request a special enrollment period for himself, if applicable, his newly acquired ***dependent*** and his spouse, if not already covered under this ***Plan*** and otherwise eligible for coverage.

For the purposes of this provision, the acquisition of a new ***dependent*** includes:

- marriage
- birth of a ***dependent*** child
- adoption or ***placement for adoption*** of a ***dependent*** child

The ***employee*** must request the special enrollment within thirty-one (31) days of the acquisition of the ***dependent***.

The ***effective date*** of coverage as the result of a special enrollment shall be:

1. in the case of marriage, the ***employee*** shall choose to have his or her spouse covered on either the date of such marriage or the first day of the first calendar month following the date of such marriage. The ***employee*** must indicate the effective date on the ***employee's*** written application for coverage;
2. in the case of a ***dependent's*** birth, the date of such birth;
3. in the case of adoption or ***placement for adoption***, the date of such adoption or ***placement for adoption***.

Coverage will be effective for the ***dependents***, and for the ***employee*** if the ***employee*** is eligible to be enrolled under this ***Plan*** but failed to enroll during a previous enrollment period, as follows:

1. When coverage is requested to add a newborn, adopted child or child ***placed for adoption***, coverage will be offered to the ***employee***, eligible spouse, and all other eligible ***dependents*** in addition to the newly acquired child. Coverage will become effective for the ***employee***, spouse and all other eligible ***dependents*** in addition to the newly acquired child retroactive to the date of birth, adoption or ***placement for adoption***.
2. When coverage is requested to add ***dependents*** acquired due to marriage, coverage will be offered to the ***employee***, spouse and all other eligible ***dependents*** acquired as a result of the marriage. Coverage will become effective for the ***employee***, spouse and all other eligible ***dependents*** acquired as a result of the marriage retroactive to the date of the marriage or the first day of the first calendar month following the date of such marriage, as indicated on the ***employee's*** written application for coverage.

**Effective May 1, 2008**

**Received and accepted for Buckeye Ohio Risk Management Association (BORMA) – City of Bowling Green**