



**PLAN DOCUMENT
and
SUMMARY PLAN DESCRIPTION**

for

**CITY OF TOLEDO, OHIO
EMPLOYEE HEALTH BENEFIT PLAN**

Effective: June 1, 2016

Restated: June 1, 2018; January 1, 2021

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ARTICLE I
ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by the City of Toledo, Ohio (the "Plan Sponsor") as of January 1, 2021, hereby amends and restates the City of Toledo, Ohio Employee Health Benefit Plan (the "Plan"), which was originally adopted by the Company, effective June 1, 2006.

1.01 Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein.

1.02 Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

This Plan is maintained pursuant to agreements between the Plan Sponsor and the Toledo Police Patrolmen's Association, Toledo Police Command Officers Association, Toledo Fire Chiefs' Association, Teamsters Local 20, AFSCME Local 7, Local 2058, Local 3411, UAW Local 12, Exempt Employees, Municipal Court Judges Division, and Elected Officials, designated collectively as the "unions." A copy of the agreements between the Plan Sponsor and the union may be obtained upon written request to the Plan Administrator and is available for examination at the Plan Sponsor's principal office, and at each establishment of the Plan Sponsor in which at least fifty (50) Employees are customarily working. In the case of Employees who do not usually work at, or report to, a single establishment of the Plan Sponsor, a copy of the agreement is available for examination at the meeting halls or offices of said union in which there are at least fifty (50) Employees.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

CITY OF TOLEDO, OHIO

By: _____

Name: _____

Title: _____

Date: _____

ARTICLE II
INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

2.01 Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Plan benefits are self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Participants and/or the Plan Sponsor, or are funded solely from the general assets of the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for eligible Employees, the economic effects arising from a Non-occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by the Company and may be inspected at any time during normal working hours by any Participant.

2.02 General Plan Information

This group health plan believes this plan is a "Grandfathered Health Plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a Grandfathered Health Plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a Grandfathered Health Plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, Grandfathered Health Plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a plan to change from Grandfathered Health Plan status can be directed to the Plan Administrator at the following address:

Benefits Plan Administrator
Department of Human Resources
One Government Center, Suite 1920
Toledo, OH 43604
(419) 245-1500

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to Grandfathered Health Plans.

Name of Plan: City of Toledo, Ohio Employee Health Benefit Plan

Plan Sponsor: The City of Toledo, Ohio
One Government Center, Suite 1920
Toledo, OH 43604
(419) 245-1500

Plan Administrator: The City of Toledo, Ohio
(Named Fiduciary) One Government Center, Suite 1920
Toledo, OH 43604
(419) 245-1500

Plan Sponsor ID No. (EIN): 34-6401447

Plan Status:	Grandfathered
Source of Funding:	Self-Funded
Applicable Law:	Federal, State of Ohio
Plan Year:	January 1 through December 31
Plan Type:	Medical
Third Party Administrator:	HealthSCOPE Benefits, Inc. 27 Corporate Hill Drive Little Rock, AR 72205 (501) 225-1551
Participating Employer(s):	City of Toledo, Ohio
Agent for Service of Process:	Benefits Plan Administrator Department of Human Resources City of Toledo, Ohio One Government Center, Suite 1920 Toledo, OH 43604 (419) 245-1500

2.03 Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

2.04 Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

2.05 Mental Health Parity

Pursuant to the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

2.06 Applicable Law

This is a self-funded benefit plan not subject to the Employee Retirement Income Security Act of 1974 (“ERISA”). The Plan is funded with employee and/or employer contributions. The Plan is subject to Federal law and the laws of the State of Ohio.

2.07 Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participants’ rights; and to determine all questions of fact and law arising under the Plan.

ARTICLE III SUMMARY OF BENEFITS

3.01 General Limits

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions. All coverage figures are after the out-of-pocket Deductible has been satisfied. Benefits for Pregnancy expenses are available to all female Participants and are paid the same as any other Sickness.

Failure to comply with Utilization Management will result in a higher cost to Participants. **“Utilization Management”** includes hospital pre-admission certification, continued stay review, length-of-stay determination and discharge planning. These programs are designed to ensure that Medically Necessary, high-quality patient care is provided and enables maximum benefits under the Plan. See pre-certification requirements in the section entitled “Cost Containment.”

The following services may require pre-certification (or reimbursement from the Plan may be reduced):

- Air Ambulance (see Cost Containment section for specific procedures);
- Inpatient Hospitalization;
- Inpatient and Residential Mental/Nervous facility-based programs;
- Inpatient and Residential Substance Abuse facility-based programs;
- Transplant Candidacy Evaluation and Transplant (organ and/or tissue);
- Gender Reassignment Surgery;
- Home Health services;
- Home Infusion;
- Hospice;
- Sleep studies;
- Magnetic Resonance Imaging (MRI and MRA);
- Uvulopalatopharyngoplasty;
- Arthroscopy;
- Blepharoplasty and Ptosis Surgery;
- Foot Surgery (major joint Surgery), including bunionectomy/correction, hallux valgus, bone spur removal/ostectomy, hammertoe/capsulotomy, Osteotomy Procedures, and Ostectomy Procedures;
- Treatment for varicose veins (Surgical treatment and sclerotherapy);
- Breast Surgery, other than biopsy procedures and for malignancy;
- Surgical treatment of morbid obesity, at least fourteen (14) days in advance of Surgery;
- Skilled Nursing Facility stays;
- Observation more than 23 hours.

Remember that although the Plan will automatically pre-authorize a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours for a cesarean delivery, it is important to have your Physician call to obtain pre-certification in case a longer stay is needed. See pre-certification requirements in the section entitled “Cost Containment” for more details.

The Plan contracts with the medical provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical provider Networks are called “Network Providers.” Those who have not contracted with the Networks are referred to in this Plan as “Non-Network Providers.” This arrangement results in the following benefits to Participants:

1. The Plan provides different levels of benefits based on whether the Provider Participants use is a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:

- a. If a Network facility is utilized (Inpatient or outpatient), any non-Network radiology, lab, pathology, or anesthesiology services provided at the facility will be paid as though provided by a Network Provider.
 - b. The Network Provider level of benefits is payable when a Participant receives emergency care either Out of Area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency.
2. If the charge billed by a Non-Network Provider for any covered service is higher than the Usual and Customary fees determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee.
 3. To receive benefit consideration, Participants may be required to submit claims for services provided by Non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.
 4. Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.
 5. Covered non-Network services are paid according to Data iSight reimbursement methodology (see definition of “Maximum Amount/Maximum Allowable Charge” under Article IV). For additional information, refer to dataisight.com or 866-835-4022.

3.02 Primary Care Providers

A current list of PPO providers is available, without charge, through the Third Party Administrator’s website (located at www.healthscopebenefits.com). Each Participant has a free choice of any physician or surgeon, and the physician-patient relationship shall be maintained. The Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The PPO providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any PPO provider.

This Plan generally allows the designation of a primary care Provider. You have the right to designate any primary care Provider who participates in the Network and who is available to accept you or your family members. For information on how to select a primary care Provider, and for a list of the participating primary care Providers, contact the Plan Administrator.

3.03 Claims Audit

In addition to the Plan’s Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient’s medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document. Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Plan Document.

3.04 Wellbeing Program

The Wellbeing Program is designed to respond to an employee’s recognized needs for guidance and provide encouragement, empowerment, and education regarding dealing with areas of health and wellbeing concerns. It provides the employee with knowledge to recognize health risks and the means of addressing those risks. It also provides employees opportunities to address wellness needs to improve physical, mental, emotional, and financial health concerns. Contact the Human Resources Department at (419) 245-1507 for more information.

3.05 Maximum Benefits

The following benefit maximums apply to each Participant:

Calendar Year Maximum Benefits for:	
Chiropractic Care (including x-ray and lab)	\$1,000
Post-Surgical Bras	3
Surgical Stockings	3 Pairs
Diabetic Shoes/Inserts	1 Pair
All Essential Health Benefits	Unlimited
Other Maximum Benefits:	
Morbid Obesity Surgery	\$15,000 per Lifetime
Gender Reassignment Surgery	1 per Lifetime, up to \$10,000

3.06 Summary of Medical Benefits

The following benefits are per Participant per calendar year:

	Network	Non-Network
Deductible		
<ul style="list-style-type: none"> • Individual • Family Unit 	\$100 \$200	\$100 \$200
	The Network Family Deductible includes an embedded Individual Deductible. Network and non-Network charges cross-apply to meet Deductible amounts.	
Payment Level (unless otherwise stated)	100%	80%
Office Visit Rider Benefit (Copay Rider)	<ul style="list-style-type: none"> • Individual: \$300 per calendar year • Family: \$600 per calendar year 	
	Services subject to Copay Rider are paid at 100% for Network Providers and 80% for Non-Network Providers, up to the amounts stated above. Once Copay Rider has been exhausted, services are paid subject to the Deductible and coinsurance.	

Covered Service	Network	Non-Network
Allergy Services		
<ul style="list-style-type: none"> • Treatment and Serum • Allergy Testing 	80% after Deductible 100% no Deductible	60% after Deductible 80% no Deductible
Ambulance (Ground or Air)	80% after Deductible	80% after Deductible
	Precertification is required for scheduled air ambulance transfers.	

Covered Service	Network	Non-Network
Ambulatory Surgical Center	100% no Deductible	80% no Deductible
	See list of surgery services requiring pre-certification under Section 3.01.	
Anesthesia	100% no Deductible	80% no Deductible
Birth Control <ul style="list-style-type: none"> • Devices, Implants, IUDs • Voluntary sterilization • Birth control pills 	100% no Deductible 100% no Deductible Covered under Prescription Drug benefits	80% no Deductible 80% no Deductible 80% no Deductible
	Removal of birth control devices is included. Reversal of sterilization is not covered.	
Birth Center	100% no Deductible	80% no Deductible
Cardiac Rehabilitation—Outpatient	100% no Deductible	80% no Deductible
Chemotherapy <ul style="list-style-type: none"> • Services • Associated Office Visit 	100% no Deductible \$10 Copay Copay Rider—until exhausted Then 80% after Deductible	80% no Deductible \$10 Copay Copay Rider—until exhausted Then 80% after Deductible
	Limited to \$1,000 per Participant per calendar year.	
Chiropractic Services <ul style="list-style-type: none"> • Office Visits and Manipulation • X-rays and Lab 	\$10 Copay Copay Rider—until exhausted Then 80% after Deductible 100% no Deductible	\$10 Copay Copay Rider—until exhausted Then 60% after Deductible 80% no Deductible
	Limited to \$1,000 per Participant per calendar year.	
Consultation Services During Inpatient Stay <ul style="list-style-type: none"> • Physician Inpatient Visit—First Inpatient Consultation • Additional Visits (including 2nd and 3rd opinions) 	100% no Deductible (limited to 1 visit per day per Physician) 80% after Deductible	80% no Deductible (limited to 1 visit per day per Physician) 60% after Deductible
	Limited to \$1,000 per Participant per calendar year.	
Consultation Services in Physician’s Office	\$10 Copay Copay Rider—until exhausted Then 80% after Deductible	\$10 Copay Copay Rider—until exhausted Then 60% after Deductible
COVID-19 <ul style="list-style-type: none"> • Testing & Associated Office Visit, ER Visit, or Urgent Care Visit • Virtual Care Visits* (PCP or Specialist) 	100% no Deductible 100% no Deductible	100% no Deductible 100% no Deductible
	*Benefit available for services rendered from February 4, 2020 on a temporary basis through the COVID-19 emergency.	
Diabetes Management Program	100% no Deductible	Not Covered
	Covered at participating Kroger, and ProMedica Diabetic locations. To enroll, contact COT Human Resources at (419) 245-1507.	
Diagnostic X-ray and Lab	100% no Deductible	80% no Deductible
	Precertification is required for MRI AND MRA.	
Dialysis Treatment – Outpatient	100% no Deductible	80% no Deductible
	100% of the Usual and Reasonable Charge after all applicable deductibles and coinsurance. NOTE: Outpatient Dialysis Treatment claims are subject to specific conditions which do not apply to other types of claims. Please refer to Dialysis Treatment Outpatient Description (Section 15.03).	

Covered Service	Network	Non-Network
Durable Medical Equipment	80% after Deductible	60% after Deductible
Education Services <ul style="list-style-type: none"> • Billed by Facility • Billed by Physician 	100% no Deductible 80% after Deductible	80% no Deductible 60% after Deductible
	See Section 15.01 for covered services.	
Emergency Room Services	\$200 Copay, then 100% no Deductible	\$200 Copay, then 80% no Deductible
	Copay applies only to facility charge and is waived if the Participant is admitted to the same facility on same date of service. Upon receipt of documentation, the ER copay may be reduced to \$100 if covered member is referred directly from an urgent care facility, physician's office or telemedicine provider. The Plan does not cover ER visit room charge in the case of a non-emergency.	
Gender Dysphoria Services	100% no Deductible	80% no Deductible
	Covers mental health care, prescription drug therapy (including related hormone therapy), and 1 Medically Necessary gender reassignment surgery per Participant per lifetime, up to \$10,000. See Section 15.01 for more information.	
Glaucoma	100% no Deductible	80% no Deductible
Home Health Care	100% no Deductible	80% no Deductible
	Precertification is required.	
Home Infusion/IV Therapy	100% no Deductible	80% no Deductible
	Precertification is required.	
Hospice Care	100% no Deductible	80% no Deductible
	Bereavement and respite services are not covered.	
Hospital <ul style="list-style-type: none"> • Inpatient Treatment • Outpatient Treatment 	100% no Deductible 100% no Deductible	80% no Deductible 80% no Deductible
	Precertification is required for inpatient treatment and some outpatient surgery (see Section 3.01).	
Impotence Treatment <ul style="list-style-type: none"> • Surgical treatment • Other Services 	100% no Deductible 80% after Deductible	80% no Deductible 60% after Deductible
	Penile implants and other Medically Necessary treatments or devices are covered. Viagra and other Drugs used to treat impotence are covered under Prescription Drug benefits.	
Infertility Diagnosis	100% no Deductible	80% no Deductible
	Limited to testing and initial diagnosis of infertility.	
Inhalation Therapy <ul style="list-style-type: none"> • Outpatient Hospital • Physician's Office • Inhalers for Asthma & Respiratory Disorders 	100% no Deductible 80% after Deductible 80% after Deductible	80% no Deductible 60% after Deductible 60% after Deductible
Morbid Obesity Surgery	100% no Deductible	80% no Deductible
	Precertification is required at least 14 days in advance of surgery. Surgical benefit limited to \$15,000 per lifetime of Participant. See Section 15.01 for additional information and requirements.	
Newborn Care	100% no Deductible	80% no Deductible
	Initial newborn services covered under baby.	

Covered Service	Network	Non-Network
Physician Services <ul style="list-style-type: none"> • PCP/Specialist Office Visit • Lab, x-rays and Surgery • All Other Services 	\$10 Copay Copay Rider—until exhausted Then 80% after Deductible 100% no Deductible 80% after Deductible	\$10 Copay Copay Rider—until exhausted Then 80% after Deductible 80% no Deductible 60% no Deductible
Podiatry <ul style="list-style-type: none"> • PCP/Specialist Office Visit • Diagnostic Lab, X-ray & Surgery 	\$10 Copay Copay Rider—until exhausted Then 80% after Deductible 100% no Deductible	\$10 Copay Copay Rider—until exhausted Then 80% after Deductible 80% no Deductible
Precertification is required for foot surgery (see Section 3.01).		
Pregnancy Expenses <ul style="list-style-type: none"> • Initial Office Visit • Prenatal, Postnatal, and Delivery Services 	\$10 Copay* Copay Rider—until exhausted Then 80% after Deductible 100% no Deductible	\$10 Copay* Copay Rider—until exhausted Then 80% after Deductible 80% no Deductible
*If billed separately from subsequent obstetrical visits. Certified Nurse Midwife services are covered.		
Preventive Care	100% no Deductible	100% no Deductible
See Section 15.01 for covered services.		
Prosthetics, Orthotics, Supplies and Surgical Dressings	80% after Deductible	60% after Deductible
Includes breast prostheses and 3 surgical bras per calendar year.		
Psychiatric Expenses <ul style="list-style-type: none"> • Office Visit • Inpatient Treatment Facility • Outpatient Treatment Facility • Residential Treatment • Partial Day Treatment • Psychotherapy • Psychological Testing 	\$10 Copay Copay Rider—until exhausted Then 80% after Deductible 100% no Deductible 100% no Deductible 100% no Deductible 100% no Deductible 80% after Deductible 100% no Deductible	\$10 Copay Copay Rider—until exhausted Then 80% after Deductible 80% no Deductible 80% no Deductible 80% no Deductible 80% no Deductible 60% after Deductible 80% no Deductible
Precertification is required for inpatient and residential treatment.		
Pulmonary Rehabilitation	100% no Deductible	80% no Deductible
Reconstructive Surgery	100% no Deductible	80% no Deductible
Routine/Preventive Care	100% no Deductible	100% no Deductible
See Section 15.01 for covered services.		
Second and Third Surgical Opinion	80% after Deductible	60% after Deductible
Skilled Nursing Facility	100% no Deductible	80% no Deductible
Precertification is required.		
Sleep Disorders	100% no Deductible	80% no Deductible
Precertification is required for sleep studies.		

Covered Service	Network	Non-Network
Substance Abuse Benefits <ul style="list-style-type: none"> • Office Visit • Inpatient Treatment • Outpatient Treatment • Residential Treatment • Partial Day Treatment 	\$10 Copay Copay Rider—until exhausted Then 80% after Deductible 100% no Deductible 100% no Deductible 100% no Deductible 100% no Deductible	\$10 Copay Copay Rider—until exhausted Then 80% after Deductible 80% no Deductible 80% no Deductible 80% no Deductible 80% no Deductible
	Precertification is required for inpatient and residential treatment.	
Surgical Services—Inpatient and Outpatient	100% no Deductible	80% no Deductible
Therapy <ul style="list-style-type: none"> • Chemotherapy • Occupational Therapy • Physical Therapy • Radiation Therapy • Respiration Therapy • Speech Therapy 	100% no Deductible 80% after Deductible 80% after Deductible 100% no Deductible 100% no Deductible 80% after Deductible	80% no Deductible 60% after Deductible 60% after Deductible 60% after Deductible 80% no Deductible 80% no Deductible
	Outpatient speech therapy requires a pre-determination, along with the Participant's completed speech evaluation and treatment plan. Aquatic therapy is included under physical therapy.	
Transplants	100% no Deductible	80% no Deductible
	Precertification is required. See Section 15.01 for more details.	
Urgent Care Facilities	\$10 Copay, then 100% no Deductible	80% no Deductible
Weight Management Program	100% no Deductible	Not Covered
	Covered at participating Kroger's pharmacy locations and ProMedica Toledo Hospital. To enroll, contact COT Human Resources at (419) 245-1507.	

ARTICLE IV DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for that information.**

“Accident”

“Accident” shall mean a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

“Accidental Bodily Injury”

“Accidental Bodily Injury” shall mean an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

“ADA”

“ADA” shall mean the American Dental Association.

“Adverse Benefit Determination”

“Adverse Benefit Determination” shall mean any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A rescission of coverage;
4. A termination of benefits; or
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant’s eligibility to participate in the Plan.

“Affordable Care Act (ACA)”

The “Affordable Care Act (ACA)” means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

“AHA”

“AHA” shall mean the American Hospital Association.

“Allowable Expenses”

“Allowable Expenses” shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with Section 10.06A herein, this Plan’s Allowable Expenses shall consist of the Plan Participant’s responsibility, if any, after the Other Plan has paid but shall in no event exceed the Other Plan’s Allowable Expenses. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

“Alternate Recipient”

“Alternate Recipient” shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant’s Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent.

“AMA”

“AMA” shall mean the American Medical Association.

“Ambulatory Surgical Center”

“Ambulatory Surgical Center” shall mean any public or private State licensed and approved (whenever required by law) establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures, with continuous Physician services and registered professional nursing service whenever a patient is in the facility, and which does not provide service or other accommodations for patients to stay overnight.

“Approved Clinical Trial”

“Approved Clinical Trial” means a phase I, II, III, or IV trial that is federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, CMS, Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the FDA (if such application is required).

The Affordable Care Act requires that if a “qualified individual” is in an “Approved Clinical Trial,” the Plan cannot deny coverage for related services (“routine patient costs”).

A “qualified individual” is someone who is eligible to participate in an “Approved Clinical Trial” and either the individual’s doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

“Routine patient costs” include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan’s Network area unless out-of-Network benefits are otherwise provided under the Plan.

“Assignment of Benefits”

“Assignment of Benefits” shall mean an arrangement whereby the Plan Participant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a provider accepts said arrangement, Providers’ rights to receive Plan benefits are equal to those of a Plan Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an “Assignment of Benefits” as consideration in full for services, supplies, and/or treatment rendered.

“Birthing Center”

“Birthing Center” shall mean a facility that meets professionally recognized standards and all of the following requirements:

1. It mainly provides an outpatient setting for childbirth following a normal, uncomplicated Pregnancy, in a home-like atmosphere.
2. It has the following: at least 2 delivery rooms; all the medical equipment needed to support the services furnished by the facility; laboratory diagnostic facilities; and emergency equipment, trays, and supplies for use in life threatening situations.
3. It has medical staff that: is supervised by a Physician on a full-time basis; and includes a Registered Nurse at all times when Covered Persons are at the facility.
4. If it is not part of a Hospital, it has a written agreement with a local Hospital and a local ambulance company for the immediate transfer of Covered Persons who develop complications or who require either pre or post-natal care.
5. It admits only Covered Persons who: have undergone an educational program to prepare them for the birth; and have medical records of adequate prenatal care.
6. It schedules confinements of not more than 24 hours for a birth.
7. It maintains medical records for each Covered Person.

8. It complies with all licensing and other legal requirements that apply.
9. It is not the office or clinic of one or more Physicians or a specialized facility other than a Birthing Center.

“Break in Service”

“Break in Service” means a period of at least 13 consecutive Weeks during which the Employee has no Hours of Service, as defined herein. A Break in Service may also include any period for which the Employee has no Hours of Service that is at least four (4) consecutive Weeks in duration and longer than the prior period of employment (determined after application of the procedures applicable to Special Unpaid Leaves absence prescribed herein).

“Cardiac Care Unit”

“Cardiac Care Unit” shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the treatment of patients who require special medical attention because of their critical condition;
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
4. It contains at least two beds for the accommodation of critically ill patients; and
5. It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

“Cardiac Rehabilitation Therapy”

“Cardiac Rehabilitation Therapy” means those Medically Necessary services that are rendered under the supervision of a Physician in connection with a myocardial infarction, coronary occlusion, or coronary bypass Surgery. Therapy must be initiated within twelve (12) weeks after being discharged from an Inpatient confinement for the medical condition and must be rendered in a facility covered by the Plan.

“Centers of Excellence”

“Centers of Excellence” shall mean medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator shall determine what Network Centers of Excellence are to be used.

Any Participant in need of an organ transplant may contact the Claims Administrator to initiate the pre-certification process resulting in a referral to a Center of Excellence. The Claims Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admission taking place at a Center of Excellence.

If a Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence. Additional information about this option, as well as a list of Centers of Excellence, will be given to covered Employees and updated as requested.

“Child”

“Child” shall mean, in addition to the Employee’s own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee’s Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, or any other Child for whom the Employee or his/her spouse has obtained legal guardianship.

“CHIP”

“CHIP” refers to the Children’s Health Insurance Program or any provision or section thereof, which is herein specifically referred to as such act, provision, or section may be amended from time to time.

“CHIPRA”

“CHIPRA” refers to the Children’s Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

“Chiropractic Care”

“Chiropractic Care” shall mean office visits, x-rays, manipulations, supplies, heat treatment, and cold treatment.

“Claim Determination Period”

“Claim Determination Period” shall mean each calendar year.

“Clean Claim”

A “Clean Claim” is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute covered expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Plan Participant has failed to submit required forms or additional information to the Plan as well.

“COBRA”

“COBRA” shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Cosmetic Surgery”

“Cosmetic Surgery” shall mean any Surgery, service, Drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

“Covered Expense”

“Covered Expense” means a Usual and Customary fee for a Reasonable, Medically Necessary service, treatment, or supply, meant to improve a condition or participant’s health, which is eligible for coverage in this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option. All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

“Custodial Care”

“Custodial Care” shall mean care or confinement provided primarily for the maintenance of the Participant, essentially designed to assist the Participant, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered, and all domestic activities.

“Deductible”

“Deductible” shall mean an amount of money that is paid once a calendar year per Participant and Family Unit. Typically, there is one Deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each calendar year, a new Deductible amount is required.

“Dentist”

“Dentist” shall mean an individual holding a D.D.S. or D.M.D. degree, licensed to practice dentistry in the jurisdiction where such services are provided.

“Dependent”

“Dependent” shall mean one or more of the following person(s):

1. An Employee’s lawfully married spouse possessing a marriage license who is not divorced from the Employee. For purposes of this section, “marriage or married” means a legal union between a couple of the same or opposite sex, but excludes domestic partnerships and common law marriages.
2. An Employee’s Child who is less than 26 years of age, regardless of the Child’s dependency, residency, or student or financial dependence status. Coverage shall continue until the date the Child turns twenty-six (26) years of age.
3. An Employee’s unmarried Child who is over the age of 26, is permanently disabled at the time he/she reaches the age of 26, and meets the dependency requirements set forth in this paragraph. The Dependent Child must be incapable of sustaining his or her own living due to mental retardation or physical handicap, and must be primarily dependent upon the covered Employee for support and maintenance. The covered Employee must notify Employer of the Child’s disability within 31 days after the Child reaches the age of 26. Such notification shall include proof satisfactory to Employer of the Child’s incapacity and dependence upon the covered Employee. After a two-year period following the date the Child turns 26, the Employee may be required to provide additional proof of the Child’s continued dependence and incapacity.

A child who is the subject of a National Medical Support Notice (NMSN) or Qualified Medical Child Support Order (QMCSO) will be considered a Dependent under the Plan. The NMSN entitles such child to coverage even if (a) the child does not reside with the covered Employee or is not dependent on the Employee for support, and (b) even if the Employee does not enroll for coverage under the Plan or does not have legal custody of the child. If the eligible Employee has not satisfied the applicable Service Waiting Period, the Plan must cover the Dependent Child upon the eligible Employee’s completion of such Service Waiting Period. All other applicable enrollment provisions of the Plan (e.g., Dependent limiting age, benefit options, right to continued coverage, etc.) that are available to covered Employees or other covered Dependents shall be made available to the Dependent Child who is eligible pursuant to a NMSN or QMCSO.

“Dependent” does not include any person who is a member of the armed forces of any Country or who is a resident of a Country outside the United States.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship.

“Diagnosis”

“Diagnosis” shall mean the act or process of identifying or determining the nature and cause of a Disease or Injury through evaluation of patient history, examination, and review of laboratory data.

“Diagnostic Service”

“Diagnostic Service” shall mean a test or procedure performed for specified symptoms to detect or to monitor a Disease or condition. It must be ordered by a Physician or other professional Provider.

“Disease”

“Disease” shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an employee under any worker’s compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine

of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a Sickness, Illness or Disease.

“Drug”

“Drug” shall mean insulin and prescription legend drugs. A prescription legend drug is a Federal legend drug (any medicinal substance which bears the legend: “Caution: Federal law prohibits dispensing without a prescription”) or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law) and which, in either case, is legally obtained from a licensed drug dispenser only upon a prescription of a currently licensed Physician.

“Durable Medical Equipment”

“Durable Medical Equipment” shall mean equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an Illness or Injury; and
4. Is appropriate for use in the home.

“Emergency”

“Emergency” shall mean a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

“Emergency Medical Condition”

“Emergency Medical Condition” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

“Emergency Services”

“Emergency Services” shall mean, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

“Employee”

“Employee” shall mean the classes of Employees who are eligible for coverage under the Plan as set forth in the Eligibility for Coverage section of this Summary Plan Description and the Plan’s Eligibility Appendix. Contact the Plan Administrator for more information or to obtain a copy of the Plan’s Eligibility Appendix.

“Essential Health Benefits”

“Essential Health Benefits” shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

“Experimental” and/or “Investigational”

“Experimental” and/or “Investigational” (“Experimental”) shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA’s Council on Medical Specialty Societies.

All phases of clinical trials shall be considered Experimental. A drug, device, or medical treatment or procedure is Experimental:

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;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
 - a) maximum tolerated dose;
 - b) toxicity;
 - c) safety;
 - d) efficacy; and
 - e) efficacy as compared with the standard means of treatment or diagnosis; or
3. if reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
 - a) maximum tolerated dose;
 - b) toxicity;
 - c) safety;
 - d) efficacy; and
 - e) efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Notwithstanding the above, a prescription drug for a treatment that has been approved by the FDA but is used as a non-approved treatment shall not be considered Experimental/Investigational for purposes of this Plan and shall be afforded coverage to the same extent as any other prescription drug; provided that the drug is recognized by one of the following as being Medically Necessary for the specific treatment for which it has been prescribed:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or
4. A clinical study or review article in a reviewed professional journal;

or subject to a medical opinion, if no other FDA approved treatment is feasible and as a result the Participant faces a life or death medical condition, the Plan Administrator retains discretionary authority to cover services or treatment not otherwise covered under the Plan. The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

“Family Unit”

“Family Unit” shall mean the Employee, his or her Dependents covered under the Plan.

“Final Internal Adverse Benefit Determination”

“Final Internal Adverse Benefit Determination” shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

“FMLA”

“FMLA” shall mean the Family and Medical Leave Act of 1993, as amended.

“FMLA Leave”

“FMLA Leave” shall mean a leave of absence, which the Company is required to extend to an Employee under the provisions of the FMLA.

"Genetic Testing"

"Genetic Testing" shall mean medical tests used to identify changes in chromosomes, genes, or proteins.

“GINA”

“GINA” shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

“HIPAA”

“HIPAA” shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

“Home Health Care”

“Home Health Care” shall mean the continual care and treatment of an individual if:

1. The institutionalization of the individual would otherwise have been required if home health care was not provided;
2. The treatment plan covering the home health care service is established and approved in writing by the attending Physician; and
3. The home health care is the result of an Illness or Injury.

“Home Health Care Agency”

“Home Health Care Agency” shall mean an agency or organization which provides a program of home health care and which:

1. Is approved as a Home Health Agency under Medicare;
2. Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
3. Meets all of the following requirements:
 - a. It is an agency which holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive services to the home;
 - b. It has a full-time administrator;
 - c. It maintains written records of services provided to the patient;
 - d. Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and
 - e. Its employees are bonded and it provides malpractice insurance.

“Hospital”

“Hospital” shall mean an Institution that meets all of the following requirements:

1. It provides medical and Surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis;
2. It is under the supervision of a staff of Physicians;
3. It provides 24-hour-a-day nursing service by registered nurses;

4. It is duly licensed as a hospital, except that this requirement will not apply in the case of a State tax-supported Institution;
5. It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type Institution, or an Institution which is supported in whole or in part by a Federal government fund; and
6. It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

“Hospital” shall also have the same meaning, where appropriate in context, set forth in the definition of “Ambulatory Surgical Center.”

“Hours of Service”

“Hours of Service” means each hour for which the Employee is paid or entitled to payment for performance of services for the Employer AND any hour for which the employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following, consistent with 29 C.F.R. 2530.200b-2(a)(i):

1. Vacation
2. Holiday
3. Illness or incapacity
4. Layoff
5. Jury duty
6. Military duty or leave of absence.

“Illness”

“Illness” shall have the meaning set forth in the definition of “Disease.”

“Impregnation and Infertility Treatment”

“Impregnation and Infertility Treatment” shall mean artificial insemination, fertility drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency drugs such as Viagra™, in-vitro fertilization, sterilization and/or reversal of a sterilization operation, surrogate mother, donor eggs, or any type of artificial impregnation procedure, whether or not such procedure is successful.

“Incurred”

A covered expense is “Incurred” on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, covered expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, covered expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

“Injury”

“Injury” shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

“Inpatient”

“Inpatient” shall mean any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for Room and Board is made by the Hospital.

“Institution”

“Institution” shall mean a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, Home Health Care Center, or any other such facility that the Plan approves.

“Intensive Care Unit”

“Intensive Care Unit” shall have the same meaning set forth in the definition of “Cardiac Care Unit.”

“Leave of Absence”

“Leave of Absence” shall mean a leave of absence of an Employee that has been approved by his or her Participating Employer, as provided for in the Participating Employer’s rules, policies, procedures, and practices.

“Mastectomy”

“Mastectomy” shall mean the surgical removal of all or part of a breast.

“Maximum Amount” or “Maximum Allowable Charge”

“Maximum Amount” and/or “Maximum Allowable Charge” shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be the lesser of:

- The Usual and Customary amount;
- The allowable charge specified under the terms of the Plan;
- The Reasonable charge specified under the terms of the Plan;
- The negotiated rate established in a contractual arrangement with a Provider;
- For outpatient dialysis, the Usual and Reasonable charge; or
- The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service. The **Maximum Allowable Charge** will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Note: Covered non-Network services are paid according to Data iSight reimbursement methodology. Except as otherwise required under state or Federal regulations, the maximum amount the Plan is obligated to pay for services provided by a non-Network Provider will be the lesser of the Provider’s billed charges for covered services and an amount determined by one or more of the following:

- Using current publicly-available data reflecting fees typically reimbursed to Providers for the same or similar professional services, adjusted for geographical differences where applicable.
- Using current publicly-available data reflecting the costs for facilities providing the same or similar services, adjusted for geographical differences where applicable, plus a margin factor.
- Using amounts calculated based on what Medicare would reimburse for the services billed.

“Medical Child Support Order”

“Medical Child Support Order” shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Participant’s Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

“Medically Necessary”

“Medical Care Necessity”, “Medically Necessary”, “Medical Necessity,” and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, diagnosis, or treatment of that Plan Participant’s Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site, and duration for the diagnosis or treatment of the Plan Participant’s Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Plan Participant’s medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary, must be

no more costly than alternative interventions, including no intervention, and must be at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant's Sickness or Injury without adversely affecting the Plan Participant's medical condition. Additionally:

- a. It must not be maintenance therapy or maintenance treatment.
- b. Its purpose must be to restore health.
- c. It must not be primarily custodial in nature.
- d. It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).
- e. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed, or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Off-label Drug use is considered Medically Necessary when all of the following conditions are met:

- a. The Drug is approved by the FDA;
- b. The prescribed Drug use is supported by one of the following standard reference sources:
 - 1) DRUGDEX;
 - 2) The American Hospital Formulary Service Drug Information;
 - 3) Medicare approved Compendia; or
 - 4) Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the Drug is safe and effective for the specific condition; and
- c. The Drug is Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

"Medical Record Review"

"Medical Record Review" is the process by which the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the **Maximum Allowable Charge** according to the medical record review and audit results.

"Medicare"

"Medicare" shall mean the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

"Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)"

"The Mental Health Parity Provisions" shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are

applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and

2. The treatment limitations applicable to such mental health or substance use order benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

“Mental or Nervous Disorder”

“Mental or Nervous Disorder” shall mean any disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

“Morbid Obesity”

“Morbid Obesity” shall mean the following:

1. At least 100 pounds over or twice the ideal weight, whichever is less; and
2. Body Mass Index (BMI) greater than 40.

“National Medical Support Notice” or “NMSN”

“National Medical Support Notice” or “NMSN” shall mean a notice that contains the following information:

1. Name of an issuing State agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

“Network”

“Network” shall mean the medical provider network the Plan contracts to access discounted fees for service for Participants. The Network Provider will be identified on the Participants identification card.

“Other Plan”

“Other Plan” shall include, but is not limited to:

1. Any primary payer besides the Plan;
2. Any other group health plan;
3. Any other coverage or policy covering the Participant;
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Worker’s compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

“Participant” / “Plan Participant”

“Participant” shall mean any Employee or retiree or Dependent who is eligible for benefits under the Plan.

“Physician”

“Physician” shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), psychiatrist or midwife.

“Plan Year”

“Plan Year” shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

“Pre-admission Tests”

“Pre-admission Tests” shall mean those Diagnostic Services done prior to scheduled Surgery, provided that:

1. The tests are approved by both the Hospital and the Physician;
2. The tests are performed on an outpatient basis prior to Hospital admission; and
3. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the Surgery.

“Preferred Provider Organization (PPO)”

“Preferred Provider Organization (PPO)” shall mean an organization that contracts with a network of providers from which the health plan Participant can choose. Participants do not need to select a primary care physician (PCP) and do not need referrals to see other providers in the network.

“Pregnancy”

“Pregnancy” shall mean carrying a child, resulting childbirth, miscarriage and non-elective abortion. The Plan considers Pregnancy as a Sickness for the purpose of determining benefits.

“Prior Plan”

“Prior Plan” shall mean the coverage provided on a group or group-type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

“Prior to Effective Date” or “After Termination Date”

“Prior to Effective Date” or “After Termination Date” are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

“Privacy Standards”

“Privacy Standards” shall mean the standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

“Provider”

“Provider” shall mean a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

“Psychiatric Hospital”

“Psychiatric Hospital” shall mean an Institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician;
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
3. It is licensed as a psychiatric hospital;
4. It requires that every patient be under the care of a Physician; and
5. It provides 24-hour-a-day nursing service.

The term Psychiatric Hospital does not include an Institution, or that part of an Institution, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational care.

“Qualified Medical Child Support Order” or “QMCSO”

“Qualified Medical Child Support Order” or “QMCSO” is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan.

“Reasonable”

“Reasonable” and/or “Reasonableness” shall mean in the administrator’s discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating Provider. Determination that fee(s) or services are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care, and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed “reasonably preventable” through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines. The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

“Regular Full-time Employee”

“Regular Full-time Employee” means an individual who is employed with and compensated for services by the City of Toledo, Ohio, and who is regularly scheduled to work thirty (30) Hours of Service or more per week. The work performed by the Regular Full-time Employee may occur either at the usual place of business of the City of Toledo or at a location to which the business of the City of Toledo requires the Regular Full-time Employee to travel.

“Rehabilitation Hospital”

“Rehabilitation Hospital” shall mean an Institution which mainly provides therapeutic and restorative services to Sick or Injured people. It is recognized as such if:

1. It carries out its stated purpose under all relevant Federal, State and local laws;
2. It is accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities; or
3. It is approved for its stated purpose by Medicare.

“Room and Board”

“Room and Board” shall mean a Hospital’s charge for:

1. Room and linen service;
2. Dietary service, including meals, special diets and nourishment;
3. General nursing service; and
4. Other conditions of occupancy which are Medically Necessary.

“Security Standards”

“Security Standards” shall mean the final rule implementing HIPAA’s Security Standards for the Protection of Electronic PHI, as amended.

“Service Waiting Period”

“Service Waiting Period” shall mean an interval of time during which the Employee is in the continuous, Active Employment of his or her Participating Employer.

“Sickness”

“Sickness” shall have the meaning set forth in the definition of “Disease.”

“Substance Abuse”

“Substance Abuse” shall mean any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of “Substance Use Disorder” is applied as follows:

- A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
 - 1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);
 - 2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
 - 3. Craving or a strong desire or urge to use a substance; or
 - 4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);

- B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

“Substance Abuse Treatment Center”

“Substance Abuse Treatment Center” shall mean an Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

- 1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
- 2. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
- 3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

Substance Dependence: Substance use history which includes the following: (1) substance abuse (see above); (2) continuation of use despite related problems; (3) development of tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms.

“Surgery”

“Surgery” shall mean any of the following:

- 1. The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
- 2. The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
- 3. The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
- 4. The induction of artificial pneumothorax and the injection of sclerosing solutions;
- 5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
- 6. Obstetrical delivery and dilatation and curettage; or
- 7. Biopsy.

“Surgical Procedure”

“Surgical Procedure” shall have the same meaning set forth in the definition of “Surgery.”

“Total Disability”

“Total Disability” shall mean an individual is determined as being disabled for Social Security purposes and provides such evidence to the Plan of the determination as the Plan Administrator may, in its sole discretion, require.

“Totally Disabled”

“Totally Disabled” shall have the same meaning set forth in the definition of “Total Disability.”

“Uniformed Services”

“Uniformed Services” shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

“USERRA”

“USERRA” shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”).

“Usual and Customary”

“Usual and Customary” (U&C) shall mean covered expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same “area” by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) “same geographic locale” and/or “area” shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons, or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term “Usual” refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale. The term “Usual and Customary” does not necessarily mean the actual charge made or the specific service or supply furnished, to a Plan Participant by a Provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service, or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ARTICLE V ELIGIBILITY FOR COVERAGE

5.01 Eligibility for Individual Coverage

The following classes of Employees will be eligible for coverage under the Plan:

1. **New Hires -**

- a. Regular Full-time Employees: An Employee designated by the Employer as Regular Full-time Employee who is actively working and is not a temporary Employee, who works the number of hours required by his or her collective bargaining agreement, and who makes any required contributions to coverage, will be eligible for coverage under the Plan. Coverage for Regular Full-time Employees, if properly elected, will be effective following completion of a Service Waiting Period determined by Employer.

- b. Part-time Employees: An Employee designated by the Employer as a Part-time Employee who is actively working and is not a temporary Employee, who works the number of hours required by his or her collective bargaining agreement, and who makes any required contributions to coverage, will be eligible for coverage under the Plan. Coverage, if properly elected, will be effective following the Service Waiting Period.

Whether an Employee averages thirty (30) Hours of Service per week will be determined in accordance with policies and procedures adopted by the Plan Administrator.

Impact of Breaks In Service

Any Employee who resumes Hours of Service following a Break in Service (as defined in the Plan Eligibility Appendix) will be treated as a New Hire and eligibility for coverage under the Plan upon return will be determined in accordance with the New Hire rules above. If, however, the Employee experiences a period without any Hours of Service, and resumes Hours of Service without experiencing a Break in Service, the Employee will be treated as a continuous employee. A continuous employee resuming Hours of Service after a period with no Hours of Service that does not constitute a Break in Service will be eligible for coverage under the Plan upon return if they were enrolled in coverage prior to the start of the period with No Hours of Service. Such coverage will be effective on the first day of the month that coincides with or follows the date you resume Hours of Service.

Waiver of Coverage

Regular Full-time Employees covered by another group health plan due to marriage or other reasons may waive coverage under this Plan and receive additional life insurance coverage in the amount of \$25,000. This Waiver of Coverage option shall also be extended to City of Toledo Employees whose spouses are also employed by the City of Toledo.

5.01.1 Eligibility Dates for Dependent Coverage

Each Employee will become eligible for coverage under this Plan for his or her Dependents on the latest of the following dates:

1. His or her date of eligibility for coverage for himself or herself under the Plan;
2. The date coverage for his or her Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan; and
3. The first date upon which he or she acquires a Dependent.

Spouses who are both employed by the City of Toledo must jointly enroll for family coverage under the Plan as an Employee and a Dependent spouse. If the spouse of a City of Toledo Employee is employed by a different employer and coverage is available through his/her employer's plan, the spouse will not be eligible for coverage under this Plan. Special consideration will be given to cases of demonstrated hardship due to excessive premiums based on spousal income. An "excessive premium" is identified in the following circumstances:

1. A spouse whose gross base income is less than \$30,000 and who is required to pay 30% or more of their premium cost for employee-only primary coverage;

2. A spouse whose gross base income is more than \$30,000 but less than \$50,000 must accept their employer's plan for employee-only coverage. However, if the spouse is required to pay 40% or more of their premium cost for family coverage, the eligible Dependents may be eligible to enroll in this Plan as primary and the spouse may be eligible for coverage under this Plan as secondary;
3. A spouse whose gross base income is more than \$50,000 must accept their employer's plan coverage and must carry any eligible Dependents in accordance with the "birthday rule." The spouse and Dependents may be eligible for secondary coverage through this Plan.

If both spouses are eligible for an employer-sponsored group health plan, their Dependent Children must be enrolled as Dependents under the parent's plan whose birthday falls earliest in the calendar year.

In no event will any Dependent Child be covered as a Dependent of more than one Employee who is covered under the Plan.

Any reference in this Plan to an Employee's Dependent being covered means that such Employee is covered for Dependent Coverage.

5.02 Effective Dates of Coverage; Conditions

The coverage for which an individual is eligible under this Plan will become effective on the date specified below, subject to the conditions of this section.

1. Enrollment Form. Coverage for an Employee or his or her Dependents must be requested by the Employee on a form furnished by the Plan Administrator and will become effective on the date such Employee or Dependents are eligible, provided the Employee has enrolled for such coverage on a form satisfactory to the Plan Administrator within the 31-day period immediately following the date of eligibility.
2. Birth of Dependent Child. If a Dependent Child is born after the date the Employee's coverage for himself or herself under the Plan becomes effective, coverage shall take effect from and after the moment of birth, to the extent of the benefits provided herein, and any limitations of this Plan with respect to congenital defects shall not apply to such Child. If the Employee does not have coverage under this Plan for any Dependents at the date of such Child's birth, then coverage for such Child shall continue for 31 days. After the 31-day period, coverage shall only continue if the Employee makes written application to the Plan for such Child and agrees to make any required contribution.
3. Newly Acquired Dependents. If an Employee acquires a Dependent while the Employee is eligible for coverage for Dependents, coverage for the newly acquired Dependent shall be effective on the date the Dependent becomes eligible, provided application is made to the Plan within 31 days of the date of eligibility and any required contributions are made.
4. Requirement for Employee Coverage. No coverage for Dependents of an Employee will become effective unless the Employee is, or simultaneously becomes, eligible for coverage for himself or herself under the Plan.
5. Coverage as Both Employee and Dependent. No person may be simultaneously covered under this Plan as both an Employee and a Dependent.
6. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.
7. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

5.03 Special and Open Enrollment

The Plan provides special enrollment periods that allow Employee's to enroll in the Plan, even if they declined enrollment during an initial or subsequent eligibility period.

5.03A Loss of Other Coverage

If an Employee declined enrollment for himself or herself or his or her Dependents (including his or her spouse) because of other health coverage, he or she may enroll for coverage for himself or herself and/or his or her Dependents if the other health coverage is lost. The Employee must make written application for special enrollment within 31 days of the date the other health coverage was lost.

The following conditions apply to any eligible Employee and Dependents:

An Employee may enroll during this special enrollment period:

1. If the Employee is eligible for coverage under the terms of this Plan;
2. The Employee is not currently enrolled under the Plan;
3. When enrollment was previously offered, the Employee declined because of coverage under another group health plan or health insurance coverage. The Employee must have provided a written statement that other health coverage was the reason for declining enrollment under this Plan; and
4. If the other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

An Employee who is already enrolled in a benefit package may enroll in another benefit package under the Plan if a Dependent of that Employee has a special enrollment right in the Plan because the Dependent lost eligibility for other coverage. The Employee must make written application for special enrollment in the new benefit package within 31 days of the date the other health coverage was lost.

The Employee is not eligible for this special enrollment right if:

1. The other coverage was COBRA continuation coverage and the Employee did not exhaust the maximum time available to him or her for that COBRA coverage; or
2. The other coverage was lost due to non-payment of requisite contribution / premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request is received by the Plan.

5.03B New Dependent

If an Employee acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and his or her Dependents during a special enrollment period. The Employee must make written application for special enrollment no later than 31 days after he or she acquires the new Dependent.

The following conditions apply to any eligible Employee and Dependents:

An Employee may enroll himself or herself and/or his or her eligible Dependents during this special enrollment period if:

1. The Employee is eligible for coverage under the terms of this Plan; and
2. The Employee has acquired a new Dependent through marriage, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, coverage for the Employee and his or her Dependent(s) will be effective at 12:01 A.M.:

1. For a marriage, on the date of the marriage;
2. For a birth, on the date of birth; or
3. For an adoption or placement for adoption, on the date of the adoption or placement for adoption.

5.03C Additional Special Enrollment Rights

Employees and Dependents who are eligible but not enrolled are entitled to enroll under the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

5.03D Open Enrollment

Participants may enroll for coverage during Open Enrollment Periods. Coverage for Participants enrolling during an Open Enrollment Period will become effective on June 1, unless the Employee has not satisfied the Service Waiting Period, in which event coverage for the Employee and his or her Dependents will become effective on the day following completion of the Service Waiting Period.

“Open Enrollment Period” shall mean the month of April in each Plan Year.

5.03E Effective Date of Coverage; Conditions

All conditions for effectiveness of coverage under the Plan, which are set forth in the section entitled “Effective Dates of Coverage; Conditions,” will apply to Participants enrolling during a Special or Open Enrollment Period. Coverage for Participants enrolling during a Special Enrollment Period will become effective on the date of the event for loss of coverage, marriage, domestic partnership, birth, adoption, or placement for adoption in the case of such events.

5.04 Qualified Medical Child Support Orders

The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a “Qualified Medical Child Support Order” (“QMCSO”) if such an individual is not already covered by the Plan as an eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

“Alternate Recipient” shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent.

“Medical Child Support Order” shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

“National Medical Support Notice” or “NMSN” shall mean a notice that contains the following information:

1. Name of an issuing State child support enforcement agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan or eligible for enrollment;
3. Name and mailing address each of the Alternate Recipients (i.e., the child or children of the Participant or the name and address of a State or local office may be substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

“Qualified Medical Child Support Order” or “QMCSO” is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive

benefits for which a Participant or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of “National Medical Support Notice”;
2. a. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;
- b. Informs the Plan Administrator that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan’s default option (if any); and
3. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as “qualified” if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and Eligible Plan Participants without regard to this section, except to the extent necessary to meet the requirements of a State law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan’s procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall:

1. Notify the State agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
 - a. Whether the child is covered under the Plan; and
 - b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and

2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

5.05 Late Enrollee

“Late Enrollee” shall mean a Participant who enrolls in the Plan other than:

1. On the earliest date on which coverage can become effective for the individual under the terms of the Plan;
or
2. Through special enrollment.

5.06 Acquired Companies

Eligible Employees of an acquired company who are Actively at Work and were covered under the prior plan of the acquired company will be eligible for the benefits under this Plan on the date of acquisition. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the Service Waiting Period of this Plan. In the event that an acquired company did not have a health plan, all eligible Employees will be eligible on the date of the acquisition.

5.07 “GINA”

“GINA” prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term “genetic information” means, with respect to any individual, information about:

1. Such individual’s genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a disease or disorder in family members of such individual.

The term “genetic information” includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying pre-existing condition limitations. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

5.08 Effect of Section 125 Tax Regulations on This Plan

The Plan Administrator has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, by enrolling in this plan, the Participant agrees to pretax salary reduction put toward the cost of his or her benefits.

Coverage Elections: Per Section 125 regulations, Participants are generally allowed to enroll for or change Coverage only during each annual enrollment period. However, exceptions are allowed if the Plan Administrator agrees and the Participant enrolls for or changes coverage within 31 days of the date the Participant meets the criteria shown below. The change must be consistent with the event.

Change of Status: A change in status is defined as:

- Change in legal marital status due to marriage, death of a spouse, or divorce;
- Change in number of dependents due to birth, adoption, placement for adoption, or death of a dependent;
- Change in employment status of employee, spouse or dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- Changes in employment status of employee, spouse or dependent resulting in eligibility or ineligibility for coverage;
- Changes which cause a dependent to become eligible or ineligible for coverage; and
- Change in residence from the network coverage area.

Court Order: A change in Coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

Medicare or Medicaid Eligibility/Entitlement: The Employee, Spouse or Dependent cancels or reduces Coverage due to entitlement to Medicare or Medicaid, or enrolls or increases Coverage due to loss of Medicare or Medicaid eligibility. The Employee or Dependent must request to enroll or cancel Coverage within 60 days after the Employee or Dependent is terminated from, or determined to be eligible, for such assistance.

Children's Health Insurance Program (CHIP): Employees and Dependents who are eligible but not enrolled for Coverage may enroll if: 1) the Employee's or Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or 2) the Employee or Dependent becomes eligible for a subsidy under Medicaid or CHIP. The Employee or Dependent must request to enroll or cancel Coverage within 60 days after the Employee or Dependent is terminated from, or determined to be eligible, for such assistance.

Change in Cost of Coverage: If the cost of benefits increases or decreases during a benefit period, the Plan Administrator may, in accordance with plan terms, automatically change the Participant's elective contribution.

When the change in cost is significant, the Participant may either increase his or her contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option the Participant has elected, the Participant may elect another available benefit option. When a new benefit option is added, the Participant may change his or her election to the new benefit option.

Changes in Coverage of Spouse or Dependent Under Another Employer's Plan: The Participant may make a Coverage election change if the plan of the Participant's Spouse or Dependent: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of Coverage or open enrollment periods.

Revocation Due to Reduction in Hours: The Participant may revoke coverage under this Plan if he or she experiences a change in employment status so that the Participant is reasonably expected to average less than 30 hours of service per week, even if such a change does not cause the Participant to be ineligible, and the revocation of the election of coverage corresponds to the intended enrollment of the Participant and his or her dependents in another plan that provides minimum essential coverage with an effective date no later than the first day of the second month following the date coverage under this Plan is revoked.

Revocation Due to Enrollment in a Qualified Health Plan: The Participant may revoke coverage under this Plan if he or she is eligible for a Special Enrollment Period in a Qualified Health Plan through a Marketplace or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period and the revocation of the election of coverage corresponds to the intended enrollment of the Participant and his or her dependents in a Qualified Health Plan through a Marketplace for new coverage with an effective date no later than the day immediately following the last day of coverage under this Plan.

There may be additional situations that qualify for a special enrollment opportunity. Contact the Plan Administrator for additional details.

ARTICLE VI TERMINATION OF COVERAGE

6.01 Termination Dates of Individual Coverage

The coverage of any Employee for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. The date the Plan terminates;
2. The last day of the calendar month in which the Employee ceases to be eligible for coverage under the Plan (including death or termination of Active Employment);
3. For a Part-Time Employee, the last day of the calendar month in which any required contribution by the Employer or Employee has been made, if payment of any required contribution for coverage has not been submitted when due;
4. Immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

For the purposes of this Article, the following actions by any Participant, or a Participant's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire family unit of which the Participant is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Plan Participant;
2. Attempting to file a claim for a Participant for services which were not rendered or Drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

6.02 Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date the Plan terminates;
2. The date the Employee's coverage terminates;
3. The last day of the month of the Employee's death;
4. The date a Dependent loses dependency status under the Plan;
5. The date of a legal separation or divorce, in the case of a spouse of a covered Employee who is legally separated or divorced from the covered Employee. Such spouse must meet all legal requirements;
6. For a Dependent of a Part-Time Employee, the end of the period for which any required contribution by the Employer or Employee has been made, if payment of any required contribution for coverage has not been submitted when due;
7. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:
 - a. Cessation of such inability;
 - b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or
 - c. Upon the Child's no longer being dependent on the Employee for his or her support;
8. The day immediately preceding the date such person ceases to be a Dependent, as defined herein, except for termination due to age, in which case coverage shall terminate at the end of the month in which the Dependent turns twenty-six (26) years of age; or
9. Immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

6.03 Notice of Rights Upon Termination of Coverage

Upon request, the Plan will provide a Certificate of Coverage at any time while an individual is covered under a plan, and up to 24 months after he or she loses coverage under the Plan.

6.04 Prohibition on Rescission

The Plan will not rescind coverage for Covered Persons. This provision does not apply to cases where the Covered Person has engaged in fraud or made an intentional misrepresentation of material fact and advance notice of rescission is made by the Plan.

ARTICLE VII CONTINUATION OF COVERAGE

7.01 Employer Continuation Coverage

In the event a covered Employee temporarily ceases to be Actively Employed due to an unpaid employer-approved leave of absence, coverage will continue in place for a period of thirty (30) days or until the Employee's return to Active Employment. The covered Employee is only eligible under this provision if his or her leave of absence or disability is continued temporarily, the Employee continues to remain in the employ of the Employer, he or she continues to receive employee-related benefits, and he or she continues to make any required contributions.

If the leave of absence is a qualified leave of absence under FMLA (see the next section), the Employer may require the Employee to use this leave of absence prior to the FMLA leave of absence benefits. The Employer may also require the Employee to substitute this leave of absence for the FMLA leave of absence benefits. Contact the Employer or Plan Sponsor to determine how this FMLA provision impacts the Employer's paid sick leave or leave of absence policy.

7.02 Continuation During FMLA Leave

The Plan shall at all times comply with FMLA. During any leave taken under FMLA, the Employee will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

The Family and Medical Leave Act is a Federal law that applies, generally, to employers with 50 or more Employees, and provides that an eligible Employee may elect to continue coverage under this Plan during a period of approved FMLA Leave at the same cost as if the leave had not been taken.

If provisions under the Plan change while an Employee is on FMLA Leave, the changes will be effective for him or her on the same date as they would have been had he or she not taken leave.

7.02A Eligible Employees

Employees are eligible for FMLA Leave if all of the following conditions are met:

1. The Employee has been employed with the Participating Employer for at least 12 months;
2. The Employee has been employed with the Participating Employer at least 1,250 hours during the 12 consecutive months prior to the request for FMLA Leave; and
3. The Employee is employed at a worksite that employs at least 50 employees within a 75-mile radius.

7.02B Qualifying Circumstances for FMLA Leave

Coverage under FMLA Leave is limited to a total of 12 workweeks during any 12-month period that follows:

1. The birth of, and to care for, a Son or Daughter;
2. The placement of a Child with the Employee for adoption or foster care;
3. The Employee's taking leave to care for his or her Spouse, Son or Daughter, or Parent who has a Serious Health Condition;
4. The Employee's taking leave due to a Serious Health Condition which makes him or her unable to perform the functions of his or her position; or,
5. A Qualifying Exigency arising out of the fact that a Spouse, Son, Daughter, or Parent of the Employee is a member of a regular or reserve component of the Armed Forces and is on (or has been notified of impending call to) covered active duty.

Coverage under FMLA Leave is limited to a total of 26 workweeks during any 12-month period for the following situations:

1. To care for a covered service member following a Serious Illness or Injury to that covered service member, when the Employee is that service member's Spouse, Son or Daughter, Parent, or Next of Kin; or

2. To care for a veteran who is undergoing medical treatment, recuperation, or therapy for a Serious Illness or Injury that occurred any time during the five years preceding the date of treatment, when the Employee is that veteran's Spouse, Son or Daughter, Parent, or Next of Kin.

***The FMLA definitions of "serious Injury or Illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition".**

This leave may be considered as a paid (accrued vacation time, personal leave or family or sick leave, as applicable) or unpaid leave. The Participating Employer has the right to require that all paid leave be used prior to providing any unpaid leave.

An Employee must continue to pay his or her portion of the Plan contribution, if any, during the FMLA Leave. Payment must be made within 30 days of the due date established by the Plan Administrator. If payment is not received, coverage will terminate on the last date for which the contribution was received in a timely manner.

7.02C Notice Requirements

An Employee must provide at least 30 days' notice to his or her Participating Employer prior to beginning any leave under FMLA. If the nature of the leave does not permit such notice, the Employee must provide notice of the leave as soon as possible. The Participating Employer has the right to require medical certification to support the Employee's request for leave due to a Serious Health Condition for the Employee or his or her eligible family members.

7.02D Length of Leave

During any one 12-month period, the maximum amount of FMLA Leave may not exceed 12 workweeks for most FMLA related situations. The maximum periods for an Employee who is the primary care giver of a service member with a Serious Illness or Injury that was Incurred in the line of active duty may take up to 26 weeks of FMLA Leave in a single 12-month period to care for that service member. The Participating Employer may use any of four methods for determining this 12-month period.

If the Employee and his or her Spouse are both employed by the Participating Employer, FMLA Leave may be limited to a combined period of 12 workweeks, for both Spouses, when FMLA Leave is due to:

1. The birth or placement for adoption or foster care of a Child; or
2. The need to care for a Parent who has a Serious Health Condition.

7.02E Termination of FMLA Leave

Coverage may end before the maximum 12-week (or 26-week) period under the following circumstances:

1. When the Employee informs his or her Participating Employer of his or her intent not to return from leave;
2. When the employment relationship would have terminated but for the leave (such as during a reduction in force);
3. When the Employee fails to return from the leave;
4. If any required Plan contribution is not paid within 30 days of its due date;
5. The Participating Employer and/or Plan Administrator is advised and/or determines that no FMLA Qualifying Circumstance occurred.

If an Employee does not return to work when coverage under FMLA Leave ends, he or she will be eligible for *COBRA* continuation of coverage at that time, in accordance with the parameters set forth by this Plan and applicable law.

7.02F Recovery of Plan Contributions

The Participating Employer has the right to recover the portion of the Plan contributions it paid to maintain coverage under the Plan during an unpaid FMLA Leave if an Employee does not return to work at the end of the leave. This right will not apply if failure to return is due to the continuation, recurrence or onset of a Serious Health Condition that entitles the Employee to FMLA Leave (in which case the Participating Employer may require medical certification) or other circumstances beyond the Employee's control.

7.02G Reinstatement of Coverage

The law requires that coverage be reinstated upon the Employee's return to work following an FMLA Leave whether or not the Employee maintained coverage under the Plan during the FMLA Leave.

On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA Leave had not been taken. The Service Waiting Period will be credited as if the Employee had been continually covered under the Plan.

7.02H Definitions

For this provision only, the following terms are defined as stated.

“Next of Kin”

“Next of Kin” shall mean the nearest blood relative to the service member.

“Parent”

“Parent” shall mean the Employee's biological parent or someone who has acted as his or her parent in place of his or her biological parent when he or she was a Son or Daughter.

“Qualifying Exigency”

“Qualifying Exigency” shall mean:

1. Short-notice deployment.
 - a. To address any issue that arises from the fact that a covered military member is notified seven or less calendar days prior to the date of deployment of an impending call or order to active duty in support of a contingency operation; and
 - b. Leave taken for this purpose can be used for a period of seven calendar days beginning on the date a covered military member is notified of an impending call or order to active duty in support of a contingency operation;
2. Military events and related activities.
 - a. To attend any official ceremony, program, or event sponsored by the military that is related to the active duty or call to active duty status of a covered military member; and
 - b. To attend family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations, or the American Red Cross that are related to the active duty or call to active duty status of a covered military member;
3. Childcare and school activities.
 - a. To arrange for alternative childcare when the active duty or call to active duty status of a covered military member necessitates a change in the existing childcare arrangement for a biological, adopted, or foster Child, a stepchild, or a legal ward of a covered military member, or a Child for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence;
 - b. To provide childcare on an urgent, immediate need basis (but not on a routine, regular, or everyday basis) when the need to provide such care arises from the active duty or call to active duty status of a covered military member for a biological, adopted, or foster Child, a stepchild, or a legal ward of a covered military member, or a Child for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence;
 - c. To enroll in or transfer to a new school or daycare facility, a biological, adopted, or foster Child, a stepchild, or a legal ward of the covered military member, or a Child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence, when enrollment

- or transfer is necessitated by the active duty or call to active duty status of a covered military member; and
- d. To attend meetings with staff at a school or a daycare facility, such as meetings with school officials regarding disciplinary measures, parent-teacher conferences, or meetings with school counselors, for a biological, adopted, or foster Child, a stepchild, or a legal ward of the covered military member, or a Child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence, when such meetings are necessary due to circumstances arising from the active duty or call to active duty status of a covered military member;
4. Financial and legal arrangements.
 - a. To make or update financial or legal arrangements to address the covered military member's absence while on active duty or call to active duty status, such as preparing and executing financial and healthcare powers of attorney, transferring bank account signature authority, enrolling in the Defense Enrollment Eligibility Reporting System (DEERS), obtaining military identification cards, or preparing or updating a will or living trust; and
 - b. To act as the covered military member's representative before a Federal, State, or local agency for purposes of obtaining, arranging, or appealing military service benefits while the covered military member is on active duty or call to active duty status, and for a period of 90 days following the termination of the covered military member's active duty status;
 5. Counseling. To attend counseling provided by someone other than a health care Provider for oneself, for the covered military member, or for the biological, adopted, or foster Child, a stepchild, or a legal ward of the covered military member, or a Child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence, provided that the need for counseling arises from the active duty or call to active duty status of a covered military member;
 6. Rest and recuperation. To spend time with a covered military member who is on short-term, temporary, rest and recuperation leave during the period of deployment. Eligible Employees may take up to five days of leave for each instance of rest and recuperation;
 7. Post-deployment activities.
 - a. To attend arrival ceremonies, reintegration briefings, and events, and any other official ceremony or program sponsored by the military for a period of 90 days following the termination of the covered military member's active duty status; and
 - b. To address issues that arise from the death of a covered military member while on active duty status, such as meeting and recovering the body of the covered military member and making funeral arrangements; and
 8. Additional activities. To address other events which arise out of the covered military member's active duty or call to active duty status provided that the Participating Employer and Employee agree that such leave shall qualify as an exigency, and agree to both the timing and duration of such leave.

“Serious Health Condition”

“Serious Health Condition” shall mean an Illness, Injury, impairment, or physical or mental condition that involves:

1. Inpatient care in a Hospital, hospice, or residential medical facility; or
2. Continuing treatment by a health care Provider (a doctor of medicine or osteopathy who is authorized to practice medicine or Surgery, as appropriate, by the State in which the doctor practices, or any other person determined by the Secretary of Labor to be capable of providing health care services).

“Serious Illness or Injury (of a service member or covered veteran)”

“Serious Illness or Injury” shall mean an Illness or Injury Incurred in the line of duty that may render the service member medically unfit to perform his or her military duties. A serious Injury or Illness for a current service member includes an Injury or Illness that existed before the beginning of the service member’s active duty and was aggravated by service in the line of duty on active duty in the armed forces. A serious Injury or Illness for a covered veteran means an Injury or Illness that was Incurred or aggravated by the service member in the line of duty on active duty in the armed forces and manifested itself before or after the service member became a veteran.

“Son or Daughter”

“Son or Daughter” shall mean the Employee’s biological child, adopted child, stepchild, foster child, a child placed in the Employee’s legal custody, or a child for which the Employee is acting as the parent in place of the child’s natural blood related parent.

“Spouse”

“Spouse” shall mean an Employee’s husband or wife.

NOTE: For complete information regarding FMLA rights, contact the Participating Employer.

7.03 Continuation During USERRA

Participants who are absent from employment because they are in the Uniformed Services may elect to continue their coverage under this Plan for up to 24 months. If a Participant elected to continue coverage under USERRA before December 10, 2004, the maximum period for continuing coverage is 18 months. To continue coverage, Participants must comply with the terms of the Plan, including election during the Plan’s annual enrollment period, and pay their contributions, if any. In addition, USERRA also requires that, regardless of whether a Participant elected to continue his or her coverage under the Plan, his or her coverage and his or her dependents’ coverage be reinstated immediately upon his or her return to employment, so long as he or she meets certain requirements contained in USERRA. Participants should contact their participating employer for information concerning their eligibility for USERRA and any requirements of the Plan.

7.04 Continuation During COBRA – Introduction

The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participants family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if the Participant or their covered dependents fail to make timely payment of contributions or premiums. Participants should check with their employer to see if COBRA applies to them and/or their covered dependents.

Participants may have other options available when group health coverage is lost. For example, a Participant may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the Participant may qualify for lower costs on his or her monthly premiums and lower out-of-pocket costs. Additionally, the Participant may qualify for a 30-day special enrollment period for another group health plan for which the Participant is eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

7.04A COBRA Continuation Coverage

“COBRA Continuation Coverage” is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a “Qualifying Event.” Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of the employer’s plan) are not considered for continuation under COBRA.

7.04B Qualifying Events

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a “Qualified Plan Participant.” The Employee, the Employee’s spouse, and the Employee’s dependent children could become Qualified Plan Participants if coverage under the Plan is lost because of the Qualifying Event.

A covered Employee (meaning an employee covered under the Plan) will become a Qualified Plan Participant if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced; or
2. The employment ends for any reason **other than gross misconduct**.

The spouse of a covered Employee will become a Qualified Plan Participant if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The spouse dies;
2. The spouse's hours of employment are reduced;
3. The spouse's employment ends for any reason other than his or her gross misconduct;
4. The spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. The spouse becomes divorced or legally separated from his or her spouse.

Dependent children will become Qualified Plan Participants if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-covered Employee dies;
2. The parent-covered Employee's hours of employment are reduced;
3. The parent-covered Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Plan as a Dependent Child.

If a proceeding in bankruptcy is filed with respect to The City of Toledo, Ohio, and that bankruptcy results in the loss of coverage of any retired employee, spouse, surviving spouse, and Dependent Children covered under the Plan, such member will become a Qualified Plan Participant with respect to the bankruptcy.

7.04C Employer Notice of Qualifying Events

When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Third Party Administrator of the Qualifying Event.

7.04D Employee Notice of Qualifying Events

Each covered Employee or Qualified Plan Participant is responsible for providing the Third Party Administrator with the following notices, in writing, by U.S. First Class Mail:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee (or former employee) from his or her spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Plan Participant has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. Notice that a Qualified Plan Participant entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of Continuation Coverage; and
5. Notice that a Qualified Plan Participant, with respect to whom a notice described above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The Third Party Administrator is:

HealthSCOPE Benefits
P.O. Box 2459
Little Rock, AR 72203

A form of notice is available, free of charge, from the Third Party Administrator and must be used when providing the notice.

7.04E Deadline for providing the notice

For Qualifying Events described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;
2. The date on which the Qualified Plan Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
3. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Third Party Administrator.

For the disability determination described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA;
2. The date on which a Qualifying Event occurs;
3. The date on which the Qualified Plan Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Third Party Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Plan Participant is no longer disabled; or
2. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Third Party Administrator.

The notice must be postmarked by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

7.04F Who Can Provide the Notice

Any individual who is the covered Employee (or former employee), a Qualified Plan Participant with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee (or former employee) or Qualified Plan Participant, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Plan Participants with respect to the Qualifying Event.

7.04G Required Contents of the Notice

The notice must contain the following information:

1. Name and address of the covered Employee or former employee;
2. Identification of the initial Qualifying Event and its date of occurrence, if the person is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period;
3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the covered Employee or former employee, death of the covered Employee or former employee, disability of a Qualified Plan Participant or loss of disability status);
4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of spouse and dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;
5. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former employee, date of entitlement, and name(s) and address(es) of spouse and Dependent child(ren) covered under the Plan;
6. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age, lost student status, married or other);
7. In the case of a Qualifying Event that is the death of the covered Employee or former employee, the date of death, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan;
8. In the case of a Qualifying Event that is disability of a Qualified Plan Participant, name and address of the disabled Qualified Plan Participant, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Plan Participant who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or legal separation or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or legal separation or the SSA's determination within 30 days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or legal separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the Third Party Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Third Party Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the covered Employee (or former employee), the Qualified Plan Participants, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

7.04H Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Third Party Administrator within 14 days of receiving the notice of the Qualifying Event. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Plan Participant will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the Plan Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the Third Party Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

7.04I Duration of COBRA Continuation Coverage

COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is “entitlement to Medicare,” the 36-month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the covered Employee (or former employee), the covered Employee’s (or former employee’s) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or legal separation, or a Dependent Child’s losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee’s hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Plan Participants other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee’s hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

7.04J Disability Extension of COBRA Continuation Coverage

If an Employee or anyone in an Employee’s family covered under the Plan is determined by the SSA to be disabled and the Employee notifies the Third Party Administrator as set forth above, the Employee and his or her entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

7.04K Second Qualifying Event Extension of COBRA Continuation Coverage

If an Employee’s family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the spouse and Dependent Children in the family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the spouse and any Dependent Children receiving COBRA Continuation Coverage if the covered Employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

7.04L Shorter Duration of COBRA Continuation Coverage

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date the employer ceases to provide a group health plan to any employee;
2. The date on which coverage ceases by reason of the Qualified Plan Participant’s failure to make timely payment of any required contributions or premium;
3. The date that the Qualified Plan Participant first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) except as stated under COBRA’s special bankruptcy rules; or
4. The first day of the month that begins more than 30 days after the date of the SSA’s determination that the Qualified Plan Participant is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

7.04M Contribution and/or Premium Requirements

Once COBRA Continuation Coverage is elected, the individual must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

7.05 Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator, who is:

The City of Toledo
Plan Administrator
One Government Center, Suite 1920
Toledo, OH 43604
(419) 245-1500

For more information about a Participant's rights under COBRA, the Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

7.06 Current Addresses

In order to protect the rights of the Employee's family, the Employee should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

ARTICLE VIII GENERAL LIMITATIONS AND EXCLUSIONS

This section applies to all benefits provided under any section of this Plan. This Plan does not cover any charge for care, supplies, treatment, and/or services:

Alcohol. That arise from a Participant taking part in any activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Plan Participants other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This exclusion does not apply if the (a) injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

Applicable Section. The Plan will not cover expenses that are payable under one section of this Plan under any other section of this Plan;

Charges Incurred Due to Non-Payment. The Plan will not cover charges for sales tax, mailing fees, and surcharges incurred due to non-payment;

Controlled Substance. The Plan will not cover charges for the care or treatment of an Illness or Injury resulting from the voluntary taking of, or while under the influence of, any controlled substance, drug, hallucinogen, or narcotic not prescribed or administered by a Physician;

Court Ordered Treatment. The Plan will not cover charges for court-ordered treatment not specifically mentioned as covered under the Plan;

Custodial Care. That do not restore health, unless specifically mentioned otherwise;

Deductible Applicable. That are not payable due to the application of any specified Deductible provisions contained herein;

Effective and Termination Date. The Plan will not cover charges for services and supplies for which a charge was incurred before the Participant was covered under this Plan, or after their date of termination. If the Participant is admitted to the Hospital on their date of termination, charges will be covered until their discharge;

Error. That are required to treat injuries that are sustained or an illness that is contracted, including infections and complications, while the Plan Participant was under, and due to, the care of a Provider wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense;

Excess. That are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document;

Exclusions. The Plan will not cover charges for services and supplies specifically excluded under this Plan;

Experimental. That are Experimental or Investigational;

Government. That are expenses to the extent paid, or which the Participant is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government. The Plan also will not cover charges for services and supplies in a Hospital owned or operated by the United States government or any government outside the United States in which the Participant is entitled to receive benefits, except for the reasonable cost of services and supplies which are billed, pursuant to federal law, by the Veterans Administration or the Department of Defense of the United

States, for services and supplies which are eligible herein and which are not incurred during or from service in the Armed Forces of the United States or any other country;

Hazardous Pursuit, Hobby or Activity. That are of an injury or sickness that results from engaging in a hazardous pursuit, hobby or activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Plan Participant's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm, **including but not limited to:** hang gliding, skydiving, bungee jumping, parasailing, rock climbing, use of explosives, automobile, motorcycle, aircraft, or speed boat racing, reckless operation of a vehicle or other machinery, and travel to countries with advisory warnings;

Hospital/Facility Employee. The Plan will not cover charges for services billed by a Provider (Physician or nurse) who is an employee of a Hospital/facility and is paid by the Hospital/facility for the services rendered;

Illegal Acts. For services and supplies incurred as a result of an Illness or Injury, caused by or contributed to by engaging in an illegal act, by committing or attempting to commit a crime or by participating in a riot or public disturbance. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

Immediate Family Member. That are rendered by a member of the Participant's immediate family unit. For the purposes of this exclusion, "immediate family member" means the covered Employee, his or her spouse, brother, sister, parent, or Dependent Child. "Immediate family member" also includes the brother, sister, parent, or Dependent Child of the Employee's spouse;

Incurred by Other Persons. For expenses actually incurred by other persons;

Maximum Benefit. Which exceed the maximum benefit, as shown in this Plan Document;

Medical Necessity. That are not Medically Necessary. The Plan Administrator retains discretionary authority in determining Medical Necessity regarding inter-facility patient transport, and will consider assessment by Sentinel Air Medical Alliance, LLC in determining Medical Necessity of such inter-facility patient transport. The Plan Administrator retains the discretionary authority to limit benefit availability to alternative providers of inter-facility air transport if and when a Provider fails to comply with the terms of the Plan, or proposed charges exceed the Maximum Allowable Charge in accordance with the terms of the Plan;

Medicare. For benefits that are provided, or which would have been provided had the Participant enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation, except as provided in the sections entitled "Coordination of Benefits" and "Medicare;"

Military Related Disability. The Plan will not cover charges for services and supplies for any military service-related disability or condition;

Negligence. For Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician;

No Legal Obligation. That are provided to a Participant for which the Provider of a service customarily makes no direct charge, or for which the Participant is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including but not limited to fees, care, supplies, or services for which a person, company or any other entity except the Participant or this benefit plan, ***may be liable*** for necessitating the fees, care, supplies, or services;

Non-Medical Charges. The Plan will not cover charges for: telephone consultations; failure to keep a scheduled visit; completion of a claim form; attending Physician statements; transfer of medical records between Providers; or requests for information omitted from an itemized billing;

Non-Prescription Drugs. The Plan will not cover charges for non-prescription drugs, except as otherwise stated herein;

Not Acceptable. That are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration;

Not Actually Rendered. That are not actually rendered;

Not Specifically Covered. That are not specifically covered under this Plan;

Not Under Care of Physician. The Plan will not cover charges for services and supplies not recommended and approved by a Physician; or services and supplies when the Participant is not under the care of a Physician;

Occupational. For any condition, disease, defect, ailment, illness, or accidental injury or complication thereof arising out of or in the course of employment (for wage or profit), including self-employment, whether or not benefits are available under any Workers' Compensation Act or other similar law. This Exclusion applies if the Participant receives the benefits in whole, part, or even if there is no Workers' Compensation coverage in place. This Exclusion also applies whether or not the Participant claims the benefits or compensation;

Other than Attending Physician. That are other than those certified by a Physician who is attending the Participant as being required for the treatment of injury or disease, and performed by an appropriate Provider;

Participant Liability Waived. For charges in connection with a claim where the Participant does not meet his or her cost-sharing responsibility (i.e. copay, deductible or coinsurance). This exclusion applies regardless of whether the Provider charges or attempts to collect the Participant's cost-sharing responsibility.

Prior to Coverage. That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein;

Prohibited by Law. That are to the extent that payment under this Plan is prohibited by law;

Provider Error. That are required as a result of unreasonable provider error;

Self-inflicted. That are the result of intentionally self-inflicted injuries or illnesses. This exclusion does not apply if the injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

Subrogation, Reimbursement, and/or Third Party Responsibility. That are of an injury or sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions; or due to the action or inaction of any party if the Participant fails to provide information as specified under Subrogation;

Travel Outside United States. The Plan will not cover charges for services and supplies obtained outside of the United States if the Covered Person traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies;

War. That are related to any illness, injury, or disability caused by or attributed to an act of war, act of terrorism, riot, civil disobedience, insurrection, nuclear explosion, or nuclear accident. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized military forces;

With respect to any injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a documented medical condition.

ARTICLE IX PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services.

9.01 Plan Administrator

The Plan is administered by the Plan Administrator in accordance with these provisions. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Participant is entitled to them.

9.02 Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Participant's rights and/or availability of benefits;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
10. To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate; and
11. To perform each and every function necessary for or related to the Plan's administration.

9.03 Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend, or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust Agreement (if any). This includes amending the benefits under the Plan.

Any such amendment, suspension, or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable Federal and State law. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable Federal and State law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his or her own discretion.

If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

9.04 Final Authority of the Plan Document

The terms and provisions contained in this Plan Document and Summary Plan Description shall be final and binding upon all Participants. Contradictory benefit information received from any other source will not effect the terms of the Plan as set forth herein. Participants are advised to conclusively rely upon the benefit information provided in this Plan Document and Summary Plan Description only.

9.05 Summary of Material Reduction (SMR)

A Material Reduction generally means any modification that would be considered by the average Participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in Deductibles or copayments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Participant. The 60 day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

Material Reduction disclosure provisions are subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

9.06 Summary of Material Modification (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to Deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective.

Note: The Affordable Care Act (ACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Participants at least 60 days before the effective date of the Material Modification.

9.07 Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered Participant of the Family Unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of 31 days from the date written notice is given.

ARTICLE X CLAIM PROCEDURES; PAYMENT OF CLAIMS

The procedures outlined below must be followed by Participants to obtain payment of health benefits under this Plan.

10.01 Health Claims

All claims and questions regarding health claims should be directed to the Third Party Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them based on its interpretation of the Plan and such interpretation, choice determination, or other exercise of Authority by the Plan Administrator will be binding and final upon all affected parties. The responsibility to process claims in accordance with the Plan Document may be delegated to the Third Party Administrator; provided, however, that the Third Party Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Participant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Participant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the Participant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a “claim,” since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions.** Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a “Post-service Claim”). At that time, a determination will be made as to what benefits are payable under the Plan.

Benefits will be payable to a Plan Participant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care, and Post-service.

1. Pre-service Claims. A “pre-service claim” is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A “pre-service urgent care claim” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the Participant’s ability to regain maximum function, or, in the opinion of a physician with knowledge of the Participant’s medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A physician with knowledge of the Participant’s medical condition may determine if the claim is a pre-service urgent care claim. If there is no such physician, an individual acting on behalf of the Plan may make the determination applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If the Plan does not require the Participant to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The Participant simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

2. Concurrent Claims. A “concurrent claim” arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

- a. The Plan Administrator determines that the course of treatment should be reduced or terminated; or
- b. The Participant requests extension of the course of treatment beyond that which the Plan Administrator has approved.

If the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

3. Post-service Claims. A "post-service claim" is a claim for a benefit under the Plan after the services have been rendered.

10.01A When Health Claims Must Be Filed

Post-service health claims must be filed with the Third Party Administrator within 365 days of the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.**

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Third Party Administrator in accordance with the Plan's procedures. However, a Post-service Claim is considered to be filed when the following information is received by the Third Party Administrator, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the Provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges, which reflect any applicable PPO re-pricing;
6. The name of the Plan;
7. The name of the covered employee; and
8. The name of the patient.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Contract Administrator within 45 days from receipt by the Participant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

10.01B Timing of Claim Decisions

The Plan Administrator shall notify the Participant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Non-urgent Care Claims:
 - a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
 - a. If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Participant will be given 45 days to respond and provide the specified information. The Participant will be notified of a determination of benefits within a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant (if additional information was requested during the extension period).

2. Concurrent Claims:
 - a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
 - b. Request by Participant Involving Urgent Care. If the Plan Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Participant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.
 - c. Request by Participant Involving Non-urgent Care. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).
3. Post-service Claims:
 - a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
 - a. If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.
4. Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
5. Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
6. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

10.01C Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile, or similar method, with written or electronic notice following within three (3) days), containing the following information:

1. A reference to the specific portion(s) of the Plan Document upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures;
5. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits;
6. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Participant, free of charge, upon request);
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided to the Participant, free of charge, upon request.
9. In a claim involving urgent care, a description of the Plan's expedited review process.

10.02 Appeal of Adverse Benefit Determinations

In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The Plan provides for 2 levels of appeal following an Adverse Benefit Determination. The Participant has 180 days following an initial Adverse Benefit Determination to file an appeal of that determination, and 60 days following a second Adverse Benefit Determination to file an appeal of that determination. To initiate the appeal process, the Third Party Administrator must receive written request from the Participant, or an Authorized Representative of the Participant, with the proper form for review of an Adverse Benefit Determination.

10.02A Full and Fair Review of All Claims

The appeal process of this Plan provides a Participant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. Participants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;
2. Participants at least 60 days following receipt of a second Adverse Benefit Determination within which to appeal the determination;
3. Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
4. Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.
5. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
6. For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
7. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

8. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;
9. That a Participant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances;
10. That a Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Participant to respond to such new evidence or rationale; and
11. Claim appeals will be decided within the timeframe applicable to the type of claim as set forth below.

FIRST APPEAL LEVEL

10.02B Requirements for Appeal

The Participant must file the first appeal, in writing (although oral appeals are permitted for pre-service urgent care claims), within 180 days following receipt of the notice of an Adverse Benefit Determination. For pre-service urgent care claims, if the Participant chooses to orally appeal, the Participant may telephone:

**HealthSCOPE Benefits
P.O. Box 2860
Little Rock, AR 72203
1-888-249-8247**

Oral appeals should be submitted in writing as soon as possible after it has been initiated. To file any appeal in writing, the Participant's appeal must be addressed as follows:

1. For Pre-service Claims: Participants should refer to their identification card for the name and address of the utilization review administrator. All pre-service claims must be sent to the utilization review administrator.
2. For Post-service Claims:
HealthSCOPE Benefits
P.O. Box 2860
Little Rock, AR 72203

It shall be the responsibility of the Participant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the employee/Participant;
2. The employee/Participant's social security number or alternate identification number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal;**
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

6. Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If the Participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

10.02C Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal at each level.
3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent, or post-service.
4. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal at each level.
5. Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

10.02D Manner and Content of Notification of Adverse Benefit Determination on First Appeal

The Plan Administrator shall provide a Participant with notification, with respect to pre-service urgent care claims, by telephone, facsimile, or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the summary plan description on which the denial is based;
3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the Plan Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Plan Participant's claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Plan Participant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Plan Participant's medical circumstances, will be provided free of charge upon request;
7. A statement of the Plan Participant's right to bring an action, if any, following an adverse benefit determination on final review; and

8. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

10.02E Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

10.02F Decision on Review to be Final

If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.**

SECOND APPEAL LEVEL

A. Adverse Decision on First Appeal; Requirements for Second Appeal

Upon receipt of notice of the Plan's Adverse Benefit Determination regarding the first appeal, the Participant has 60 days to file a second appeal of the denial of benefits. The Participant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Participant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Participant's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

B. Timing of Notification of Benefit Determination on Second Appeal

The Plan shall notify the Participant of the Plan's Benefit Determination on review within a reasonable period of time, but not later than the applicable time period specified in the section Timing of Notification of Benefit Determination on Review above.

The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

C. Manner and Content of Notification of Adverse Benefit Determination on Second Appeal

The same information must be included in the Plan's response to a second appeal as a first appeal, except for: (a) a description of any additional information necessary for the Participant to perfect the Claim and an explanation of why such information is needed; and (b) a description of the Plan's review procedures and the time limits applicable to the procedures. See the section entitled "Notice of Benefit Determination on First Appeal."

D. Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to the Notice of Benefit Determination on First Appeal, as appropriate.

E. Decision on Second Appeal to be Final

If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision will be final, binding, and conclusive, and will be afforded the maximum deference permitted by law. **All Claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within 3 years after the Plan's Claim review procedures have been exhausted. Any action with respect to a fiduciary's breach of any responsibility, duty, or obligation hereunder must be brought within 3 years after the date of service.**

10.03 Standard External Claim Procedure

This section applies to the standard external review process in accordance with Ohio Revised Code Chapter 3922.

10.03A Requesting a Standard External Review. Participants may request an external review with the Plan, provided the request is filed within four (4) months after the date of receipt of the Adverse Benefit Determination. If there is not a corresponding date that is four months after receipt of the benefits denial notice, the external review request must be filed by the first of the 5th month following receipt of the notice. The external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Participant or beneficiary fails to meet the requirements for eligibility under the terms of the Plan.

The external review process applies only to:

1. An Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by the Plan that involves medical judgment (including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

10.03B Preliminary Review by the Plan. The Plan must complete a preliminary review of the Participant's external review request within five business day, and the review must determine whether:

1. the Participant is (or was) covered under the Plan when the health care service was requested. For retroactive reviews, the Plan must determine whether the individual was covered under the Plan when the health care service was provided;
2. the benefit denial does not relate to the Participant's failure to meet the Plan's eligibility requirements;
3. the Participant has exhausted the Plan's internal claims appeal process (unless he or she is not required to so under Federal law); and
4. the Participant has provided all the information and forms needed to process the external review.

The Plan must provide the Participant with written notice of its preliminary review determination within one (1) business day after completing the review. If the request is complete but not eligible for external review, the notice must state the reason for ineligibility. If the request is incomplete, the notice must describe the information or materials needed to complete the request. The Plan must permit the Participant to complete the external review request with the four (4) month filing period or, if later, 48 hours after receipt of the notice.

10.03C Referral to IRO. The Plan is then required to select an accredited independent review organization (IRO) to perform the external review. The Plan must ensure against bias and ensure independence relative to the review. Toward this end, the Plan must contract with a minimum of three (3) IROs for assignments and rotate claims assignments among the IROs. The Plan may also select other permitted methods, as permitted by the Department of Labor, for selecting an IRO. The Participant should contact the Plan Administrator to request assistance in determining the Plan's IRO for the Participant's external review process.

The IRO is required to provide the Participant with written notice of the eligibility and acceptance for external review. The notice must inform Participants that they can submit additional written information to the IRO within ten (10) business days following receipt of the notice and that the IRO must consider the additional information in its external review. The IRO may also accept and consider additional information that is submitted after ten days, though it is not required to do so.

Within five (5) business days after the date the IRO is assigned, the Plan must provide the IRO documents and information considered in making the benefit denial. The Plan's failure to timely provide such documents or information, however, is not cause for the delaying the external review. Rather, if the Plan fails to provide the documents and information on a timely basis, the IRO may terminate the external review and decide to reverse the benefit denial. If the IRO elects to reverse the benefits denial, the IRO must notify the Participant and the Plan within one (1) business day after making the decision.

10.03D Reconsideration of Benefits Denial by the Plan. Upon receiving any information submitted by the Participant, the IRO must forward the information to the Plan within one (1) business day. The Plan may then reconsider its benefits denial, though such reconsideration may not delay the external review. If the Plan decides, on reconsideration, to reverse its benefits denial and provide coverage or payment, the external review can be terminated. The Plan must provide written notice to the Participant and the IRO within one (1) business day after making this decision. On receiving the Plan's notice, the IRO must terminate its external review.

10.03E Standard of Review and Documents Considered. The IRO will review all information documents timely and will not give deference or a presumption of correctness to the Plan's decisions or conclusions. Furthermore, the IRO is not bound by any decisions or conclusions reached under the Plan's internal claims and claim appeals process. In addition to documents and information provided by the Covered Person, the IRO will consider the following items in reaching its decision:

1. The Participant's medical records;
2. The recommendation of the attending health care professional;
3. Reports from appropriate health care professionals and other documents submitted by the Plan, Participant, or treating Provider;
4. The governing Plan terms;
5. Appropriate practice guidelines, which must include applicable evidence-based standards;
6. Any applicable clinical review criteria developed and used by the Plan; and
7. The opinion of the IRO's clinical reviewer(s).

10.03F IRO's Final External Review Decision. Within 45 days after the IRO receives the external review request, it must provide written notice of the final external review decision. The notice must be delivered to the Participant and the Plan and must include:

1. A general description of the reason for the external review request, including information sufficient to identify the claim. This information includes the date(s) of service, the provider, claim amount (if applicable), diagnosis and treatment codes, and the reason for the prior denial;
2. The date the IRO received the assignment to conduct the external review, and the date of the IRO's decision;
3. References to the evidence or documentation considered in reaching the decision, including specific coverage provisions and evidence-based standards;
4. A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards relied on in making the decision;
5. A statement that the IRO's determination is binding, unless other remedies are available to the Plan or Participant under state and/or federal law;
6. A statement that judicial review may be available to the Participant; and
7. The phone number and other current contact information for any applicable office of health insurance consumer assistance or ombudsman.

If the IRO's decision is to reverse the Plan's benefits denial, the Plan must immediately provide Coverage or payment for the claim. This includes immediately authorizing or paying benefits.

10.03G Deadlines for Standard External Review. The following chart identifies the key steps and timelines for the external review process.

External Review Procedure	Timeline
Participant's filing period to request standard external review	Within four months after receipt of benefits denial notice
Plan's preliminary review determination	Within five business days following receipt of external review request from Participant
Plan's notice to Participant regarding preliminary review determination	Within one business day after completion of preliminary review
Participant's time period for perfecting incomplete external review request	Remainder of four-month filing period or, if later, 48 hours following receipt of notice
Notice by IRO to Participant (of acceptance for review and deadline for submissions of additional information)	In timely manner
Time period for Plan to provide IRO documents and information considered in making benefit determination	Within five business day of assignment of IRO
Submission of additional information by Participant	Within ten business days following Participant's receipt of notice from IRO
IRO forwards to the Plan any additional information submitted by the Participant	Within one business day of receipt
Notice to Participant and IRO if Plan reverses its denial and provides coverage	Within one business day of decision
Decision by IRO	Within 45 days of receipt of request for review

10.04 Expedited External Review Process

10.04A Requesting an Expedited External Review. An expedited external review process must be made available when the Participant receives:

1. A benefits denial involving a Participant's medical condition where the timeframe for completing an expedited internal appeal would seriously jeopardize the Covered Person's life or health or jeopardize the Covered Person's ability to regain maximum function and the Covered Person has filed an expedited internal appeal request; or
2. A final internal benefits denial involving (a) a Participant's medical condition where the timeframe for completing the standard external review would seriously jeopardize the Participant's life or health or jeopardize the Participant's ability to regain maximum function, or (b) an admission, availability of care, continued stay, or health care service for which the Participant received emergency services, but has not been discharged from a facility. Immediately upon receiving the external review request, the Plan must assess whether the request meets the reviewability requirements and send the Participant a notice regarding the Plan's reviewability assessment.

10.04B Referral to an IRO. Following a preliminary determination that a request is eligible for external review, the Plan will assign an IRO. The same process for selecting an IRO as is applicable under the standard external review process is applicable under the expedited external review process. The Plan must transmit all necessary documents and information considered in making the benefits denial to the assigned IRO. The IRO must consider the information or documents as listed under the standard external review process.

10.04C Standard of Review and Documents Considered. The IRO will review all information documents timely and will not give deference or a presumption of correctness to the Plan's decisions or conclusions. Furthermore, the IRO is not bound by any decisions or conclusions reached under the Plan's internal claims and claim appeals process.

10.04D IRO's Final External Review Decision. The IRO must provide notice of its final external review decision. The notice must meet the requirements that apply in the context of a standard external review process and response. The notice must be provided as expeditiously as the Participant's medical condition or circumstances require, but in no event, more than 72 hours after the IRO receives the request for an expedited external request. If the IRO fails to

provide written notice within 48 hours after it provides notice of its decision, the IRO must provide written confirmation of the decision to both the Participant and the Plan.

10.05 Appointment of Authorized Representative

A Participant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Participant to a Provider will not constitute appointment of that Provider as an authorized representative. To appoint such a representative, the Participant must complete a form which can be obtained from the Plan Administrator or the Third Party Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Participant's medical condition to act as the Participant's authorized representative without completion of this form. In the event a Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Plan Administrator, in writing, to the contrary.

10.06 Physical Examinations

The Plan reserves the right to have a Physician of its own choosing examine any Participant whose condition, Sickness, or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Participant must comply with this requirement as a necessary condition to coverage.

10.07 Autopsy

The Plan reserves the right to have an autopsy performed upon any deceased Participant whose condition, Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

10.08 Payment of Benefits

All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Sickness or Injury, or whose covered Dependent's Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

10.08A Assignments

Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. A Provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

10.08B Non U.S. Providers

Treatment for Emergency medical conditions, urgent care, and sick visits while traveling in a foreign country will be covered at the Network level of payment. Participants receiving medical treatment in another country may be asked to pay for the service at the time it is rendered. To receive reimbursement for expenses, the services rendered must be eligible for coverage in accordance with the benefits described in this Plan Document, subject to all Plan exclusions, limitations, maximums, and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non U.S. Provider;
2. The Participant is responsible for making all payments to Non U.S. Providers, and submitting itemized statements to the Plan for reimbursement. The Participant must obtain an itemized bill from the Provider at

- the time of service that has the name and address of the foreign Provider, the diagnosis, type of service provided, and the cost for each service received;
3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date;
 4. The Non U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
 5. Claims for benefits must be submitted to the Plan in English.

10.08C Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations, or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant or dependent on whose behalf such payment was made.

A Plan Participant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-10 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Plan Participant, Provider or other person or entity to enforce the provisions of this section, then that Plan Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;

3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Plan Participant or by any of his Covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant. If the Plan seeks to recoup funds from a Provider due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the plan participant for any outstanding amount(s).

10.08D Medicaid Coverage

A Participant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Participant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Participant, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

10.08E Limitation of Action

A Participant cannot bring any legal action against the Company or the Third Party Administrator to recover reimbursement until ninety (90) days after the Participant has properly submitted a request for reimbursement as described in this section and all required reviews of the Participant's claim have been completed. If the Participant wants to bring a legal action against the Company or the Third Party Administrator, he/she must do so within 3 years from the expiration of the time period in which a request for reimbursement must be submitted or he/she loses any rights to bring such an action against the Company or the Third Party Administrator.

A Participant cannot bring any legal action against the Company or the Third Party Administrator for any other reason unless he/she first completes all the steps in the appeal process described in this section. After completing that process, if he/she wants to bring a legal action against the Company or the Third Party Administrator he/she must do so within three (3) years of the date he/she is notified of the final decision on the appeal or he/she will lose any rights to bring such an action against the Company or the Third Party Administrator.

ARTICLE XI COORDINATION OF BENEFITS

11.01 Benefits Subject to This Provision

This provision shall apply to all benefits provided under any section of this Plan.

11.02 Excess Insurance

If at the time of injury, sickness, disease, or disability there is available, or potentially available, any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage. The Plan's benefits will be excess to, whenever possible:

1. Any primary payer besides the Plan;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Worker's compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability, or other benefit payments, and school insurance coverage.

11.03 Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title, or classification.

11.04 Allowable Expenses

"Allowable Expenses" shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with Section 10.06A herein, this Plan's Allowable Expenses shall consist of the Plan Participant's responsibility, if any, after the Other Plan has paid but shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

11.05 "Claim Determination Period"

"Claim Determination Period" shall mean each calendar year.

11.06 Effect on Benefits:

11.06A Application to Benefit Determinations

The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the plan's Allowable Expenses. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier. In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
2. The rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

11.06B Order of Benefit Determination

For the purposes of the section entitled “Application to Benefit Determinations,” the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan;
2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent;
3. If the person for whom claim is made is a dependent child covered under both parents’ plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
 - a. When the parents are separated or divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or
 - b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child’s health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a dependent child; and

4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

11.07 Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any Other Plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

11.08 Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

11.09 Right of Recovery

In accordance with section 10.06C, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person’s legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents. **Please see 10.06C above for more details.**

ARTICLE XII MEDICARE

12.01 Applicable to Active Employees and Their Spouses Ages 65 and Over

An active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

12.02 Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the Article entitled "Coordination of Benefits"). The Participant will be assumed to have full Medicare coverage (that is, both Part A & B) whether or not the Participant has enrolled for the full coverage. If the Provider accepts assignment with Medicare, covered expenses will not exceed the Medicare-approved expenses.

12.03 Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Plan Participants Who Are Covered Under This Plan

If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 18 months of Medicare entitlement (with respect to charges incurred on or after February 1, 1991 and before August 5, 1997), and for the first 30 months of Medicare entitlement (with respect to charges incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

ARTICLE XIII
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

13.01 Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease, or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as “Plan Participant(s)”) or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively “Coverage”).
2. Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan’s conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee. By accepting benefits the Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan’s name as a co-payee on any and all settlement drafts.
3. In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan’s attempt to recover such money.
4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an “identifiable” fund from which the plan may seek reimbursement.

13.02 Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan’s discretion.
2. If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.
3. The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
4. If the Plan Participant(s) fails to file a claim or pursue damages against:
 - a. The responsible party, its insurer, or any other source on behalf of that party;

- b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c. Any policy of insurance from any insurance company or guarantor of a third party;
- d. Worker's compensation or other liability insurance company; or
- e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Plan Participant(s) authorizes the Plan to pursue, sue, compromise, and/or settle any such claims in the Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

13.03 Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).
5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

13.04 Excess Insurance

1. If at the time of injury, sickness, disease, or disability there is available, or potentially available, any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

- a. The responsible party, its insurer, or any other source on behalf of that party;
- b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c. Any policy of insurance from any insurance company or guarantor of a third party;
- d. Worker's compensation or other liability insurance company; or
- e. Any other source, including but not limited to crime victim restitution funds, any medical, disability, or other benefit payments, and school insurance coverage.

13.05 Separation of Funds

Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

13.06 Wrongful Death

In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

13.07 Obligations

1. It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
 - a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
 - b. To provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information, and any other requested additional information;
 - c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
 - e. To promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received; and
 - f. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.
2. If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment, or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).
3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

13.08 Offset

If timely repayment is not made, or the Participant and/or his/her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan.

13.09 Minor Status

In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

13.10 Language Interpretation

The Plan Administrator retains sole, full, and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

13.11 Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

ARTICLE XIV MISCELLANEOUS PROVISIONS

14.01 Clerical Error/Delay

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Participants have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

14.02 Conformity With Applicable Laws

This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation, or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including but not limited to stated maximums, exclusions, or limitations. In the event that any law, regulation, or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document. It is intended that the Plan will conform to the requirements of applicable law.

14.03 Fraud

The following actions by any Participant, or a Participant's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire Family Unit of which the Participant is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Participant of the Plan;
2. Attempting to file a claim for a Participant for services which were not rendered or Drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

14.04 Headings

The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

14.05 No Waiver or Estoppel

No term, condition, or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

14.06 Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan. The amount of the Participant's contribution (if any) will be determined from time to time by the Plan Administrator.

14.07 Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Participant for benefits from this Plan. In so acting, the Plan

Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

14.08 Written Notice

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

14.09 Right of Recovery

In accordance with 10.06C, whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Participant or his or her Dependents. **See 10.06C above for full details.**

14.10 Statements

All statements made by the Company or by a Plan Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Plan Participant.

Any Plan Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Plan Participant may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

14.11 Protection Against Creditors

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his/her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

14.12 Binding Arbitration

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Participant and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Participant and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Participant waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Participant.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Participant making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”) according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Participant and the Plan Administrator, or by order of the court, if the Participant and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

14.13 Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by the Third Party Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Participant subsequently requests payment with respect to the voided check, the Third Party Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to any applicable State law(s).

ARTICLE XV MEDICAL BENEFITS

15.01 Medical Benefits

Subject to the Plan's provisions, limitations and exclusions, the following are covered major medical benefits:

1. **Abortion.** Expenses incurred directly or indirectly as the result of an abortion when the pregnancy is the result of rape or incest or the mother's life is endangered;
2. **Allergy Services.** Charges related to the Treatment of allergies;
3. **Ambulance.** Transportation by professional ambulance, including approved available air and ground transportation (excluding chartered air flights), to the nearest facility having the capability to treat the condition, or for transfer from facility to facility for medical treatment, including:
 - a. From the Participant's home or scene of accident/medical emergency to a Hospital;
 - b. Between Hospitals;
 - c. Between Hospital and Skilled Nursing Facility; and
 - d. From a Hospital or Skilled Nursing Facility to the Participant's home.

Surface trips must be to the closest local facility that can give covered services appropriate for the Participant's condition. If none, the Participant is covered for trips to the closest such facility outside his/her local area.

Air transportation is only covered when such transportation is Medically Necessary because of a life-threatening Injury or Illness. Air ambulance is air transportation by a vehicle designed, equipped, and used only to transport the sick and injured to and from a Hospital for Inpatient care.

Ambulance (ground). Transportation by professional ambulance, including approved available train transportation, to a local Hospital or transfer to the nearest facility having the capability to treat the condition, if the transportation is connected with an Inpatient Confinement.

Ambulance (air/flight). Inter-facility patient transport by air transport, for Participants if there is a life threatening situation or it is deemed to be Medically Necessary. For a Participant who is in a Hospital or other health care facility under the care or supervision of a licensed health care Provider pre-certification is required before transport of the Participant via air transport / any form of flight to another Hospital or facility.

Failure to notify Sentinel Air Medical Alliance, LLC and subsequently obtain a pre-certification number from Sentinel Air Medical Alliance, LLC may, solely in the Plan Administrator's discretion, result in a reduction or denial of benefits for charges arising from or related to inter-facility patient transport via air/flight. Non-compliance penalties imposed for failure to notify Sentinel Air Medical Alliance, LLC will not be included as part of the annual out of pocket maximum.

The Plan Administrator retains the discretionary authority to limit benefit availability to alternative Providers of flight-based inter-facility patient transport if and when a Provider fails to comply with the terms of the Plan, or proposed charges exceed the Maximum Allowable Charge in accordance with the terms of the Plan.

4. **Ambulatory Surgical Center.** Services of an Ambulatory Surgical Center for Medically Necessary care provided;
5. **Anesthesia.** Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff;
6. **Birth Control/Contraceptives.** The Plan covers charges for contraceptive devices, implants, and intrauterine devices such as cervical cap, diaphragm, Depo Provera, Mirena, Paraguard, and Implanon. Removal of birth control device is covered;

7. **Birthing Center.** Services of a Birthing Center for Medically Necessary care provided within the scope of its license;
8. **Blood and Plasma.** Blood transfusions, plasma and blood derivatives and charges for whole blood not donated or replaced by a blood bank;
9. **Botox.** Charges for Botox, for migraine headaches and when used to treat FDA-approved conditions;
10. **Breast Pumps.** The Plan covers rental of a manual or standard electric breast pump during pregnancy.
11. **Cardiac Rehabilitation Therapy—Outpatient.** Charges for Cardiac Rehabilitation programs in connection with the rehabilitation of the Participant following a myocardial infarction, coronary occlusion, or coronary bypass Surgery when such rehabilitation services are rendered under the supervision of a Physician in a facility;
12. **Chemotherapy.** Charges for chemotherapy. The Plan shall refer to the Centers for Medicare and Medicaid Services (CMS) authoritative compendia, including the NCCN Drugs and Biologics Compendium and Thomson Micromedex, in the determination of medically accepted drugs and biological used off-label in an anti-cancer chemotherapeutic regimen;
13. **Chiropractic Services—Outpatient.** Charges for chiropractic treatment when rendered by a Physician or a Chiropractor on an outpatient basis and in a covered setting. As used herein, chiropractic treatment means treatment of the spine by physical means, including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound, and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following Disease or Injury. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or other medical professional Provider are required;
14. **Cosmetic Surgery.** Cosmetic Surgery shall be a covered expense provided:
 - a. The Participant received an injury as a result of an accident or a deformity due to surgery, and as a result requires additional surgery. Cosmetic surgery and treatment must be for the purpose of restoring the Participant to his normal function immediately prior to the accident;
 - b. It is required to correct a congenital anomaly for a child, such as a birth defect; it is in connection with a mastectomy, subject to compliance with Federal Regulations, for: (a) reconstruction on the breast on which the mastectomy was performed; (b) surgery and reconstruction on the other breast to produce asymmetrical appearance; and (c) prostheses and physical complications in all stages of mastectomy including lymphedema;
15. **COVID-19.** Charges for COVID-19 related testing and associated office visit, Emergency Room visit, or Urgent Care visit are covered at 100% of the Plan's Maximum Allowable Charge, regardless of a Provider's Network participation status and with no cost sharing to the Participant from February 4, 2020 on a temporary basis through the COVID-19 emergency.

For services rendered from February 4, 2020 on a temporary basis through the COVID-19 emergency, the Plan also covers COVID-19 related virtual care visits with a PCP or Specialist at 100% of the Plan's Maximum Allowable Charge, regardless of a Provider's Network participation and with no cost sharing to the Participant. Non-COVID-19 related PCP or Specialist virtual care visits are covered at the Plan's regular benefit level.

Charges for other services associated with a COVID-19 diagnosis, including complications arising from COVID-19, are covered on a temporary basis through the COVID-19 emergency at 100% of the Maximum Allowable Charge, regardless of a Provider's Network participation status and with no cost sharing to the Participant.

16. **Diagnostic Services—Outpatient.** The Plan will cover Outpatient Diagnostic Services rendered in an outpatient facility or Physician office setting when the Participant has specific symptoms and such tests and procedures are needed to detect and diagnose an Illness or Injury. Outpatient Diagnostic Services include, but are not limited to, preadmission testing and allergy testing. Specific services covered under this benefit include:
- a. Laboratory examinations;
 - b. X-ray tests or examinations;
 - c. EKGs;
 - d. EEGs; and
 - e. MRIs, MRAs, and CAT Scans;
17. **Durable Medical Equipment.** Charges for rental (or, at the Plan’s option, the purchase) of Durable Medical Equipment prescribed by a Physician. At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan does not pay for:
- a. Any purchases without its advance written approval;
 - b. The rental or purchase of items which do not fully meet the definition of “Durable Medical Equipment”; or
 - c. Insulin pump replacement of a pump that is less than 48 months old and can be repaired.
18. **Education.** Charges for Medically Necessary patient education programs in a covered Inpatient or outpatient setting, including services performed in an office visit setting, for the following patient education programs:
- a. Diabetic education;
 - b. Dietary and nutritional education when the Participant’s diagnosis is hypoglycemia, hyperlipidemia, acute or chronic renal failure, obesity, or liver disease; and
 - c. Ostomy care.

Educational supplies and education for weight control is not covered;

19. **Foot Disorders.** Surgical treatment of foot disorders, including associated services, performed by a licensed podiatrist (excluding routine foot care);
20. **Gender Dysphoria and Gender Reassignment Surgery.** Medically Necessary services and treatments for Participants diagnosed with gender dysphoria, including but not limited to: mental health care as otherwise provided herein, prescription drug therapy, including related hormone therapy and gender reassignment surgery. The following requirements and limitations apply.

Procedure Eligibility Requirements:

- a. Mastectomy for female-to-male Participants:
 - i. A Referral Letter from a Qualified Mental Health Professional;
 - ii. A persistent, well-documented diagnosis of gender dysphoria;
 - iii. Participant must be at least 18 years old and have the capacity to make a fully informed decision and consent to treatment; and
 - iv. If the Participant suffers from significant medical or mental health concerns, they must be reasonably well controlled.

A trial of hormone therapy is not a pre-requisite to approval for a mastectomy.
- b. Gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to female Participants):
 - i. 2 Referral Letters from Qualified Mental Health Professionals, one in a purely evaluative role;
 - ii. A persistent, well-documented diagnosis of gender dysphoria;

- iii. Participant must be at least 18 years old and have the capacity to make a fully informed decision and consent to treatment;
 - iv. If the Participant suffers from significant medical or mental health concerns, they must be reasonably well controlled; and
 - v. 12 months of continuous hormone therapy as appropriate to the Participant's gender goals (unless the Participant has a medical contraindication or is otherwise unable or unwilling to take hormones). If testosterone is used for hormone therapy, participant is required to have an adequate trial and treatment failure with injectable testosterone cypionate prior to the use of topical testosterone products.
- c. Genital reconstructive surgery (i.e. vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female-to-male Participants; penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male-to-female Participants):
- i. 2 Referral Letters from Qualified Mental Health Professionals, one in a purely evaluative role;
 - ii. A persistent, well-documented diagnosis of gender dysphoria;
 - iii. Participant must be at least 18 years old and have the capacity to make a fully informed decision and consent to treatment;
 - iv. If the Participant suffers from significant medical or mental health concerns, they must be reasonably well controlled;
 - v. 12 months of continuous hormone therapy as appropriate to the Participant's gender goals (unless the Participant has a medical contraindication or is otherwise unable or unwilling to take hormones). If testosterone is used for hormone therapy, participant is required to have an adequate trial and treatment failure with injectable testosterone cypionate prior to the use of topical testosterone products; and
 - vi. 12 months of living in a gender role that is congruent with the Participant's gender identity (real life experience).

Limitations and Exclusions

- a. Gender reassignment surgery is limited to 1 procedure per Participant per lifetime;
- b. Certain procedures performed as a component of gender reassignment surgery may be determined by the Plan Administrator in its discretion to be cosmetic and will not be covered. Examples of cosmetic procedures, include, but are not limited to: body contouring (including breast augmentation and liposuction), hair removal, hair transplants, voice modification surgery or lessons, skin resurfacing, facial implants and reconstruction;
- c. The Plan's prescription formulary status will apply to any pharmacologic treatments for gender dysphoria.

Definitions

- a. Referral Letter. As used herein, a Referral Letter shall mean a letter from a Qualified Mental Health Professional and shall contain the following: the Participant's general identifying characteristics; results of the Participant's psychosocial assessment, including any diagnoses; and the duration of the Mental Health Professional's relationship with the Participant, including the type of evaluation and therapy or counseling to date; a statement about the fact that informed consent has been obtained from the Participant; and a statement that the Mental Health Professional is available for coordination of care and welcomes a phone call to establish this.
- b. Qualified Mental Health Professional. As used herein, a Qualified Mental Health Professional shall mean an individual with: a Master's degree or equivalent in a clinical behavioral science field granted by an institution accredited by the appropriate national accrediting board; competence in using the Diagnostic Statistical Manual of Mental Disorders and/or the International Classification of Disease for diagnostic purposes; ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria; knowledge about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria; continuing education in the assessment and treatment of gender dysphoria;

21. **Glaucoma.** Treatment of glaucoma, cataract Surgery and one set of lenses (contacts or frame-type);
22. **Hearing Exams (Non-Routine).** Charges for non-routine hearing examinations;
23. **Home Health Care.** Charges by a Home Health Care Agency:
 - a. Registered Nurses or Licensed Practical Nurses;
 - b. Registered therapist performing physical, occupational or Speech Therapy;
 - c. Physician calls in the office, clinic, or Outpatient department; and
 - d. Services, drugs and medical supplies which are Medically Necessary for the treatment of the Plan Participant that would have been provided in the Hospital, but not including Custodial Care.

NOTE: This benefit does not include transportation services, home health aide services, Physician home calls, or rental or purchase of Durable Medical Equipment;

24. **Hospice Care.** Charges relating to Hospice Care, provided the Plan Participant has a life expectancy of 6 months or less, subject to the maximums, if any, stated in the Summary of Benefits. Covered Hospice expenses are limited to:
 - a. Confinement in a Hospice facility to include ancillary charges and room and board;
 - b. Services, supplies and treatment provided by Hospice to a covered person in a home setting;
 - c. Physician services and/or nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse;
 - d. Nutrition services to include nutritional advice by a Registered Dietitian, and nutritional supplements such a diet substitutes administered intravenously or through hyper alimentation;
 - e. Counseling services provided through Hospice for spouse, dependent children or parents of a dependent child;

Bereavement is a covered benefit. Respite is not a covered benefit.

25. **Hospital.** Charges made by a Hospital for:
 - a. Inpatient Treatment
 - i. Daily Semi-Private Room and Board charges;
 - ii. Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges;
 - iii. General nursing services; and
 - iv. Medically Necessary services and supplies furnished by the Hospital, other than Room and Board
 - b. Outpatient Treatment
 - i. Emergency room;
 - ii. Treatment for chronic conditions;
 - iii. Physical Therapy treatments;
 - iv. Hemodialysis; and
 - v. X-ray, laboratory and linear therapy;
26. **Impotence.** Charges for penile implants and other Medically Necessary treatments or devices to treat impotence. Viagra and other Drugs used to treat impotence are covered under Prescription Drug benefits.
27. **Infertility Diagnosis.** 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 an eligible expense;

28. **Inhalation Therapy—Outpatient.** The Plan will cover outpatient inhalation therapy services when rendered and billed by a Provider. Inhalation therapy is a type of therapy that involves the introduction of dry or moist gases into the lungs. Treatment must be rendered in a covered setting;
29. **Mammography Services—Outpatient.** The Plan will cover routine mammography services on an outpatient basis. Coverage includes the following:
- For women age 35-39, the Plan will cover one (1) routine baseline mammogram;
 - For women age 40 or older, the Plan will cover one (1) routine mammogram every calendar year.

As used in connection with coverage for routine mammography screenings, the Maximum Allowable Charge shall be determined as the lesser of the following:

- The Provider's billed charge; or
 - 130% of Ohio's Medicare Reimbursement Rate for screening mammography, or if there is more than one such rate for screening mammography or a component thereof, less than 130% of the lowest Medicare Reimbursement Rate in Ohio. In this event, the Maximum Allowable Charge shall be increased to equal 130% of of Ohio's Medicare Reimbursement Rate or 130% of the lowest Medicare Reimbursement Rate in Ohio.
 - In the event a Provider provides a service that is a component of the mammography screen and submits a separate claim from that component, a separate payment shall be made to the Provider in an amount that corresponds to the ratio paid by Medicare in Ohio for that component. Regardless of whether separate payments are made for the benefit, the total benefit for a mammography screening shall equal the maximum benefit as set forth in the preceding paragraph.
 - As used herein, Medicare Reimbursement Rate means the reimbursement rate paid in Ohio under the Medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.
30. **Mastectomy.** The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The new Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy. As required by law, you are being provided this notice to inform you about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:
- Reconstruction of the breast on which the Mastectomy has been performed;
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - Prostheses and physical complications from all stages of Mastectomy, including lymphedemas;
- in a manner determined in consultation with the attending Physician and the patient. This coverage will be subject to the same annual Deductible and coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with you and your attending Physician;
31. **Medical Supplies.** Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes, but including syringes for diabetic and allergy diagnosis, and lancets and chemstrips for diabetics;
32. **Morbid Obesity.** For Participants diagnosed as having morbid obesity and an Illness that is directly caused by morbid obesity, the Plan will cover Surgical treatment when Surgical intervention is recommended by the Participant's Physician. The Plan will cover the Surgical procedure and Hospital admission, as well as any related complications and related services following Surgical treatment.

The lifetime benefit maximum set forth in the Summary of Benefits applies per Participant and applies to all covered Surgical procedures, the Hospital admission, any related complications, and related services following Surgery. Coverage for Surgical treatment begins when the Surgical expense is incurred. The Plan will not cover

services rendered prior to Surgery. The Plan will cover all Surgically-related procedures from the point of Surgery and Medically Necessary follow-up services after the Surgery, including but not limited to related services for conditions resulting from the Surgery (e.g., Surgical removal of excess skin). Medical Necessity review requirements must be met to qualify for the procedure;

33. **Newborn Care.** Hospital and Physician nursery care for Newborns who are natural children of the Employee or spouse and properly enrolled in the Plan, as set forth below. Benefits will be provided under the baby's coverage and are not subject to Deductible or coinsurance.
- a. Hospital routine care for a Newborn during the child's initial Hospital Confinement at birth; and
 - b. The following Physician services for well-baby care during the Newborn's initial Hospital Confinement at birth:
 - i. The initial Newborn examination and a second examination performed prior to discharge from the Hospital; and
 - ii. Circumcision.

NOTE: The Plan will cover Hospital and Physician nursery care for an ill Newborn as any other medical condition, provided the Newborn is properly enrolled in the Plan. These benefits are provided under the baby's coverage;

34. **Nursing Services.** Services of a Registered Nurse or Licensed Practical Nurse, as specified under the Home Health Care benefit;
35. **Nutritional Supplies.** Charges for Medically Necessary nutritional supplies.
36. **Occupational Therapy--Outpatient.** The Plan will cover outpatient Occupational Therapy when rendered and billed by a Physician or other medical professional Provider in a covered outpatient setting. As used herein, Occupational Therapy means treatment rendered on an Inpatient or outpatient basis as a part of a physical medicine and rehabilitation program to improve functional impairments where the expectation exists that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. No benefits are provided for diversional, recreational, and vocational therapies (such as hobbies, arts and crafts);
37. **Oral Surgery.** Oral Surgery in relation to the bone, including tumors, cysts and growths, not related to the teeth and extraction of soft tissue impacted teeth by a Physician or Dentist;
38. **Pathology Services.** Charges for Pathology Services;
39. **Physical Therapy—Outpatient.** The Plan will cover physical therapy when rendered by a Physician or Physical Therapist in a covered outpatient setting. As used herein, Physical Therapy means treatment by physical means, including modalities such as whirlpool and diathermy; and procedures such as massage, ultrasound, and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following disease, injury, or loss of body part. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or other medical professional Provider are required. Aquatic therapy is covered under this benefit. Treatment of the spine is covered under the chiropractic benefit;
40. **Physician Medical Services During an Inpatient Confinement.** The Plan will cover the following medical services rendered and billed by a Physician when the Participant is a Hospital Inpatient:
- a. One (1) in-Hospital visit per day from the Participant's treating Physician during a Participant's Inpatient confinement;
 - b. Constant care and treatment while the Participant is confined in an intensive care unit (ICU);
 - c. When the Participant's condition requires the skills of separate Physicians, the Plan will cover the medical care and treatment by two (2) or more Physicians received during the same Hospital Confinement; and

d. When the Participant's Physician requests another Physician's consultation, the Plan will cover one (1) such consultation per Hospital admission. Staff consultations required by Hospital rules are excluded from coverage.

41. **Physician Office Visit for Non-Routine Care.** The Plan will cover charges incurred during a visit to the Participant's Physician for non-routine care in connection with a specific Injury or Illness, as set forth in the Summary of Benefits. Covered services includes screening examinations, evaluation procedures, medical care, treatment, or services directly related to assist in the diagnosis or treatment of a specific Injury or Illness that is known or reasonably suspected. Any diagnostic tests requested by the Physician in connection with the office visit will be covered under the "Diagnostic Services – Outpatient" benefit;

42. **Pregnancy Expenses.** Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a 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 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending provider" include a plan, hospital, managed care organization, or other issuer.

Benefits are payable in the same manner as for medical or Surgical care of an Illness, shown in the "Summary of Benefits" and this section, and subject to the same maximums;

43. **Prosthetics, Orthotics, Supplies, and Surgical Dressings.** Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, fitting, and adjustment. Orthotic devices and braces, including fitting, adjustment, and replacement. Includes breast prostheses and surgical bras (as limited in the Summary of Benefits).

The Plan will cover medical and Surgical supplies that serve a specific medical purpose and are purchased by the Participant for use in the home, including but not limited to:

- a. Oxygen;
- b. Surgical dressings;
- c. Surgical stockings (as limited in the Summary of Benefits);
- d. Casts and splints;
- e. Braces;
- f. Catheters;
- g. Colostomy and ileostomy bags and supplies required for their use;
- h. Soft lenses and sclera shells intended for use in the treatment of an Illness or Injury of the eye; and
- i. Allergy serum and intravenous solutions, unless such serum and IV solutions are obtained from a pharmacy;

44. **Radiation Therapy.** Charges for radiation and dialysis therapy and treatment;

45. **Respiration Therapy.** Respiration therapy services, when rendered in accordance with a Physician's written treatment plan;

46. **Routine Patient Costs for Clinical Trial.** The Plan will cover routine patient costs for a qualified individual in an Approved Clinical Trial. This benefit does not include:

- a. the investigational item, device, or service itself;
- b. items and services solely for data collection and analysis purposes and not for direct clinical management of the Participant; or
- c. any service inconsistent with the established standard of care for the Participant's diagnosis.

Routine patient costs, services, treatment, or items provided by a Non-Network Provider are covered only if the Approved Clinical Trial is only offered outside the Participant's state of residence;

47. **Routine/Well Care for Dependent Children—Newborn through Age Eight.** Coverage will include charges for a Dependent Child for routine periodic examinations, screening examinations, medical assessments, evaluation procedures, preventive medical care, and treatment or services not directly related to the specific Injury, Illness, or pregnancy-related condition which is known or reasonably suspected. Specific services covered under this benefit include:
- a. Routine Physician examinations according to the schedule of examinations recommended by the American Pediatric Association for Dependent Children from birth through eight (8) years of age. Thereafter, routine Physician examinations will be limited to one (1) per calendar year;
 - b. Routine immunizations;
 - c. All diagnostic laboratory examinations in connection with the routine Physician office visit; and
 - d. Hearing screening for newborns from birth to age one (1);
48. **Routine/Well Care for Adults and Dependent Children Age Nine (9) and Older.** Coverage will include charges for all Participants for routine periodic examinations, screening examinations, medical assessments, evaluation procedures, preventive medical care, and treatment or services not directly related to a specific Illness, Injury, or pregnancy-related condition which is known or reasonably suspected. Specific services covered under this benefit include:
- a. One (1) routine physical examination per calendar year;
 - b. Routine immunizations with no limit, including hepatitis, flu, Pneumovax, Gardasil (males and females ages 9-26), and H1N1;
 - c. One (1) routine gynecological exam per calendar year and one (1) routine Pap smear screening per calendar year;
 - d. One (1) routine prostate (PSA) screening per calendar year;
 - e. Routine mammogram screenings for women age 35 and older (see Mammography Services—Outpatient);
 - f. Screening colonoscopy for adults age 50-75 once every five (5) years. Screening Colonoscopy for adults will begin at age 45 for the following circumstances:
 - A personal history of colorectal cancer or polyps
 - A family history of colorectal cancer
 - A personal history of inflammatory bowel disease (ulcerative colitis or Crohn's disease)
 - A confined or suspected hereditary colorectal cancer syndrome, such as familial adenomatous polyposis (FA) or Lynch syndrome (hereditary non-polyposis colon cancer or HNPCC)
 - A personal history of getting radiation to the abdomen or pelvic area to treat a prior cancer.
 - g. Routine bone density scan for women over 65 and post-menopausal women under 65 who have been determined to be at increased risk of osteoporosis;
 - h. Shingrix or Herpes Zoster vaccine beginning at age 50;
49. **Second and Third Surgical Opinions—Inpatient.** If the Participant's Physician recommends that a Surgical procedure be performed, the Plan will cover the Participant's consultation with another Physician in order to obtain a second surgical opinion. If the second opinion differs from the first, the Plan will cover the Participant's consultation with a third Physician to obtain a third surgical opinion. The second and/or third Physician with whom the Participant consults must be a specialist in the field of medicine for which the Surgery is related;
50. **Skilled Nursing Facility.** Charges made by a Skilled Nursing Facility or a Convalescent Care Facility, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury (excluding drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation or other Mental or Nervous Disorders) for which the Plan Participant is confined;
51. **Sleep Disorders.** The Plan will cover the diagnosis and treatment of a sleep disorder when services are rendered and billed by a Physician or other medical professional Provider in a covered setting. For purposes of determining

what services will be covered in connection with this benefit, a “sleep disorder” will be considered the same as any other Illness under this Plan Document;

52. **Speech Therapy.** The Plan will cover Speech Therapy when rendered and billed by a Physician or Speech Therapist in a covered outpatient setting. As used herein, Speech Therapy means active treatment for improvement of an organic medical condition causing a speech impairment. Treatment must be either post-operative or for the convalescent stage of an active Illness or Disease. Treatment for developmental delays, language disorders, or articulation is not covered;
53. **Sterilization.** Charges for voluntary sterilization, as set forth in the Summary of Benefits;
54. **Surgery.** Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:
 - a. Multiple procedures adding significant time or complexity will be allowed at:
 - i. 100% of the full Usual and Customary fee value for the first or major procedure;
 - ii. 50% of the Usual and Customary fee value for the secondary and subsequent procedures;
 - b. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at 100% of Usual and Customary fee value for the major procedure, and 50% of the Usual and Customary fee value for the secondary or lesser procedure;
 - c. Charges made for services rendered by an assistant surgeon will be allowed at 25% of the Usual, and Customary fee value for the type of surgery performed;
 - d. No benefit will be payable for incidental procedures, such as appendectomy during an abdominal Surgery, performed during a single operative session;
55. **Surgical Treatment of Jaw.** Surgical treatment of Diseases, Injuries, fractures and dislocations of the jaw by a Physician or Dentist;
56. **Transplants.** Organ or tissue transplants are covered for the following human to human organ or tissue transplant procedures:
 - a. Bone marrow (allogenic and autologous);
 - b. Heart;
 - c. Lung;
 - d. Heart and lung;
 - e. Liver;
 - f. Pancreas;
 - g. Kidney; and
 - h. Cornea.

In addition, the Plan will cover any other transplant that is not Experimental.

The Plan will cover services for in connection with the transplant procedures described in this section when such services are rendered and billed by a Physician and/or Hospital. Such services will be include all covered services that would be available for the treatment of any other Illness.

In addition, the Plan will cover expenses for the acquisition and transportation of the organ or tissue and will cover travel and lodging expenses in connection with the Participant receiving a covered procedure. Travel and lodging expenses will be limited to the travel expenses of the Participant receiving the transplant procedure and, if the Participant is a minor, the travel and lodging expenses of two adult companions (e.g., the Participant’s parents). If the Participant is an adult, the Plan will cover the travel and lodging expenses of one adult companion.

Although a Participant is free to choose the Hospital that will perform a covered transplant procedure, the Plan will pay a higher benefit when the Participant uses a Hospital that is a “Center of Excellence” to receive transplant services. This higher benefit level, which is set forth in the Summary of Benefits, applies to all covered services received in connection with the covered transplant procedure when a Center of Excellence performs the actual transplant surgery. To determine which Hospitals are considered a Center of Excellence, the Participant or his/her Physician should contact Medical Cost Management (MCM) at 1-800-367-9938 as soon as the Participant becomes a candidate for a transplant procedure;

57. **Urgent Care in Urgent Care Facility.** The Plan will cover services rendered by an urgent care facility in connection with the treatment and diagnosis of an Illness or Injury, including the services provided by the Physician and other medical professional Providers who are urgent care facility employees. Coverage will be provided for screening examinations, evaluation procedures, medical and surgical care, treatment, or services directly related to a specific Injury or Illness which is known or reasonably suspected.

15.02 Psychiatric and Substance Abuse Benefits

The Plan will provide benefits for intermediate levels of care for mental health conditions and substance abuse disorders in parity with medical or surgical care of the same level. For instance, if the Plan provides benefits for a skilled nursing or rehabilitation facility for medical or surgical treatment, the Plan will provide equal benefits for intensive outpatient therapy, partial hospitalization or residential treatment. Contact the customer service number on the back of the member ID card for more information.

15.02A Inpatient Benefits

Subject to the limitations contained in the Summary of Benefits, the Plan will pay covered expenses for:

1. Semi-private hospital Room and Board.
2. Miscellaneous facility charges on days a Room and Board charge is covered.
3. Individual psychotherapy.
4. Group psychotherapy.
5. Psychological testing.
6. Residential treatment.
7. Family counseling: Counseling with family members to assist in the Participant’s diagnosis and treatment, but not including marriage counseling.
8. Convulsive therapy treatment limited to Inpatient care (includes electroshock treatment or convulsive drug therapy).

The benefits above are also available when receiving treatment during the day only or during the night only at a day/night Psychiatric Hospital or at a Substance Abuse Treatment Center and/or Rehabilitation Hospital.

15.02B Outpatient Benefits

Subject to the limitations contained in the Summary of Benefits, the Plan will pay covered expenses for:

1. Individual psychotherapy.
2. Group psychotherapy.
3. Psychological testing.
4. Family counseling: Counseling with family members to assist in the Participant’s diagnosis and treatment, but not including marriage counseling.
5. Prescription drugs or medicines for the treatment of mental illness or chemical dependency.

15.03 Dialysis Treatment – Outpatient

This Section describes the Plan’s Dialysis Benefit Preservation Program (the “Dialysis Program”). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan Participants and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

1. Reasons for the Dialysis Program. The Dialysis Program has been established for the following reasons:
 - a. the concentration of dialysis providers in the market in which Plan Participants reside may allow such providers to exercise control over prices for dialysis-related products and services,
 - b. the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan Participants,
 - c. evidence of (i) significant inflation of the prices charged to Plan Participants by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan Participants to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of non-governmental and non-commercial plans, such as the Plan, by dialysis providers as profit centers, and
 - d. the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan Participants, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the interests of Plan Participants, such as subsidies for other plans and discriminatory profit-taking.
2. Dialysis Program Components. The components of the Dialysis Program are as follows:
 - a. Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan Participants for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis (“dialysis-related claims”).
 - b. Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan for expenses incurred on or after June 1, 2018, regardless of when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan Participant.
 - c. Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination, the Plan Administrator shall consider factors including:
 - i. Market concentration: The Plan Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration, multiple dialysis facilities under common ownership or control shall be counted as a single provider.
 - ii. Discrimination in charges: The Plan Administrator shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.
 - d. In the event that the Plan Administrator’s charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factor resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan Administrator may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan Administrator may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the Participant, to the following payment limitations, under the following conditions:
 - i. Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the Participant, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.
 - ii. Maximum Benefit. Except as provided in the preceding subsection or where an acceptable provider agreement is entered into, the maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

- iii. Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan Administrator shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.
 - iv. Additional Information related to Value of Dialysis-Related Services and Supplies. The Participant, or provider where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.
 - vi. All charges must be billed by a provider in accordance with generally accepted industry standards.
3. Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Plan Participant is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.
 4. Discretion. The Plan Administrator shall have full authority and discretion to interpret, administer, and apply this Section to the greatest extent permitted by law. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of this Section, to make determinations regarding issues which relate to eligibility for benefits under this Section, to decide disputes which may arise relative to a Participant's rights under this Section, and to decide questions of interpretation of this Section and those of fact relating to the application of this Section. The decisions of the Plan Administrator will be final and binding on all interested parties.
 5. Provider Acceptance. A provider that accepts the payment from the Plan under this Section will be deemed to consent and agree that (i) such payment shall be for the full amount due for the provision of services and supplies to a Plan member, and (ii) it shall not "balance bill" a Plan member for any amount billed but not paid by the Plan.

15.04 Oncology Program

This provision describes a specialty case management program designed for certain aspects of care received by cancer patients who are beneficiaries under the Plan.

Your Plan has entered into an arrangement with American Health Holding, a company specializing in oncology case management, to assist you and your oncologist during the course of cancer treatment when administered either in an outpatient setting (e.g., in the physician's office or other covered outpatient setting) or an inpatient setting. The program applies to the plan of treatment for all cancer types and stages and begins with a treatment planning phase (including drug and/or radiation treatment) and continues through active treatment and transitional care.

A Registered Nurse will be assigned to you and will contact you to provide support, education, and answer any questions you might have about your disease and your treatment plan and will remain in contact with you and your oncologist for the duration of your cancer journey.

Unless your oncologist has entered into an agreement with HealthSCOPE Benefits to accept other reimbursement rates, the payment for all drugs used in the treatment of cancer will be limited to the rate of Average Sales Price plus 10%. Average Sales Price is the price calculated by pharmaceutical manufacturers and submitted to the Centers for Medicare and Medicaid Services (CMS) on a quarterly basis.

15.05 Exclusions

Some health care services are not covered by the Plan. In addition to the General Exclusions set forth in Article VII, these include, but are not limited to, any charge for care, supplies, or services, which are:

1. **Admissions Primarily for Diagnostic Studies.** Charges for room, board, and general nursing care for Hospital admissions mainly for diagnostic studies;
2. **Admissions Primarily for Physical Therapy.** Charges for room, board, and general nursing care for Hospital admissions mainly for Physical Therapy;
3. **Alternative Treatments.** The Plan will not cover treatments that are deemed to be “alternative treatments”, including but not limited to the following: acupressure, acupuncture, naturopathy, psychosurgery, massage therapy, megavitamin therapy, nutritionally based alcoholism therapy, holistic or homeopathic care including drugs, ecological or environmental medicine, hypnotherapy or hypnotic anesthesia, hippotherapy, and sleep therapy;
4. **Biofeedback.** Biofeedback therapy;
5. **Braces and Artificial Limbs.** Expenses for replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is a sufficient change in the Participant’s physical condition to make the original device no longer functional;
6. **Certain Counseling Services.** The Plan will not cover marriage counseling, family counseling, pastoral counseling, financial counseling, legal counseling, and custodial care counseling, except as specifically set forth in this Plan Document;
7. **Certain Examinations and Services.** The Plan will not cover examinations or medical services the Participant receives specifically for the purpose of employment, recreation, insurance, school attendance, or licensure;
8. **Consultations.** Consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
9. **Cosmetic Surgery.** Charges for Cosmetic Surgery, except as provided for herein;
10. **Custodial Care.** Custodial Care, domiciliary care, or rest cures, or home health care except as specifically provided herein;
11. **Dental Services.** The Plan will not cover expenses for dentistry or dental processes, except as specified, or expenses incurred or services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or group;
12. **Drugs.** The Plan will not cover expenses for over-the-counter or prescription drugs purchased and administered on an outpatient basis except as specified herein. Prescription drugs administered while an Inpatient in a Hospital will be covered;
13. **Education or Training Program.** Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein;
14. **Exercise Program.** Expenses for exercise programs for treatment of any condition, except for Physician-supervised Cardiac Rehabilitation, or for Occupational or Physical Therapy covered by the Plan;
15. **Genetic Testing.** Expenses related to Genetic Testing of any kind are not covered under the Plan;
16. **Government Unit or Program.** The Plan will not cover expenses to the extent governmental units or governmental programs provide benefits;

17. **Hair Pieces.** Wigs, artificial hair pieces, human or artificial hair transplants, or any drug, prescription or otherwise, used to eliminate baldness, whether or not prescribed by a Physician;
18. **Hearing Services/Devices.** Routine hearing examinations, hearing aids, or examinations for the prescription or fitting of hearing aids are not covered;
19. **Hypnosis.** Expenses related to the use of hypnosis;
20. **Impregnation and Infertility Treatment.** Charges related to Impregnation and Infertility Treatment, including artificial insemination, fertility drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency drugs such as Viagra™, in-vitro fertilization, surrogate mother, donor eggs, and reversal of sterilization;
21. **Lifestyle Improvement Services.** The Plan will not cover lifestyle improvement services or charges, including but not limited to physical fitness programs and equipment, spas, air conditioners, humidifiers, personal hygiene and convenience items, mineral baths, massage, and dietary supplements;
22. **Nutritional Supplements.** Charges for nutritional supplements, except as specified under Preventive Care or otherwise provided for herein;
23. **Oral Surgery.** Oral Surgery or dental treatment, except as specifically provided in the Plan;
24. **Organ Transplants.** Expenses related to donation of a human organ or tissue, except as specifically provided;
25. **Orthopedic Shoes.** Orthopedic shoes are not covered;
26. **Podiatry.** The Plan will not cover expenses for foot care only to improve comfort or appearance, such as care for flat feet, subluxation, corns, bunions (except capsular or bone surgery), calluses, toenails, and the like;
27. **Preventive and Routine Services.** The Plan will not cover preventive services, routine office visits, or routine periodical physical examinations for a Participant except as specified herein;
28. **Private Room Charges.** Charges for a private room while the Participant is an Inpatient in a Hospital or Skilled Nursing Facility, unless such private room is deemed Medically Necessary;
29. **Radial Keratotomy.** Radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses;
30. **Routine Physical Examinations.** Routine or periodic physical examinations, related x-ray and laboratory expenses, and nutritional supplements, except as provided in the Summary of Benefits;
31. **Smoking Cessation/Nicotine Addiction.** The Plan will not cover charges for care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung illness such as emphysema or asthma;
32. **Telephone Consultations, Missed Appointments, Claim Form Completion.** The Plan will not cover expenses for telephone consultations, missed appointments, or completion of claim forms;
33. **Temporomandibular Joint Disorder.** Charges for the diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofascial pain dysfunction, or orthognathic treatment. However, this service may be eligible for coverage through your Dental Plan benefits;
34. **Travel.** Travel, whether or not recommended by a Physician, except as specifically provided herein; and

35. **Veteran's Administration Facility.** The Plan will not cover services received by veterans for any Disease or Injury suffered as a result of or while in military service, to the extent that such services can be performed by a Veterans Administration Hospital or Facility;
36. **Vitamins.** Vitamins;
37. **Vision Services.** The Plan will not cover expenses for eye care except as specified herein. Eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses are not covered. In addition, eye examinations for any occupational condition, ailment, or Injury arising out of or in the course of employment will not be covered. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use in the treatment of Disease or Injury);
38. **Weight Control or Related Treatments.** The Plan will not cover exercise programs, dietary products, supplies, or treatment for controlling or reducing weight, obesity treatments, including but not limited to any Surgical procedures to correct obesity or morbid obesity, except as specified in this Plan Document;

15.06 Cost Containment

15.06A Pre-Certification Procedures

The Inpatient Utilization Management Service is simple and easy for Participants to use. Whenever a Participant is advised that Inpatient Hospital care is needed, it is the Participant's responsibility to call the pre-certification department at its toll-free number, which is **1-800-367-9938**. The review process will continue, as outlined below, until the Participant is discharged from the Hospital. **Pre-certification is required for Inpatient admission to skilled nursing facilities, convalescent or rehabilitation facilities unless otherwise stated in this document.**

Urgent Care or Emergency Admissions:

If a Participant needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible. If a Participant must be admitted on an Emergency basis, the Participant should follow the Physician's instructions carefully and contact the pre-certification department as follows:

1. For Emergency admissions after business hours on Friday, on a weekend or over a holiday weekend, a call to the pre-certification department must be made within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient; and
2. For Emergency admissions on a weekday, a call to the pre-certification department must be made within 24 hours after the admission date.

The Plan does not require the Participant to obtain approval of a medical service prior to getting treatment for an urgent care or emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Non-emergency Admissions:

Scheduled Inpatient stays must be pre-certified within three (3) business days of admission. Once the pre-certification call is received, it will be routed to an appropriate review specialist who will create an on-line patient file. The review specialist will contact the Participant's attending Physician to obtain information and to discuss the specifics of the admission request. An on-line expert system that features state-of-the-art, widely accepted clinical review criteria is used to effectively guide the review process. If appropriate, alternative care will be explored with the Physician.

If, after assessing procedure necessity, the need for an Inpatient confinement is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the Physician or Hospital during the confinement.

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board-certified Physician advisor who will immediately contact the attending Physician to negotiate an appropriate treatment plan. At the end of the Hospital confinement, the review specialist is also available to assist

with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

Ambulance (air/flight) Services:

All flight-based inter-facility patient transport services require pre-certification from the Plan Administrator via Sentinel Air Medical Alliance, LLC. Please contact Sentinel Air Medical Alliance, LLC at (877) 542-8828. Sentinel Air Medical Alliance, LLC may discuss with the Physician and/or Hospital/facility the Diagnosis and the need for inter-facility patient transport versus alternatives.

Failure to notify Sentinel Air Medical Alliance, LLC and subsequently obtain a pre-certification number from Sentinel Air Medical Alliance, LLC may, solely in the Plan Administrator's discretion, result in a reduction or denial of benefits for charges arising from or related to flight-based inter-facility patient transport. Non-compliance penalties imposed for failure to notify Sentinel Air Medical Alliance, LLC will not be included as part of the annual out of pocket maximum.

The Plan Administrator retains the discretionary authority to limit benefit availability to alternative Providers of inter-facility patient transport if and when a Provider fails to comply with the terms of the Plan, or proposed charges exceed the Maximum Allowable Charge in accordance with the terms of the Plan.

15.06B Pre-Certification Penalty

The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to obtain pre-certification as required under the Plan, the following penalties will apply:

- a. Scheduled Inpatient admission: denial of facility charges (Provider charges will be paid per contractual agreement);
- b. Non-scheduled (emergency) admission: 50% reduction of benefits for facility and admitting Physician's charges;
- c. Other services requiring pre-certification: no coverage of any and all related charges.

The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.

15.06C Alternate Course of Treatment

Certain types of conditions, such as spinal cord Injuries, cancer, AIDS or premature births, may require long-term, or perhaps lifetime, care. The claims selected will be evaluated as to present course of treatment and alternate care possibilities.

If the Plan Administrator should determine that an alternate, less expensive, course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, subject to the applicable lifetime benefit set forth in this Plan, even if these expenses normally would not be eligible for payment under the Plan. In the event the Participant and the attending Physician select a more expensive course of treatment, coverage under the Plan will be based upon the charge allowed for the alternate, less expensive, course of treatment.

ARTICLE XVI
PRESCRIPTION DRUG, DENTAL, AND VISION BENEFITS

The Plan provides prescription drug, dental, and vision benefits are not administered by HealthSCOPE Benefits. Please contact the Employer for a description of prescription drug, vision, and dental benefits (and all related terms and conditions), that are available under the City of Toledo Employee Health Benefit Plan.

ARTICLE XVII HIPAA PRIVACY

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of our Notice of Privacy Practices are available by calling 1-888-249-8247.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information (“PHI”) or Electronic Protected Health Information (“ePHI”) that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information (“PHI”)** means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the “Privacy Rule”) set forth by the U.S. Department of Health and Human Services (“HHS”) pursuant to the Health Insurance Portability and Accountability Act (“HIPAA”). Such standards control the dissemination of “protected health information” (“PHI”) of Plan Participants. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan. The Plan is required by law to take reasonable steps to ensure the privacy of the Plan Participant’s PHI, and inform him/her about:

1. The Plan’s disclosures and uses of PHI;
2. The Plan Participant’s privacy rights with respect to his/her PHI;
3. The Plan’s duties with respect to his/her PHI;
4. The Plan Participant’s right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan’s privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual’s PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;
6. Not use or disclose genetic information for underwriting purposes;
7. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;
8. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
9. Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);
10. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);
11. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);
12. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);
13. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
14. Train employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
15. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
16. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - (a) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
 - (i) Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
 - (b) In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Plan Participant. The Plan may use or disclose “summary health information” to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

Other Disclosures and Uses of PHI:

Permissible Uses and Disclosures of PHI

1. **Treatment, Payment, and Health Care Operations:** The Plan has the right to use and disclose a Plan Participant’s PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. **Business Associates:** The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Participant’s information.
3. **Other Covered Entities:** The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

Other Permissible Uses and Disclosures of PHI

1. **Required by Law:** The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.
2. **Public Health and Safety:** The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
 - (a) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse, neglect or domestic violence;
 - (b) report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
 - (c) locate and notify persons of recalls of products they may be using; and
 - (d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

3. The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by (5) above, when required or authorized by law, or with the Plan Participant's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Plan Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives, although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.
4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative, or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.
5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Plan Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Plan Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.
6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness, or missing person. Under certain circumstances, the Plan may disclose the Plan Participant's PHI in response to a law enforcement official's request if he/she is, or is suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.
7. Decedents: The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, or to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, for determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years.
8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.
9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct if the Plan believes in good faith that the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.
10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
11. Inmates: The Plan may disclose PHI when to the correctional institution or law enforcement official for: the institution to provide health care to the Plan Participant; the Plan Participant's health and safety and the health and safety of others; or the safety and security of the correctional institution.
12. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.
13. Emergency Situations: The Plan may disclose PHI in an emergency situation, or if the Plan Participant is incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. The Plan will use professional judgment and experience to determine if the disclosure is in the Plan Participant's best interest. If the disclosure is in the Plan Participant's best interest, the Plan will disclose only the PHI that is directly relevant to the person's involvement in the Plan Participant's care.

14. **Fundraising Activities:** The Plan may disclose PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If the Plan does not contact the Plan Participant for fundraising activities, the Plan will give the Plan Participant the opportunity to opt-out, or stop, receiving such communications in the future.
15. **Group Health Plan Disclosures:** The Plan may disclose PHI to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to the Plan Participant. The Plan can disclose PHI to that entity if that entity has contracted with the Plan to administer the Plan Participant’s health care program on its behalf.
16. **Underwriting Purposes:** The Plan may disclose PHI for underwriting purposes, such as to make a determination about a coverage application or request. If the Plan does not disclose the Plan Participant’s PHI for underwriting purposes, the Plan is prohibited from using or disclosing in the underwriting process the PHI that is genetic information.

Uses and Disclosures of PHI that Require Authorization

1. **Sale of PHI:** The Plan will request written authorization before it makes any disclosure that is deemed a sale of PHI, meaning the Plan is receiving compensation for disclosing the PHI in that manner.
2. **Marketing:** The Plan will request written authorization to use or disclose PHI for marketing purposes with limited exceptions, such as when the Plan has face-to-face marketing communications with the Plan Participant or when the Plan provides promotional gifts of nominal value.
3. **Psychotherapy Notes:** The Plan will request written authorization to use or disclose any of the Plan Participant’s psychotherapy notes that may be on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of PHI that are not described above will be made only with written authorization. If the Plan Participant provides the Plan with such authorization, it may be revoked in writing and the revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that the Plan already used or disclosed, relying on the authorization.

Required Disclosures of PHI

1. **Disclosures to Plan Participants:** The Plan is required to disclose to a Plan Participant most of the PHI in a Designated Record Set when the Plan Participant requests access to this information. The Plan will disclose a Plan Participant’s PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Plan Participant’s personal representative if it has a reasonable belief that the Plan Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Plan Participant’s best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Plan Participant.

2. **Disclosures to the Secretary of the U.S. Dept. of Health and Human Services:** The Plan is required to disclose the Plan Participant’s PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan’s compliance with the HIPAA Privacy Rule.
3. **Business Associates:** The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree

in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Participant's information.

4. **Other Covered Entities:** The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

Instances When Required Authorization Is Needed From Participants Before Disclosing PHI

1. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures for marketing;
3. Sale of PHI; and
4. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Potential Impact of State Law

The HIPAA Privacy Rule regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

Rights to Individuals

The Plan Participant has the following rights regarding PHI about him/her:

1. **Request Restrictions:** The Plan Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Plan Participant may request the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.
2. **Right to Receive Confidential Communication:** The Plan Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Plan Participant would like to be contacted. The Plan will accommodate all reasonable requests.
3. **Right to Receive a Notice of Privacy Practices:** The Plan Participant is entitled to receive a paper copy of the Plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.
4. **Accounting of Disclosures:** The Plan Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Plan Participant is entitled to such an accounting for the six (6) years prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Plan Participant of the basis of the disclosure, and certain other information. If the Plan Participant wishes to make a request, please contact the Privacy Compliance Coordinator.

5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI, or to have a copy of your PHI transmitted directly to another designated person, contact the Privacy Compliance Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within thirty (30) days (in some cases, the Plan can request a thirty (30) day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial.
6. Amendment: The Plan Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Plan Participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request.
7. Fundraising contacts: The Participant has the right to opt out of fundraising contacts.

Questions or Complaints

If the Plan Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Plan Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Plan Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Plan Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information:

Privacy Compliance Coordinator Contact Information:

Tyrome Alexander
City of Toledo, Ohio
One Government Center, Suite 1920
Toledo, OH 43604
Phone: (419) 245-1500
Fax: (419) 245-1511
tyrome.alexander@toledo.oh.gov

ARTICLE XVIII HIPAA SECURITY

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (“SECURITY RULE”)

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions

“*Electronic Protected Health Information*” (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

“*Security Incidents*” is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the Participant whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than sixty (60) calendar days after discovery of the breach. Breach Notification must be provided to individual by:
 - a. Written notice by first-class mail to Participant (or next of kin) at last known address or, if specified by Participant, e-mail;
 - b. If Plan has insufficient or out-of-date contact information for the Participant, the Participant must be notified by a “substitute form”;
 - c. If an urgent notice is required, Plan may contact the Participant by telephone.
 - i. The breach notification will have the following content:
 1. Brief description of what happened, including date of breach and date discovered;

2. Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);
 3. Steps Participant should take to protect from potential harm;
 4. What the Plan is doing to investigate the breach, mitigate losses and protect against further breaches;
2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered.
3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves fewer than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each calendar year.
4. When a Business Associate that provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected individuals may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.