HEALTH BENEFIT BOOKLET

Southwest General Health Center
Consumer-Driven Health Plan

EFFECTIVE DATE
January 1, 2014

REVISED DATE
June 1, 2023

Administered by
Mutual Health Services
P.O. Box 5700
Cleveland, Ohio 44101
Phone: (330) 666-0337 or
1-800-367-3762 National Toll Free

BENEFIT BOOKLET

This Benefit Booklet has been prepared by the Administrator, on behalf of the Employer, to help explain your health benefits. This document replaces and supersedes any Benefit Booklet or summary that you have received previously.

Please refer to this Benefit Booklet whenever you require health services. It describes how to access medical care, what health services are covered by the Plan, and what portion of the health care costs you will be required to pay.

This Benefit Booklet should be read and re-read in its entirety. Since many of the provisions of this Benefit Booklet are interrelated, you should read the entire Benefit Booklet to get a full understanding of your health benefits.

Many words used in the Benefit Booklet have special meanings. These words appear in capitals and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated.

This Health Benefit Booklet also contains Exclusions, so please be sure to read this Health Benefit Booklet carefully.

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MEMBER RIGHTS AND RESPONSIBILITIES

The Claims Administrator is committed to:

- Recognizing and respecting you as a Member.
- Encouraging your open discussions with your health care professionals and Providers.
- Providing information to help you become an informed health care consumer.
- Providing access to health benefits and the Claims Administrator's PPO Network Providers.
- Sharing the Claims Administrator's expectations of you as a Member.

You have the right to:

- Participate with your health care professionals and Providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with state and federal laws, and the Claims Administrator's policies.
- Receive information about the Claims Administrator's organization and services, the Claims Administrator's network of health care professionals and Providers, and your rights and responsibilities.
- Candidly discuss with your Physicians and Providers appropriate or Medically Necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities policies.
- Voice complaints or appeals about: the Claims Administrator's organization, any benefit or coverage decisions the Claims Administrator (or its' designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician(s) of the medical consequences.
- Participate in matters of the organization's policy and operations.

You have the responsibility to:

- Choose a PPO Network Provider primary care physician if required by your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor's office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and Providers in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that the Claims Administrator and/or your health care professionals and Providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and Provider.
- Tell your health care professional and Provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let the Claims Administrator's Customer Service Department know if you have any changes to your name, address, or family members covered under your policy.
- Provide the Claims Administrator with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with the Plan.

The Claims Administrator is committed to providing quality benefits and customer service to the Plan's Members. Benefits and coverage for services provided under the benefit program are governed by the Plan and not by this Rights and Responsibilities statement.

SCHEDULE OF BENEFITS

	TIER 1	TIER 2	TIER 3
All Benefits will be based upon Allowed Amount			
Benefit Period: January 1st through December 31st			
IF YOU HAVE SINGLE COVERAGE:			
Annual Deductible: Per Individual	$2,000	$2,500	$3,000
Coinsurance	You pay 20%	You pay 30%	You pay 40% 1
Out-of-Pocket Maximum: (including any applicable Medical and Prescription Drug Copayments, Deductible and Coinsurance) Per Individual	$4,000	$6,550	$22,500
Note: Tier 1 and Tier 2 Deductibles/Out-of-Pocket Maximums will cross apply and Tier 3 will accumulate separately			
IF YOU HAVE FAMILY COVERAGE:			
Annual Deductible (Aggregate): Per Individual	$4,000	$5,000	$6,000
Per Family	$4,000	$5,000	$6,000
Coinsurance	You pay 20%	You pay 30%	You pay 40% 1
Out-of-Pocket Maximum (Embedded): (including any applicable Medical and Prescription Drug Copayments, Deductible and Coinsurance) Per Individual	$4,000	$6,550	$22,500
Per Family	$8,000	$13,100	$45,000
Note: Tier 1 and Tier 2 Deductibles/Out-of-Pocket Maximums will cross apply and Tier 3 will accumulate separately			
COVERAGE LEVELS – THE ANNUAL DEDUCTIBLE DOES NOT APPLY TO SERVICES LISTED WITH AN ASTERISK (*)			
Preventive Services (when performed by a general practitioner)	**You Pay:**	**You Pay:**	**You Pay:**
General Physical Exams/ Preventive screenings	0%*	0%*	40% 1
Dietitian and Nutritional Counseling	0%*	0%*	40% 1
Well Child Care	0%*	0%*	40% 1
Immunizations	0%*	0%*	40% 1
Routine Vision Exam (one per Benefit Period) (including refractions)	0%*	0%*	40% 1
Routine Mammogram (including 3D mammogram)	0%*	0%*	40% 1
Women's Preventive Health	0%*	0%*	40% 1
Practitioner Services			
Primary Care Office Visit (Includes Office Related Charges for labs, x-rays, injections and medical supplies only) Including Scheduled Telehealth Services.	20%	30%	40% 1
Specialist Office Visit (Includes Office Related Charges for labs, x-rays, injections and medical supplies only) Including Scheduled Telehealth Services.	20%	30%	40% 1
OB/GYN Office Visit	20%	30%	40% 1
Surgical Services	20%	30%	40% 1
Impacted Extractions including soft and boney impacted wisdom teeth	20%	30%	Not Covered
Diagnostic Services (Prior Authorization is required for all CT, PET and MRI scans, unless an Emergency Service. Services performed at Southwest General Health Center are auto approved.)	20%	30%	40% 1

	TIER 1	TIER 2	TIER 3
Practitioner Services continued	**You Pay:**	**You Pay:**	**You Pay:**
Maternity services (Initial Visit to Diagnose paid under Primary Care Office Visit Benefit)	0% for services received from Southwest General Health Center only. 20% for services received from any other Tier 1 Provider.	30%	40% [1]
Home Health Services (75 visits per Benefit Period)	20%	30%	40% [1]
Speech Therapy (Autism Spectrum Disorders: 30 visits per Benefit Period) (Other Conditions: 30 visits per Benefit Period)	20%	30%	40% [1]
Physical/Occupational Therapy Office (Autism Spectrum Disorders: 30 visits per Benefit Period combined) (Other Conditions: 30 visits per Benefit Period combined)	20%	30%	40% [1]
Chiropractic Office Visit (24 visits per Benefit Period)	20%	30%	40% [1]
Outpatient Facility Services			
Diagnostic Services, including Pre-Admission Testing	20%	30%	40% [1]
Testing Surgical Services	20%	30%	40% [1]
Urgent Care Office Visit	20%	30%	40% [1]
Emergency Services (including Practitioner's Services)	20%	20%	20%
Ambulance Transportation to and/or from a Hospital	0%	0%	0%
Inpatient Facility Services			
Semi-Private Room and Board	20%	30%	40% [1]
Intensive Care in Hospital	20%	30%	40% [1]
Skilled Nursing Facility	20%	30%	40% [1]
Bariatric (Obesity) Surgery	20%	30%	40% [1]
Transplant Services Prior Authorization is required for all transplant services. Please see Covered Services for details.	0%	0%	40%[1]
Hospice Care	20%	30%	40% [1]
Medical Supplies, Equipment, and Appliances: Durable Medical Equipment	20%	30%	40% [1]
Temporomandibular Joint - TMJ	20%	30%	No Coverage
On-Demand, Virtual Telehealth Services	20%	30%	40% [1]
Compression Stockings from Southwest Community Pharmacy only (no on-line billing, reimbursement form only) Limited to 2 pair per calendar year Including mild compression (over the counter) socks and support or as ordered by a Physician and measured by a pharmacist at Southwest Community Pharmacy.	20%	No Coverage	No Coverage
Treatment of telangiectatic dermal veins (varicose veins) Medically Necessary treatment only and not a cosmetic procedure	20%	30%	40% [1]
Genetic Testing if there is a medical diagnosis associated with the testing	20%	30%	40% [1]
Infertility Testing and Treatment ($10,000 Lifetime Maximum)	50%	50%	Not Covered
Learning Disorders	Benefits are paid based on the services rendered		
Sleep Disorders	Benefits are paid based on the services rendered		
Gender Affirming Surgery	Benefits are paid based on the services rendered		
Attention Deficit Disorder (ADHD)	Benefits are paid based on the services rendered		

	TIER 1	TIER 2	TIER 3
Autism Spectrum Disorders, including Applied Behavior Analysis (ABA) Refer to Practitioner Services for Occupational, Physical and Speech Therapy limits.	Benefits are paid based on the services rendered		
Mental Health, Alcoholism and Drug Abuse In accordance with Federal Mental Health Parity requirements, this Plan will not apply any financial requirement or treatment limitation to Mental Illness, Alcoholism or Drug Abuse benefits in any classification that is more restrictive that the predominant financial requirements or treatment limitation applied to substantially all medical/surgical benefits in the same classification.			

1 You will be responsible for paying any amount in excess of the Allowed Amount in addition to the Deductible and Coinsurance.

NO SURPRISES ACT

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

MAXIMUM AGE FOR DEPENDENT CHILDREN: Age 26 (covered until the end of the calendar month)

NO PRECERTIFICATION IS REQUIRED FOR EMERGENCY SERVICES. FAILURE TO OBTAIN PRIOR AUTHORIZATION, THAT IS REQUIRED, MAY RESULT IN A PENALTY (Out of Network only).

FOR A COMPLETE LISTING OF TIER 1, TIER 2 AND TIER 3 PROVIDER FACILITIES:

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

PREFERRED PROVIDER ORGANIZATION (PPO)

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

NO SURPRISE BILLING

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

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

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

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

In addition, the following services rendered by a Provider will be considered at the corresponding Tier level:

- Ancillary Providers rendering care in a PPO facility (i.e.: pathologist, radiologist, anesthesiologist, emergency room physician);
- When a PPO Network Provider utilizes the services of a Non-PPO Network Provider for the reading or interpretation of x-ray or laboratory tests.

For example if a Tier 1 Physician sends labs out to a Provider that is not in Tier 1, the Member will not be penalized and the lab will be paid at the Tier 1 level. The same situation applies to Tier 2.

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

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

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

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

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

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

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

Serious and Complex Condition means:

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

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

Southwest General Health Center

Medical Mutual SuperMed PPO

Cigna PPO*

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

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

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PRESCRIPTION DRUG BENEFIT

	Retail (31 Day Supply)	Southwest Retail (31 Day Supply)	Southwest Community Pharmacy Maintenance Prescriptions (90 Day Supply)	Maintenance Prescriptions (90 Day Supply)
Generic	20% $5 minimum and $50 maximum	10% $5 minimum and $50 maximum	10% $5 minimum and $50 maximum	20% $10 minimum and $125 maximum
Formulary Brand	30% $30 minimum and $75 maximum	20% $30 minimum and $75 maximum	20% $30 minimum and $75 maximum	30% $75 minimum and $188 maximum
Non-Formulary Brand	50% $70 minimum and $200 maximum	50% $70 minimum and $200 maximum	40% $140 minimum and $400 maximum	50% $175 minimum and $500 maximum
Specialty	20%	20%	20%	20%
Fertility Drugs $5,000 Lifetime Maximum	50%	50%	50%	50%

Out-of-Pocket Maximum per Calendar Year:

Any Network Prescription Drug Provider Copayments, Deductibles or Coinsurance that apply to this benefit will count toward the Out-of-Pocket Maximum shown in the Comprehensive Major Medical Benefits section of this Schedule. (There is no Plan coverage for Non-Network Prescription Drug Providers.)

Please Note: For Prescription Drug Benefit inquiries, please contact your Prescription Drug Benefit Manager at 1-844-513-6007.

DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Actively at Work - Present and capable of carrying out the normal assigned job duties of the Employer. Subscribers who are absent from work due to a health-related disability, maternity leave or regularly scheduled vacation will be considered Actively at Work.

Administrative Services Agreement - The agreement between the Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health Plan.

Administrator - An organization or entity that the Employer contracts with to provide administrative and claims payment services under the Plan. The Administrator is Mutual Health Services. The Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Aggregate processing- A family plan that has one Deductible and one Out-of-Pocket Maximum for everyone in the family. However, for Covered Services provided by PPO Network Providers, each Covered Person's Out-of-Pocket Maximum will not exceed the PPO Network Out-of-Pocket Maximum applicable to self-only coverage permitted by the Affordable Care Act and its associated regulations.

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

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

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

Alternate Recipient - Any child of a Subscriber who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under the Plan with regard to such Subscriber.

Authorized Service - A Covered Service rendered by any Provider other than a PPO Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Administrator, on behalf of the Employer, to be paid at the Network level.

Benefit Booklet - This summary of the terms of your health benefits.

Benefit Period - The period of time that benefits for Covered Services are payable under the Plan. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

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

Coinsurance - A specific percentage of the Allowed Amount for Covered Services that is indicated in the Schedule of Benefits, which you must pay. Coinsurance normally applies to the Deductible that you are required to pay. See the Schedule of Benefits for any exceptions.

Condition - an Injury, ailment, disease, Illness or disorder.

Contracting - the status of a Health Care Provider:
• that has an agreement with Mutual Health Services about payment for Covered Services; or
• that is designated by Mutual Health Services as Contracting.

Copayment - A specific dollar amount of the Allowed Amount for Covered Services indicated in the Schedule of Benefits for which you are responsible. The Copayment does not apply towards any Deductible. Your flat dollar Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount charged by the Provider.

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

Covered Services - Services, supplies or treatment as described in this Benefit Booklet which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Benefit Booklet.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under the Plan is in force.
- Not Experimental/Investigative or otherwise excluded or limited by this Benefit Booklet, or by any amendment or rider thereto.
- Authorized in advance by the Administrator, on behalf of the Employer, if such Prior Authorization is required in the Plan.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you.

Covered Transplant Procedure - Any Medically Necessary human organ and tissue transplant as determined by the Administrator, on behalf of the Employer, including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services - All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Custodial Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs, and which is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Day Treatment Programs – non-residential programs for treatment of Alcoholism and Drug Abuse, which are operated by certified inpatient and outpatient Alcoholism and Drug Abuse Treatment Facilities, that provide case management, counseling, medical care, and therapies on a routine basis for a scheduled part of the day and a scheduled number of days per week; also known as partial Hospitalization.

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

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

Dependent - A person of the Subscriber's family who is eligible for coverage under the Plan.

Diagnostic Service - A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition or a test performed as a Medically Necessary Preventive Care screening for an asymptomatic patient. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

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

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

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

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

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

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

Effective Date - The date your coverage begins under the Plan. You must be Actively at Work on your Effective Date. If you are not Actively at Work on your Effective Date, your Effective Date will be the date you become Actively at Work. A Dependent's coverage under the Plan begins on the Effective Date of the sponsoring Subscriber. No benefits are payable for services and supplies received before your Effective Date or after your termination date.

Eligible Employee - as defined in the Eligibility section of this booklet.

Eligible Person - A person who satisfies the Employer's eligibility requirements and is entitled to apply to be a Subscriber.

Embedded processing- A family plan with two kinds of Deductible and Out-of-Pocket Maximums: one for an individual family member and one for the whole family. With family coverage, each Covered Person's Out-of-Pocket Maximum will not exceed the PPO Network Out-of-Pocket Maximum applicable to self-only coverage permitted by the Affordable Care Act and its associated regulations.

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

- place an individual's health in serious jeopardy
- result in serious impairment to the individual's bodily functions; or
- result in serious dysfunction of a bodily organ or part of the individual.

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

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

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

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

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

Employer – The legal entity contracting with the Administrator for administration of group health care benefits.

Enrollment Date - The first day of coverage under the Plan or, if there is a waiting period, the first day of the waiting period (typically the date employment begins).

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

Experimental/Investigative - Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Administrator or the Administrator's designee, on behalf of the Employer, determines in its sole discretion to be Experimental/Investigative. The Administrator, on behalf of the Employer, will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Administrator, on behalf of the Employer, determines that one of more of the following criteria apply when the service is rendered with respect to the use for

which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Administrator, on behalf of the Employer. In determining whether a Service is Experimental/Investigative, the Administrator, on behalf of the Employer, will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Administrator, on behalf of the Employer, to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

Family Coverage – Coverage provided by the Employer for the Subscriber and eligible Dependents.

Fee(s) - The periodic charges which are required to be paid by you and/or the Employer to maintain benefits under the Plan.

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

Identification Card - A card issued by the Administrator, on behalf of the Employer, that bears the Member's name, identifies the membership by number, and may contain information about your benefits under the Plan. It is important to carry this card with you.

Independent Freestanding Emergency Department – a health care facility that:

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

Inpatient - A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Late Enrollee - An individual whose enrollment under the Plan is a Late Enrollment.

Late Enrollment - Enrollment other than on:

- The earliest date on which benefits can become effective under the Plan; or
- The date of an event that qualifies for Special Enrollment.

Medically Necessary or Medical Necessity – An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by the Administrator, on behalf of the Employer, to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of Hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost);
- Not Experimental/Investigative;
- Not primarily for the convenience of the Member, the Member's family or the Provider.
- Not otherwise subject to exclusion under this Benefit Booklet.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary.

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

Member - A Subscriber or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Employer and for whom Fee payment has been made. Members are sometimes called "you" or "your."

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

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

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by the Administrator, on behalf of the Employer, or with another organization which has an agreement with the Administrator, on behalf of the Employer, to provide Covered Services and certain administrative functions to you for the network associated with this Benefit Booklet. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

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

Non-Network Transplant Facility - Any Hospital which has not contracted with the transplant network engaged by Administrator, on behalf of the Employer, to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Non-PPO Network Provider - A Provider who has not entered into a contractual agreement with Administrator, on behalf of the Employer, or is not otherwise engaged by Administrator, on behalf of the Employer, for the network associated with this Plan. Providers who have not contracted or affiliated with Administrator's designated Subcontractor(s) for the services they perform under this Plan are also considered Non-PPO Network Providers.

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

Other Professional Providers include the following:

- Advanced nurse practitioner (A.N.P.);
- Ambulance services;
- Certified dietician;
- Certified nurse-midwife;
- Certified nurse practitioner;
- Certified registered nurse anesthetist (CRNA);

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

Other Provider Facilities include the following institutions:

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

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

Outpatient - A Member who receives services or supplies while not an Inpatient.

Plan – The group health benefit Plan provided by the Employer and explained in this Benefit Booklet.

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

PPO Network Provider - A Provider who has entered into a contractual agreement or is otherwise engaged by the Administrator, or with another organization which has an agreement with the Administrator, regarding payment for Covered Services and certain administration functions for the Network associated with the Plan.

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

Preventive Care – As used in the SPD refer to Routine immunizations and other evidence-based items or services that are United States Preventive Services Task Force (USPSTF) A or B recommendations or recommendations from other bodies such as the American Academy of Pediatrics

Provider - A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers include, but are not limited to, the following persons and facilities:

- **Alternative Care Facility** – A non-Hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:
  1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
  2. Surgery;
  3. Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility** - A Provider that:
  1. is licensed as such, where required;
  2. is equipped mainly to do Surgery;
  3. has the services of a Physician and a Registered Nurse (R.N.) at all times when a patient is present;
  4. is not an office maintained by a Physician for the general practice of medicine or dentistry; and
  5. is equipped and ready to initiate Emergency procedures with personnel who are certified in Advanced Cardiac Lifesaving Skills.

- **Birthing Center -** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
  1. constituted, licensed, and operated as set forth in the laws that apply;
  2. equipped to provide low-risk maternity care;
  3. adequately staffed with qualified personnel who:
     a. provides care at childbirth;
     b. are practicing within the scope of their training and experience; and
     c. are licensed if required; and
  4. equipped and ready to initiate Emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Registered Nurse Anesthetist** - Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

- **Home Health Care Agency** - A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

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

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

- **Physician** -
    1. a legally licensed Doctor of Medicine, doctor of osteopathy, or optometry; or
    2. any other legally licensed practitioner of the healing arts rendering services which are:
        a. covered by the Plan;
        b. required by law to be covered when rendered by such practitioner; and
        c. within the scope of his or her license.

  Physician does not include:
    1. the Member; or
    2. the Member’s spouse, parent, child, sister, brother, or in-law.

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

- **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, which:
  1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
  2. provides care supervised by a Physician;
  3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
  4. is not a place primarily for care of the aged, Custodial or Domiciliary Care; and
  5. is not a rest, educational, or custodial Provider or similar place.

- **Urgent Care Center -** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Recovery – A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist," "Underinsured Motorist," "Medical-Payments," "No-Fault," or "Personal Injury Protection," or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Benefit Booklet.

Service Area - The geographical area within which Covered Services under the Plan are available.

Single Coverage – Coverage for the Subscriber only.

Skilled Care - Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

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

Subcontractor - The Administrator and/or Employer may subcontract particular services to organizations or entities that have specialized expertise in certain areas. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on the Administrator's or Employer's behalf.

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

Subscriber - An eligible employee or retired employee or Member of the Employer enrolled under the Plan, whose benefits are in effect and whose name appears on the Identification Card issued by the Administrator, on behalf of the Employer.

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

Therapy Services - Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Totally Disabled (Total Disability) - a Condition resulting from disease or Injury, as certified by a Physician:

- Covered Person: You are unable to perform the substantial duties of any occupation or business for which you are qualified and are not in fact engaged in any occupation for wage or profit; or

- Dependent: you are substantially unable to engage in the normal activities of an individual of the same age and gender.

ELIGIBILITY, ENROLLMENT, TERMINATION, CONTINUATION AND CONVERSION

Eligibility

Benefits payable under the Plan are available to you because of your employment, membership or retirement from the Employer.

In order for you to participate in the Plan, certain requirements must be satisfied. These requirements may include probationary or waiting periods. The specific time periods and other standards for participation in the Plan are determined by the Employer or federal law.

Eligible Employee

In order to be eligible under the Plan, an Employee must be:

1. Eligible to participate in the Employer's health benefits program under the written benefits eligibility policies of the Employer; **and**
2. Considered a bona fide Employee actively employed on a permanent basis and working at least 60 hours biweekly as a full-time Employee or not less than 40 hours biweekly as a half-time Employee.

   Note: a full-time Employee will remain in compliance with PPACA and not exceed an average of 30 hours or more per week (or 130 hours per month), to be eligible for coverage.

Eligible Dependent

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

1. Your lawful Spouse provided you are not legally separated and can provide a copy of the marriage certificate to Southwest General Health Center or the Claims Administrator;

2. Your or your lawful Spouse’s natural children, adopted children, children placed for adoption with you or legal wards are eligible for coverage until the end of the calendar month in which the child attains age 26. (Grandchildren are not covered under the Plan unless you have assumed legal guardianship for them);

3. Your stepchildren, provided you remain married to the natural, living parent and the natural parent resides in your household. Stepchildren are eligible for coverage until the end of the calendar month in which the child attains age 26. (Grandchildren are not covered under the Plan unless you have assumed legal guardianship for them).

Coverage may be continued beyond age 26 for your unmarried Dependent children who reside* with you if they are Totally Disabled by reason of a mental or physical handicap which commenced prior to reaching the limiting age, continue to be Totally Disabled and are principally dependent upon you or your Spouse for support. However, notification of the child’s Condition must be given within 31 days of the child’s normal termination date. A non-

permanent Total Disability where medical improvement is possible is not considered to be a "handicap" for the purpose of this provision. This includes Alcoholism, Drug Abuse and non-permanent mental impairments.

You may be required to supply proof, upon request by Southwest General Health Center or the Claims Administrator, that a child satisfies these eligibility criteria.

* In this scenario *reside* includes either natural parent regardless of divorce.

If You and Your Spouse are Both Southwest Employees

As Southwest General Health Center Employees, both you and your Spouse are eligible for Employee, Employee + child, Employee + Spouse w/coverage or Spouse w/out coverage, or Family coverage. If you have children, you should decide together which of you will carry Employee, Employee + child or Family coverage. Both of you cannot cover the children as Dependents. Each Employee can only be covered by one Southwest plan. If you or your Spouse leave Southwest or change to an ineligible status for benefits, the one who remains eligible for benefit coverage may re-enroll within 30 days of the date the status change takes place. If you select coverage for you and your Spouse only (if you both work at Southwest), you should select Employee + Spouse without coverage as you are not subject to the spousal surcharge.

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

Spousal Surcharge

Under the medical plan options, you will find two coverage options: Employee + Spouse with coverage and Employee + Spouse without coverage. Electing Employee + Spouse with coverage means that you are enrolling your Spouse who has medical coverage available at his or her employer. This will result in an additional $225 monthly surcharge for medical coverage. Electing Employee + Spouse without coverage means that you are enrolling your Spouse who does not have medical coverage available elsewhere and which will not result in the additional surcharge. By electing one of these options, you are indicating that the option you are selecting is valid. Falsification of this information may result in cancellation of medical coverage and disciplinary action up to and including termination of employment. If your Spouse's status changes throughout the year, you have 30 days from the date of the change to notify Human Resources.

Verification of Dependent Status

The Claims Administrator may require documentation proving Dependent status, including, but not limited to, birth certificates, spousal marriage records, or initiation of legal proceedings severing spousal or parental rights.

Verification of Incapacitated Dependent Status

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

Omnibus Budget Reconciliation Act (OBRA) of 1993

In compliance with the Omnibus Budget Reconciliation Act (OBRA) of 1993, the following provisions apply to dependent coverage:

- Adopted children are eligible for coverage immediately upon placement with the family.

- If an eligible Employee who is covered under this Plan is divorced, the children of that Employee are eligible Dependents for the Plan, regardless of other Dependent qualifications, if the eligible Employee is court ordered to provide coverage. If the eligible Employee or legal Spouse has obtained a Qualified Medical Child Support Order (QMCSO), coverage will also be provided. The Dependent may not be terminated from coverage as long as the Employee is eligible for coverage and the court order is still in effect

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Illegal Alien

Eligible Dependent shall not include any Illegal Alien. For purposes of this Plan, Illegal Alien shall mean a person who (1) is not a citizen of the United States, (2) is not lawfully admitted to the United States for permanent residence, and (3) is not authorized for employment within the United States by the United States Immigration and Naturalization Service or the Attorney General of the United States.

Qualified Medical Child Support Order

If you are required by a "Qualified Medical Child Support Order", as defined in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), to provide coverage for your children, you can enroll these children as timely enrollees as required by OBRA 93. If you are not already enrolled in the Plan, you must also enroll at the same time.

When the Plan Administrator receives an order by a court or other authorized state agency for an Employee to provide coverage for his or her child(ren), the Plan Administrator will review the order to determine whether it is a "Qualified Medical Child Support Order", entitled to enforcement by the Plan. The Plan's procedures for reviewing these orders are available, without charge, upon written request to the Plan Administrator.

Special Enrollment

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

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

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

3. If you or your eligible Dependent has COBRA coverage, the coverage must be exhausted in order to trigger a special enrollment right. Generally, this means the entire 18, 29 or 36-month COBRA period must be completed in order to trigger a special enrollment for loss of other coverage.

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

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

Open Enrollment

An Open Enrollment Period shall be held at least once every 12 consecutive months. Eligible Members and their eligible Dependents may enroll during this period. Open Enrollment means a period of time which is held no less frequently than once in any 12 consecutive months.

Late Enrollment

If you do not enroll when initially eligible or during a special enrollment period, you and your eligible Dependents may apply for coverage under the Plan only during the Plan's Open Enrollment period.

COBRA COVERAGE

Summary of Rights and Obligations Regarding Continuation of Coverage Under the Benefit Plan

Federal law requires most employers sponsoring group health plans to offer Employees and their families the opportunity to elect a temporary extension of health coverage (called "continuation coverage" or "COBRA coverage") in certain instances where coverage under the group health plan would otherwise end. You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay all of the cost of your continuation coverage.

This section is intended only to summarize, as best possible, your rights and obligations under the law. The Plan offers no greater COBRA rights than what the COBRA statute requires, and this Notice should be construed accordingly.

Both you (the Employee) and your Spouse should read this summary carefully and keep it with your records.

Qualifying Events

If you are an Employee of Southwest General Health Center and you are covered by the Plan, you have a right to elect continuation coverage if you lose coverage under the Plan because of any of the following "qualifying events":

1. Termination (for reasons other than your gross misconduct) of your employment.
2. Reduction in the hours of your employment.
3. Disability Determination

If you are the Spouse of an Employee covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following five "qualifying events":

1. The death of your Spouse.
2. A termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of employment with Southwest General Health Center.

3. Divorce or legal separation from your Spouse. (Also, if an Employee drops his or her Spouse from coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later event will be considered a qualifying event even though the ex-Spouse lost coverage earlier. If the ex-Spouse notifies the administrator within 60 days of divorce and can establish that the coverage was dropped earlier in anticipation of divorce, then COBRA coverage may be available for the period after the divorce or legal separation.)
4. Your Spouse becomes entitled to Medicare benefits.
5. Your Spouse becomes disabled.

In the case of a Dependent child of an Employee covered by the Plan, he or she has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following six "qualifying events":

1. The death of the Employee parent.
2. The termination of the Employee parent's employment (for reasons other than gross misconduct) or reduction in the Employee parent's hours of employment with Southwest General Health Center.
3. Parents' divorce or legal separation.
4. The Employee parent becomes entitled to Medicare benefits.
5. The Dependent ceases to be a "Dependent child" under the Plan.
6. Employee parent becomes disabled.

Notices and Election Procedures

Your employer is responsible for notifying the plan administrator of certain qualifying events, such as termination of employment (other than gross misconduct), reduction of hours, death and employee's Medicare entitlement. You (the Employee) and/or your qualified beneficiaries will be notified of the right to elect continuation coverage automatically (i.e., without any action required by you or a family member) upon these events that resulted in a loss in coverage.

Under the COBRA statute, you (the Employee) or a family member have the responsibility to notify the Plan Administrator upon a divorce, legal separation, a child losing Dependent status, or a disability determination. This notice is required to be submitted to your Plan Administrator in writing. You must contact your Plan Administrator to obtain an "Enrollment/Change Form" to provide proper notice. The form provides information as to whom and where the Notice is to be sent. You or a family member must provide this notice within 60 days of the date of the qualifying event, or the date coverage is lost, whichever is later.

Notification of a second qualifying event must be made to the Plan Administrator within 60 days of the qualifying event, and must be in writing as described in the above paragraph.

Notification of a disability determination must be made to the Plan Administrator within 60 days of the LATER of the date of determination, date of qualifying event, or date coverage is lost as a result of the qualifying event. Notification must be in writing as described in the above paragraph, and a copy of the SSA Determination, or another correspondence from the Social Security Administration that includes all the information the Plan Administrator will need from the original determination letter to decide whether you are eligible for the extended coverage, must accompany your notice. Please note you have 30 days from the determination to notify Plan Administrator that you are no longer disabled.

If you or family members fail to provide this notice to the Plan Administrator during this 60-day notice period, any family member who loses coverage will NOT be offered the option to elect continuation coverage. Further, if you or a family member, fail to notify the Plan Administrator, and any claims are paid mistakenly for expenses Incurred after the last day of coverage, then you and your qualified beneficiaries will be required to reimburse the Plan for any claims so paid.

If the Plan Administrator is provided timely notice of a divorce, legal separation, a child's losing Dependent status, or a disability determination that has caused a loss of coverage, the Plan Administrator will notify the affected family member of the right to elect continuation coverage.

You (the Employee) or your qualified beneficiaries must elect continuation coverage within 60 days after Plan coverage ends or, if later, 60 days after the Plan Administrator sends you or your family member notice of the right to elect continuation coverage.

If you or your qualified Beneficiaries do not elect continuation coverage within this 60-day election period, you or your qualified Beneficiaries will lose the right to elect continuation coverage. Once the election is sent to the Plan Sponsor it is effective back to the date the employer sponsored coverage was lost. Please Note: No claims will be paid until the COBRA payment is received.

A covered Employee or the Spouse of the covered Employee may elect continuation coverage for all qualified beneficiaries. The covered Employee and his or her Spouse and Dependent children each also have an independent right to elect continuation coverage. Thus, a Spouse or Dependent child may elect continuation coverage even if the covered Employee does not (or is not deemed to) elect it.

You or your qualified beneficiaries can elect continuation coverage if you or the family member, at the time you or the family member elect continuation coverage, are covered under another employer-sponsored group health plan or are entitled to Medicare.

Type of Coverage; Payments of Contributions

Ordinarily, you or your qualified beneficiaries will be offered COBRA coverage that is the same coverage that you, he or she had on the day before the qualifying event. Therefore, a person (Employee, Spouse or Dependent child) who is not covered under the Plan on the day before the qualifying event is generally not entitled to COBRA coverage except, for example, where there is no coverage because it was eliminated in anticipation of a qualifying event such as divorce. If the coverage for similarly situated Employees or their family members is modified, COBRA coverage will be modified the same way.

The premium payments for the "initial premium months" must be paid for you (the Employee) and any qualified beneficiaries by the 45th day after electing continuation coverage. The initial premium months begin from the date you lost your employer sponsored coverage, and end on or before the 45th day after the date of the COBRA election. All other premiums are due on the 1st day of the month for which the premium is paid, subject to a 30-day grace period. A premium payment is made on the date it is post-marked or actually received; whichever is earlier.

Maximum Coverage Periods

36 Months. If you (Spouse or Dependent child) lose group health coverage because of the Employee's death, divorce, legal separation, or the Employee's becoming entitled to Medicare, or because you lose your status as a Dependent under the Plan, the maximum continuation coverage period (for Spouse and Dependent child) is 36 months from the date of the qualifying event.

If the Employee is entitled to Medicare at the time of or after the initial qualifying event, please see Item 3 under Exceptions below.

18 Months. If you (Employee, Spouse or Dependent child) lose group health coverage because of the Employee's termination of employment (other than for gross misconduct), reduction in hours, or disability determination the maximum continuation coverage period (for the Employee, Spouse and Dependent child) is 18 months from the date of termination or reduction in hours.

If the Employee is entitled to Medicare at the time of or after the initial qualifying event, please see Item 3 under Exceptions below.

Exceptions. There are three exceptions:

1. If an Employee or family member is disabled at any time during the first 60 days of continuation coverage (running from the date of termination of employment or

   reduction in hours), the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to The Company or the Plan Administrator both within the 18-month coverage period and within 60 days after the date of the determination.

2. If a second qualifying event that gives rise to a 36-month maximum coverage period (for example, the Employee dies or becomes divorced) occurs within an 18-month or 29-month coverage period, the maximum coverage period becomes 36 months from the date of the initial termination or reduction in hours for the Spouse or dependent child.

3. If within the 18 month period after Medicare entitlement, the Employee experiences a qualifying event (due to termination or reduction of hours worked) then the period of continuation for family members, other than the Employee, who are qualified beneficiaries, is up to 36 months from the date of Medicare entitlement.

If the Employee experiences a qualifying event on or before the date of Medicare entitlement, or after the expiration of the 18 month period after Medicare entitlement, both Employee and family members who are qualified beneficiaries are entitled to up to 18 months from the date of the qualifying event.

If the Employee's Medicare entitlement follows an initial qualifying event (due to termination or reduction of hours worked) and would have resulted in a loss of coverage had it occurred before

the initial qualifying event, then other family members who are qualified beneficiaries will be allowed to elect COBRA coverage up to 36 months from the date of the initial qualifying event.

Children Born To, or Placed for Adoption with the Covered Employee after the Qualifying Event

If, during the period of continuation coverage, a child is born to, adopted by or placed for adoption with the covered Employee and the covered Employee has elected continuation coverage for himself or herself, the child is considered a qualified beneficiary. The covered Employee or other guardian has the right to elect continuation coverage for the child, provided the child satisfies the otherwise applicable plan eligibility requirements (for example, age). The covered Employee or a family member must notify the Plan Administrator within 30 days of the birth, adoption, or placement to enroll the child on COBRA, and COBRA coverage will last as long as it lasts for other family members of the Employee. (The 30-day period is the Plan's normal enrollment window for newborn children, adopted children or children placed for adoption). If the covered Employee or family member fails to so notify the Plan Administrator in a timely fashion, the covered Employee will NOT be offered the option to elect COBRA coverage for the child.

Termination of COBRA before the End of Maximum Coverage Period

Continuation coverage of the Employee, Spouse, and/or Dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs:

1. Southwest General Health Center no longer provides group health coverage to any of its Employees.
2. The premium for the qualified beneficiary's COBRA coverage is not timely paid.
3. After electing COBRA, you (Employee, Spouse or Dependent child) become covered under another group health plan (as an Employee or otherwise) that has no exclusion or limitation. If the "other plan" has applicable exclusions or limitations, your COBRA coverage will terminate after the exclusion or limitation no longer applies. This rule applies only to the qualified beneficiary who becomes covered by another group health plan. Note that under Federal law (the Health Insurance Portability and Accountability Act of 1996), an exclusion, or limitation of the other group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group health plan.
4. After electing COBRA, you (Employee, Spouse or Dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
5. If you (Employee, Spouse or Dependent child) became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).
6. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered Employees or their Spouses or Dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of Federal law.

Other Information
If you (the Employee) or your qualified beneficiaries have any questions about this notice or COBRA, please contact the Plan Administrator at the address listed below. Also, please contact The Company if you wish to receive the most recent copy of the Plan's Summary Plan Description, which contains important information about Plan benefits, eligibility, exclusions, and limitations.

If your marital status changes, or a Dependent ceases to be a Dependent eligible for coverage under the Plan terms, or your or your Spouse's address changes, you must immediately notify the Plan Administrator.

Southwest General Health Center
Attn: Benefits
18697 Bagley Road
Middleburg Heights, Ohio 44130
440-816-8025

Family and Medical Leave

If you take an approved leave of absence in accordance with the federal Family and Medical Leave Act of 1993, coverage for you and your dependents will be continued under the same terms and conditions as if you have continued performing services for Southwest General Health Center, provided you continue to pay your regular contribution towards coverage.

If you fail to make the required contribution for coverage within the 30-day grace period from the contribution due date, then your coverage will terminate as of the date the contribution was due.

If you do not return to work for Southwest General Health Center after the approved Family Medical Leave, or if you have given notice of intent not to return to work during the leave, or if you exhaust your FMLA entitlement, coverage may be continued under the Continuation of Coverage (COBRA) provision of this Plan, provided you elect to continue under the COBRA provision. Continuation of Coverage (COBRA) will be provided only if the following conditions have been met:

1. You were covered under this Plan on the day before the FMLA leave began or became covered during the FMLA leave;
2. You do not return to work after an approved FMLA leave; and
3. Without COBRA, you would lose coverage under this Plan.

Continuation of Coverage (COBRA) will become effective on the last day of the FMLA leave as determined below:

1. The date you fail to return to work after an approved Family or Medical Leave;
2. The date you inform Southwest General Health Center that you do not intend to return to work; or
3. The date you exhaust your FMLA entitlement and fail to return to work.

Coverage continued during a Family or Medical Leave will not be counted toward the maximum COBRA continuation period.

If you decline coverage during the FMLA leave period, or if you elect to continue coverage during the Family or Medical Leave and fail to pay the required contributions, you will still be

eligible for COBRA continuation at the end of the FMLA leave, if you do not return to work. COBRA continuation will become effective on the last day of the FMLA leave. You need not provide evidence of good health to elect COBRA continuation, even if there was a lapse in coverage during the FMLA leave period.

If coverage lapses for any reason during an FMLA leave and you return to work on a timely basis following an approved FMLA leave, coverage will be reinstated as if you have continued performing services during the leave, including Dependent coverage. Reinstatement will be provided without having to satisfy any waiting period, or provide evidence of good health.

COVERAGE DURING DISABILITY LEAVE

The Plan will allow 14 weeks of coverage after 12 weeks on FMLA (totaling 26 weeks of leave) if all Employee contributions are received.

USERRA

The following provisions are required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA):

Continuation of Coverage Due to Military Leave
If you are absent from work due to a leave for military service and were covered under this Plan prior to the leave, coverage for you and your Dependents may be continued for a period that is the lesser of twenty-four (24) months or a period that ends the day you fail to apply for or return to a position of employment. Coverage continued during the military service will be counted toward the maximum COBRA continuation period. The twenty-four (24) month period is measured from the date you leave work for military service.

If you are on military leave for less than thirty-one (31) days, your contribution for coverage will be the same as while you are actively at work. If your military leave extends for more than thirty-one (31) days, then you are required to pay the full cost of coverage.

Reinstatement of Coverage Following Military Leave
If you are reemployed following military leave, you will be covered under the same terms and conditions that would have been provided had you continued actively working.

Your coverage will be reinstated on your date of reemployment, provided the following conditions are met:

1. You have given advance written or verbal notice of the military leave to Southwest General Health Center (advance notice to your Employer is not required in situations of military necessity or if giving notice is otherwise impossible or unreasonable under the circumstances);
2. The cumulative length of the leave and all previous absences from employment do not exceed five (5) years;
3. Reemployment follows a release from military service under honorable conditions; and
4. You report to, or submit an application to Southwest General Health Center as follows:

a. On the first business day following completion of military service for a leave of thirty (30) days or less; or
b. Within fourteen (14) days of completion of military service for a leave of thirty-one(31) days to one hundred-eighty (180) days; or
c. Within ninety (90) days of completion of military service for a leave of more than one hundred-eighty days.

If you are Hospitalized for, or recovering from, an Illness or Injury when your military leave expires, you have two (2) years to apply for reemployment.

If you provide written notice of intent not to return to work after military leave, you are not entitled to reemployment benefits.

If the requirements for reemployment are satisfied, coverage will continue as though employment had not been interrupted by a military leave, even if you decline continued coverage during the leave. No new waiting periods will apply to you or your Dependents. However, a waiting period and/or Plan exclusion may apply for Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in or aggravated during military service.

Effect of Medicare on the Plan

If a Covered Person is eligible for Medicare and incurs covered expenses for which benefits are payable under this Plan, then the Plan Administrator will first determine if the Plan is Primary or Secondary to coverage provided by Medicare. Primary means that benefits payable under this Plan will be determined and paid without regard to Medicare. Secondary means that payments under the Plan will be reduced so that the total payable by Medicare and the Plan will not exceed 100% of the actual covered expense.

Coverage for a Covered Person will always be Primary if:

1. The Covered Person is entitled to benefits under Medicare based off his/her age, and is an active Employee or the Spouse of an active Employee of an employer with 20 or more Employees; or
2. The Covered Person is entitled to benefits under Medicare because of renal dialysis or kidney transplant. In this case, starting on the date the Covered Person becomes eligible for Medicare, coverage under this Plan will be Primary only during the first 30 months of the coordination period such person is so entitled; or
3. The Covered Person is entitled to Medicare on the basis of disability, and his/her employer has 100 or more Employees.

Coverage for a Covered Person will be Secondary if:

1. The Covered Person is entitled to Medicare on the basis of age, and is an active Employee or the Spouse of an active Employee of an employer with less than 20 Employees.
2. The Covered Person has been entitled to benefits under Medicare because of renal dialysis or kidney transplant for more than 30 months (coordination period). In this case, coverage under this Plan will be Secondary only after the first 30 months of the coordination period such person is so entitled; or

3. The Covered Person is entitled to Medicare on the basis of disability, and his/her employer has less than 100 Employees.
4. The Covered Person is a retired Employee or the covered Dependent of a retired Employee.

The Plan Administrator will decide whether coverage is Primary or Secondary based on the status of the Covered Person on the date the covered expense is Incurred.

If a Covered Person is eligible for Part B benefits, but does not enroll for coverage or does not make due claim for Medicare benefits, the Plan Administrator may calculate benefits as if he/she were enrolled in part B of Medicare and full claim for benefits had been made.

HOW TO OBTAIN COVERED SERVICES

No Surprises Act

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

Network Services and Benefits

If your care is rendered by a PPO Network Provider, benefits will be provided at the Network level. The Administrator is allowed by the Employer to determine whether services or supplies are Medically Necessary and to determine the Medical Necessity of the service or referral to be arranged.

The Administrator, on behalf of the Employer, may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other Facility. This decision is made upon review of your condition and treatment.

If the type of Provider is not included in the Network, contact the Administrator. The Administrator, on behalf of the Employer, may approve a Non-PPO Network Provider for that service as an Authorized Service. PPO Network Providers are described below:

- **PPO Network Providers** include Physicians, Professional Providers, Hospitals and Facility Providers who contract with the Administrator, on behalf of the Employer, to perform services for you.

  For services rendered by PPO Network Providers:
  - you will not be required to file any claims for services you obtain directly from PPO Network Providers. **PPO Network Providers will seek compensation for Covered Services rendered from the Plan and not from you except for approved Copayments, Coinsurance, and/or Deductibles.** You may be billed by your PPO Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Plan.
  - Health Care Management is the responsibility of the Member.

Contact your PPO Network Provider or the Administrator, on behalf of the Employer, to be sure that required Prior Authorization and/or pre-certification has been obtained.

Non-Network Services

Services which are not obtained from a PPO Network Provider or not an Authorized Service will be considered a Non-PPO Network Provider Service. The only exceptions are as may be required under state and/or federal law for an Emergency Medical Condition and Urgent Care. In addition, certain services are not covered unless obtained from a Network Provider, see your **Schedule of Benefits.**

For non-Emergency Services rendered by a Non-PPO Network Provider, you are responsible for:

- obtaining any Precertification which is required;
- filing claims; and
- higher cost sharing amounts.

If there is no PPO Network Provider who is qualified to perform the treatment you require, contact the Administrator prior to receiving the service or treatment and the Administrator, on behalf of the Employer, may approve a Non-PPO Network Provider for that service as an Authorized Service.

Not Liable for Provider Acts or Omissions

The Administrator and/or the Employer are not responsible for the actual care you receive from any person. The Plan does not give anyone any claim, right, or cause of action against the Administrator and/or the Employer based on what a Provider of health care, services or supplies, does or does not do.

Identification Card

When you receive care from your PPO Network Provider or other Provider, you must show your Identification Card. Possession of an Identification Card confers no right to services or other benefits under the Plan. To be entitled to such services or benefits you must be a Member on whose behalf all applicable Fees under the Plan have been paid. Any person receiving services or other benefits to which he or she is not then entitled under the provisions of the Plan will be responsible for the actual cost of such services or benefits.

PRECERTIFICATION OF BENEFITS

Precertification is designed to ensure Medical Necessity, to reduce unnecessary Hospital admissions, and to ensure that health care services are delivered in the most cost-efficient manner, while keeping quality, as well as cost, in mind. Precertification also provides a means of getting answers to your health care questions and considering alternatives to a Hospital stay.

Inpatient admissions, other than Emergency Services, and certain outpatient tests, procedures and equipment require precertification, also known as prior approval. Contracting Hospitals and PPO Network Providers will assure that any required prior approval is obtained for you. Certain PPO Network Providers who meet specified criteria for frequently approved services may receive an automatic approval for those services (also known as "gold carding"). For Non-Contracting Hospitals and Non-Contracting Health Care Providers, you are responsible for obtaining prior approval. Failure to pre-certify may subject you to significant monetary penalties, up to and including all Billed Charges.

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

- Reconstructive surgeries
- Durable medical equipment and devices
- MRI's and PET scans
- Home health care
- Weight loss surgery

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

Emergency Admissions

An emergency or urgent admission refers to a situation that requires immediate Hospitalization. In such cases, the patient, or his or her authorized representative, must call the utilization review company applicable for this Plan within 48 business hours of admission and provide them with the pertinent information concerning the admission.

COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by Providers. **Care must be received from a PPO Network Provider to be covered at the Network level, except as may be required under state and/or federal law for an Emergency Medical Condition and Urgent Care. Services which are not received from a PPO Network Provider will be considered a Non-PPO Network Provider Service, unless otherwise specified in this Benefit Booklet.** The amount payable for Covered Services varies depending on whether you receive your care from a PPO Network Provider or a Non-PPO Network Provider.

If you use a Non-PPO Network Provider, you are responsible for the difference between the Non-PPO Network Provider's charge and the Allowed Amount, in addition to any applicable Copayment, Coinsurance or Deductible. The Administrator or the Employer cannot prohibit Non-PPO Network Providers from billing you for the difference in the Non-PPO Network Provider's charge and the Allowed Amount.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Benefit Booklet, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Benefit Booklet, including use of PPO Network Providers, and obtain any required Prior Authorization or Precertification. Contact your PPO Network Provider to be sure that Prior Authorization/Precertification has been obtained. No precertification is required for Emergency Services. The Administrator, on behalf of the Employer, bases its decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on the Administrator's medical policy and Clinical Guidelines. The Administrator, on behalf of the Employer, may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Benefit Booklet. Benefits for Covered Services are based on the Allowed Amount for such service. Plan payment for Covered Services may be limited by any applicable Copayment, Coinsurance, Deductible, or Benefit Period maximum as shown in the Schedule of Benefits.

Preventive Care Services

Preventive Care services include Outpatient services and Office Services. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical Condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical Condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many Preventive Care services are covered by this Plan with no Deductible, Copayments or Coinsurance from the Member when provided by a PPO Network Provider. That means the Plan pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
   a. Breast cancer;
   b. Cervical cancer;
   c. Colorectal cancer;
   d. High Blood Pressure;
   e. Type 2 Diabetes Mellitus;
   f. Cholesterol;
   g. Child and Adult Obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive Care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. Additional Preventive Care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

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

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

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

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

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

- Gynecological services
  - Mammogram services; and
  - PAP tests.

- Physical Examinations

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

- Smoking cessation services

- Well child care services

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

Please refer to the phone number on your identification card if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive services, please visit www.healthcare.gov/coverage/preventive-care-benefits. Newly added preventive services added by the advisory entities referenced by the Affordable Care Act will start to be covered on the first plan year beginning on or after the date that is one year after the new recommendations or guideline, went into effect. You will be notified at least sixty (60) days in advance, if any item or service is removed from the list of eligible services.

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

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

Diabetes self-management training

Diabetes self-management training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Physician Office Services

Office Services include care in a Physician's office that is not related to Maternity and Mental Health Conditions, except as specified. Refer to the sections entitled **Maternity Services** and **Mental Health/Alcoholism and Drug Abuse Services** for services covered by the Plan. **For Emergency Accident or Medical Care** refer to the **Emergency Care and Urgent Care** section.

Office visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits include injections including allergy injections and serums. Allergy injection and allergy serums are covered in full when rendered in a physician's office. Allergy testing and other treatment is subject to Deductible and Coinsurance.

Diagnostic Services when required to diagnose or monitor a symptom, disease or Condition.

Surgery and Surgical services including anesthesia and supplies. The surgical fee includes normal post-operative care.

Therapy Services for Physical Medicine Therapies and Other Therapies when rendered in the office of a Physician or other professional Provider.

Telehealth Services

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

Inpatient Services

Inpatient Services do not include care related to Maternity and Mental Health Conditions, except as specified. Refer to the sections entitled **Maternity Services** and **Mental Health/Alcoholism and Drug Abuse Services** for services covered by the Plan. Inpatient Services include:

- charges from a Hospital or other Provider for room, board and general nursing services;
- ancillary services; and
- professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- a room with two or more beds;
- a private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you occupy a private room for isolation and no isolation facilities are available;
- a room in a special care unit approved by the Administrator, on behalf of the Employer. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary Services

- operating, delivery and treatment rooms and equipment;
- prescribed drugs;
- anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider;
- medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services; and
- Therapy Services.

Professional Services

- **Medical care visits** limited to one visit per day by any one Physician.
- **Intensive medical care for** constant attendance and treatment when your Condition requires it for a prolonged time.
- **Concurrent care** for a medical Condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your Condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules are excluded.
- **Surgery and the administration of general anesthesia**.
- **Newborn exam.**

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment stated in dollars per admission in the Schedule of Benefits is waived for the second admission. Coinsurance is not waived.

Outpatient Services

Outpatient Services include **both facility and professional charges** when rendered as an Outpatient at a Hospital, Alternative Care Facility or other Provider as determined by the Plan. Outpatient Services do not include care that is related to Maternity or Mental Health/Alcoholism and Drug Abuse Services, except as otherwise specified. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care Services** section below.

Emergency Care and Urgent Care Services

Emergency Services

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

In the event of an emergency:

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

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

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

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

If you obtain covered Emergency Services from a Non-PPO Network Provider or Non-Contracting Health Care Provider, the Plan pays for benefits in an amount specified by federal law.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment. Urgent Care services can be obtained from a Network or Non-PPO Network Provider. If you experience an accidental injury or a medical problem, the Administrator, on behalf of the Employer, will determine whether your injury or Condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an Emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an Emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.

See your Schedule of Benefits for benefit limitations.

Ambulance Services

Ambulance Services are transportation by a vehicle designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals (other vehicles which do not meet this definition, including but not limited to Ambulettes, are not Covered Services):

- from your home, scene of accident or medical Emergency to a Hospital;
- between Hospitals;
- between Hospital and Skilled Nursing Facility;
- from a Hospital or Skilled Nursing Facility to your home.

Ambulance services are a Covered Service only when Medically Necessary, except:

- When ordered by an Employer, school, fire, or public safety official and the Member is not in a position to refuse.
- When a Member is required by the Administrator, on behalf of the Employer, to move from a Non-PPO Network Provider to a PPO Network Provider.

Trips must be to the closest local facility that can give Covered Services appropriate for your Condition. If none, you are covered for trips to the closest such facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service.

Non Covered Services for Ambulance include but are not limited to, trips to:

- a Physician's office or clinic;
- a morgue or funeral home.

Attention Deficit Disorder

Services for the treatment of attention deficit disorder are covered.

Autism Spectrum Disorders

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

Covered Services include:

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

Diagnostic Services

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your Condition. Coverage for Diagnostic Services, including when provided as part of Preventive Care Services and Physician Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease;
- Magnetic Resonance Imaging (MRI);
- CAT scans;
- Laboratory and pathology services;
- Cardiographic, encephalographic, and radioisotope tests;
- Ultrasound services;
- Allergy tests;
- Electrocardiograms (EKG);
- Electromyograms (EMG) except that surface EMG's are not Covered Services;
- Echocardiograms;
- Bone density studies;
- Positron emission tomography (PET scanning).

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Experimental/Investigative

Claims paid by the Plan for any Experimental and/or Investigational medicine, including any equipment, drugs, devices, services, supplies, tests, treatments or procedures. A drug, device, medical treatment or procedure is Experimental or Investigational: if the drug or device cannot be

lawfully marketed without approval by the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished; if reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I, II or III clinical trials or is under study to determine maximum tolerated doses, toxicity, safety, efficacy or efficacy as compared with standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure. Provided that the Plan Sponsor's utilization review vendor has followed the requirements set forth by the Plan, then the Plan Sponsor will accept a determination by the vendor that a service is not Experimental or Investigational. If the Plan Sponsor reasonably and in good faith believes that the vendor has not followed the requirements of the Plan, then the Plan Sponsor reserves the right to make its own determination whether a service is Experimental or Investigational and, therefore, excluded from stop loss coverage.

Gender Affirming Surgery

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

Surgical Services

Coverage for Surgical Services when provided as part of Physicians Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care; and
- Other procedures as approved by the Employer.

The surgical fee includes normal post-operative care. The Plan may combine the reimbursement when more than one surgery is performed during the same operative session. Contact the Administrator for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.
- Completely bony impacted extractions are covered as surgery, including completely impacted wisdom teeth.

Sterilization
Regardless of Medical Necessity, you are covered for sterilization.

Mastectomy Notice
A Member who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, on or after the date the Women's Health & Cancer Rights Act became effective for this Plan, and who elects breast reconstruction, 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 treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual Deductible, Copayment and Coinsurance provisions otherwise applicable under the Plan.

Therapy Services

Coverage for Therapy Services when provided as part of Physician Office Services, Inpatient Facility Services, Outpatient Services, or Home Care Services is limited to the following:

Physical Medicine Therapy Services
The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).
- **Spinal manipulation services** to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Manipulation whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Spinal Manipulations as specified in the Schedule of Benefits.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.
- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes.

- **Inhalation therapy** for the treatment of a Condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation.

Physical Medicine and Rehabilitation Services
A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Certain Therapy Services rendered on an Inpatient or Outpatient basis are limited. See the Schedule of Benefits.

Home Care Services

Services performed by a Home Health Care Agency or other Provider in your residence. The services must be provided on a part-time visiting basis according to a course of treatment. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Diagnostic Services
- Medical/Social Services
- Nutritional Guidance
- Home Health Aide Services
- Therapy Services (Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.)
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing.

Home infusion therapy will be paid only if you obtain prior approval from the Administrator's Home Infusion Therapy Subcontractor (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

Hospice care may be provided in the home or Hospice for medical, social and psychological services used as palliative treatment for patients with a reduced life expectancy due to advanced Illness and includes routine home care, continuous home care, Inpatient Hospice and Inpatient

respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending Physician.

Covered Services include the following only when authorized by your PPO Network Provider:

- Skilled Nursing Services (by an R.N. or L.P.N.)
- Diagnostic Services
- Physical, speech and inhalation therapies
- Medical supplies, equipment and appliances
- Counseling services (except bereavement counseling)
- Inpatient confinement at a Hospice
- Prescription Drugs obtained from the Hospice

Human Organ and Tissue Transplant Services

For cornea and kidney transplants, the transplant and tissue services benefits or requirements described below do not apply. These services are paid as Inpatient Services, Outpatient Services or Physician Office Services depending where the service is performed.

Covered Transplant Procedure

Any Medically Necessary human organ and tissue transplant as determined by the Administrator, on behalf of the Employer, including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Notification

The Plan strongly encourages the Member to call the Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. The Administrator will then assist the Member in maximizing their benefits by providing coverage information including details regarding what is covered and whether any Medical Policies, network requirements or Benefit Booklet exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Member.

Covered Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for 364 days. If, within this time frame, a second Covered Transplant Procedure occurs, the Covered Transplant Benefit Period will begin one day prior to the second Covered Transplant Procedure and continue for 364 days.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Administrator when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be

performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Administrator when claims are filed. Contact the Administrator for detailed information.

Medical Supplies, Durable Medical Equipment, and Appliances

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your Condition, reimbursement will be based on the Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Allowed Amount for the standard item which is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your Condition.

Covered Services include, but are not limited to:

- **Medical and surgical supplies** - Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly. Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician’s office, including but not limited to, Depo-Provera.

- **Durable medical equipment** - Rental, up to the purchase price, of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, Hospital beds, oxygen equipment. Rental costs must not be more than the purchase price. Repair of medical equipment is covered. **Non-covered** items include but are not limited to air conditioners, humidifiers, dehumidifiers, special lighting or other environmental modifiers, surgical supports, and corsets or other articles of clothing.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  1. Replace all or part of a missing body part and its adjoining tissues; or
  2. Replace all or part of the function of a permanently useless or malfunctioning body part.

  Covered Services for prosthetic appliances include, but are not limited to:

  1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface,

replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction;
2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant)
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act;
4. Minor devices for repair such as screws, nails, sutures and wire mesh;
5. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.;
6. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session);
7. Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract - formulae and supplies are also covered)
8. Cochlear implant;
9. Electronic speech aids in post-laryngectomy or permanently inoperative situations;
10. "Space Shoes" when used as a substitute device when all or a substantial portion of the forefoot is absent;
11. Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).

Non-covered Prosthetic appliances include but are not limited to:
1. Dentures, replacing teeth or structures directly supporting teeth;
2. Dental appliances;
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
4. Artificial heart implants;
5. Hairpieces for male pattern alopecia (baldness);
6. Wigs (except as described above following cancer treatment);

- **Orthotic devices** – Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part . The cost of casting, molding, fittings, and adjustments are included.

Covered orthotic devices include, but are not limited to, the following:
1. Cervical collars;
2. Ankle foot orthosis;
3. Corsets (back and special surgical);
4. Splints (extremity);
5. Trusses and supports;
6. Slings;
7. Wristlets;
8. Built-up shoe;
9. Custom made shoe inserts.

Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

Non-Covered Services include but are not limited to:

1. Orthopedic shoes;
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
4. Garter belts or similar devices.

Accident Related Dental Services

Outpatient Services, Physician Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

The above exclusion for Injuries as a result of biting or chewing shall not apply if such Injury was the result of domestic violence or if an underlying medical Condition caused the biting or chewing-related Injury. For example, a Covered Person with epilepsy involuntarily clamps down on his teeth and breaks one during a seizure.

The underlying Illness must cause the chewing or biting accident that results in the Injury to the jaws, sound natural teeth, mouth or face. If a Covered Person has an underlying Illness that causes the teeth to be more susceptible to Injury, dental services related to such Injury will not be covered as an Injury sustained in an accident.

Covered Services for accidental dental include, but are not limited to:

- oral examinations;
- x-rays;
- tests and laboratory examinations;
- restorations;
- prosthetic services;
- oral surgery;
- mandibular/maxillary reconstruction;
- anesthesia.

Maternity Services

Maternity Services include Inpatient Services, Outpatient Services and Physician Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a well newborn. Maternity Services for dependent daughters is also covered.

If Maternity Services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

Coverage for the Inpatient postpartum stay for you and your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician determines further Inpatient postpartum care is not necessary for you or your newborn child, provided the following are met and the mother concurs:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Prenatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:

    1. The antepartum, intrapartum, and postpartum course of the mother and infant;
    2. The gestational stage, birth weight, and clinical condition of the infant;
    3. The demonstrated ability of the mother to care for the infant after discharge; and
    4. The availability of post-discharge follow-up to verify the condition of the infant after discharge.

- Covered Services include at-home post-delivery care visits at your residence by a Physician or Nurse when performed no later than 48 hours following you and your newborn child's discharge from the Hospital. Coverage includes, but is not limited to:

    1. Parent education;
    2. Physical assessments;
    3. Assessment of the home support system;
    4. Assistance and training in breast or bottle feeding;
    5. Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office.

Elective Abortion-Regardless of Medical Necessity, the Plan pays Covered Services from a Provider for elective abortion accomplished by any means.

Mental Health/Alcoholism and Drug Abuse Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance/Copayment information. Coverage for the diagnosis and treatment of Behavioral Health Care and Alcoholism and Drug Abuse Treatment on an Inpatient or Outpatient basis will not be subject to Deductibles or Copayment/Coinsurance provisions that are less favorable than the Deductibles or Copayment/Coinsurance provisions that apply to a physical illness as covered under this Benefit Booklet.

Hospital Inpatient Care
Benefits for Inpatient Hospital and Physician charges are Covered Services.

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

Professional Outpatient Care
Covered Services include:

- Professional care in the Outpatient department of a Hospital;
- Physician's office visits; and
- Services within the lawful scope of practice of a licensed, approved Provider.

Note: To be reimbursable, care must be given by a psychiatrist, psychologist, neuropsychologist, or a mid-level Provider such as a licensed clinical social worker, mental health clinical nurse specialist, a marriage and family therapist, or a licensed professional counselor.

Clinical Trials Program

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

In order to be eligible for benefits, the Covered Person must meet the following conditions:

1. The Covered Person is eligible to participate in an Approved Clinical Trial, according to the trial protocol with respect to treatment of cancer or other Life-threatening Conditions.
2. Either:
    a. The referring Provider is a PPO Network Provider and has concluded that the Covered Person's participation in such trial would be appropriate based upon the Covered Person meeting the conditions described in "1" above; or
    b. The Covered Person provides medical and scientific information establishing that his or her participation in such trial would be appropriate based upon the Covered Person meeting the conditions described in "1" above.

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

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

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

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

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

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

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

EXCLUSIONS

This section indicates items which are excluded and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services. This list of Exclusions is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services.

The Plan does not provide benefits for procedures, equipment, services or supplies:

- Which are determined not Medically Necessary or do not meet the Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.

- Received from an individual or entity that is not a Provider, as defined in this Benefit Booklet or recognized by the Plan.

- Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by the Administrator, on behalf of the Employer.

- For any Condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker’s Compensation Act or other similar law. If Worker’s Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

- For illness or injury that occurs as a result of any act of war, declared or undeclared while serving in the armed forces.

- For a Condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

- For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

- For Prescription Drug Copayments or Deductibles You are responsible for under other coverage with other carriers or health plans.

- For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

- For court ordered testing or care unless Medically Necessary.

- For routine genetic testing when no medical diagnosis is associated with the test.

- For which you have no legal obligation to pay in the absence of this or like coverage.

- Received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trust or similar person or group.

- Prescribed, ordered, or referred by, or received from a Member of your immediate family, including your spouse, child, brother, sister, parent, or self.

- For completion of claim forms or charges for medical records or reports unless otherwise required by law.

- For missed or canceled appointments.

- For mileage costs or other travel expenses, except as authorized by the Administrator, on behalf of the Employer.

- For which benefits would have been payable under Part B of Medicare if a Covered Person had enrolled in Part B coverage. For the purposes of the calculation of benefits, if the Covered Person is eligible for, but has not enrolled in, Medicare Part B, Mutual Health Services will calculate benefits as if he or she had enrolled. This provision only applies where Medicare is the primary payer under the law;

- Charges in excess of the Allowed Amount.

- Incurred prior to your Effective Date.

- Incurred after the termination date of this coverage except as specified elsewhere in this Benefit Booklet.

- For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts), except benefits are provided for a reconstructive service performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or previous therapeutic process. Reconstructive services are payable only if the original procedure would have been a Covered Service under this Plan. Other reconstructive services are not covered except as otherwise required by law.

- Services which are solely performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition which is resolved or stable.

- For Custodial Care, Domiciliary Care or convalescent care, whether or not recommended or performed by a professional.

- For foot care only to improve comfort or appearance including, but not limited to care for flat

feet, subluxations, corns, bunions (except capsular and bone surgery), calluses, and toenails except when Medically Necessary including but not limited to, foot care for diagnosis of diabetes or for impaired circulation to the lower extremities.

- For any treatment of teeth, gums or tooth related service except as otherwise specified as covered in this Benefit Booklet.

- Related to weight loss or weight loss programs whether or not they are under medical or Physician supervision. Weight loss programs for medical reasons are also excluded, except certain surgical treatments of morbid obesity. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs.

- For marital counseling.

- For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

- For hearing aids or examinations for prescribing or fitting them.

- For services or supplies primarily for educational services, including special education and remedial education, vocational services, recreational services, other non-clinical services, or services provided for training purposes, except as may be required by PPACA or otherwise shown as covered under the Plan.

- For reversal of sterilization.

- For personal hygiene and convenience items.

- For care received in an Emergency room which is not Emergency Care, except as specified in this Benefit Booklet.

- For expenses incurred at a health spa or similar facility.

- For self-help training and other forms of non-medical self-care, except as otherwise provided herein.

- For examinations relating to research screenings.

- For stand-by charges of a Physician.

- Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

- Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy.

- Related to any mechanical equipment, device, or organ.

- For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility.

- For Private Duty Nursing Services except when provided through the Home Care Services benefit.

- Services and supplies related to male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs**,** and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing. This exclusion does not apply to infertility testing or treatment.

- Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

- For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.

- For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.

- For services incurred as a result of any Covered Person acting or contracting to be a surrogate.

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

- For radiologic imaging with no preserved film image or digital record.

- For wilderness therapy, therapeutic living communities (including therapeutic farms), adventure-based therapy or similar programs.

CLAIMS PAYMENT

NO SURPRISES ACT

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

CLAIMS PROCEDURES

Types of Claims

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

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

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

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

Who Must File

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

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

Time Limit for Filing a Claim

A claim must be filed for you to receive benefits. For medical claims, PPO Network Providers will submit a claim for you. The following provision applies when you are submitting the claim yourself.

You must file claims within 12 months of receiving Covered Services. Your claim must have the data the Plan needs to determine benefits. Should you receive a request for additional information, this must be provided within the initial 12 months.

Where to File a Claim

Claims should be filed as indicated on your Identification Card.

What to File

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

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

Timing of Claims Determinations

Claims Involving Urgent Care. If you file a Claim Involving Urgent care in accordance with the claims procedures and sufficient information is received, you will be notified of the Plan's or its designee's benefit determination, whether adverse or not, as soon as is feasible, but not later than 72 hours after receipt of the claim. If you do not follow the claims procedures or the claim does not include sufficient information for the Plan or its designee to make a benefit determination, you will be notified within 24 hours after receipt of the claim of the applicable procedural deficiencies, or the specific deficiencies related to additional information necessary to make a benefit determination. You will have at least 48 hours to respond to correct the procedural deficiencies

and/or provide the requested information. The Plan or its designee must inform you of the benefit determination, whether adverse or not, as soon as possible, taking into account all medical exigencies, but not later than 48 hours after receipt of the additional information. The Plan or its designee may notify you of its benefit determination decision orally and follow with written or electronic notification not later than three (3) days after the oral notification.

Concurrent Care Claims. If your claim is one involving concurrent care, the Plan or its designee will notify you of its decision, whether adverse or not, within 24 hours after receiving the claim, if the claim was for urgent care and was received by the Plan or its designee at least 24 hours before the expiration of the previously approved time period for treatment or number of treatments. You will be given time to provide any additional information required to reach a decision. If your concurrent care claim does not involve urgent care or is filed less than 24 hours before the expiration of the previously approved time period for treatment or number of treatments, the Plan or its designee will respond according to the type of claim involved (i.e., urgent, other pre-service or post-service).

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

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

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

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

Notice of Claims Denial (Adverse Benefit Determination)

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

1. Information sufficient to identify the claim or health care service involved, including the date of service, Health Care Provider, and claim amount (if applicable);

2. The specific reason(s) for the adverse benefit determination, including the denial code and its corresponding meaning;
3. Reference to the specific plan provision(s) on which the adverse benefit determination was based;
4. If the adverse benefit determination relied upon any internal rules, guidelines or protocols, a statement that you may request a copy of the rule, guideline or protocol, which will be provided free of charge;
5. If the adverse benefit determination was based in whole or in part on Medical Necessity, Experimental/Investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided free of charge;
6. Notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
7. Notice of the availability of, and contact information for, an applicable office of consumer assistance established under the Public Health Service Act section 2793, if one is available;
8. A description of additional information, if any, that is required to perfect the claim and an explanation of why the information is necessary;
9. A description of the Plan's or its designee's appeal procedures and applicable time limits, including the expedited appeal process, if applicable; and
10. A statement of your right to bring a civil action under federal law following the denial of a claim after review on appeal, if your claim is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

FILING A COMPLAINT

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

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

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

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

APPEALS PROCEDURES

* Please note: The processes described here are based on the claims and appeals processes set forth in the Patient Protection and Affordable Care Act and related regulations and guidance. As those regulations and guidance are subject to change, the claims and appeals processes for this Plan are subject to change. The rules and/or procedures set forth in the most current claims and appeals

regulations and guidance at the time your claim or appeal is processed will govern your claims and appeals, even if they conflict with the claims and appeals processes set forth herein.

How and When to File a Claims Appeal

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

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

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

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

First Level Mandatory Internal Appeal

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

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

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

The claim review will be subject to the following rules:

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

Timetable for Deciding Appeals

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

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

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

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

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

Notice of Final Adverse Benefit Determination after Appeal

If the appeal has been either partially or completely denied, you will be provided with a written notice of final adverse benefit determination in a culturally and linguistically appropriate manner containing the following information:

1. Information sufficient to identify the claim or healthcare service involved, including the date of service, Health Care Provider, and claim amount (if applicable);
2. The specific reason(s) for the appeal final adverse benefit determination, including the denial code and its corresponding meaning;
3. Reference to the specific plan provision(s) on which the final adverse benefit determination is based;
4. A statement that you may request reasonable access to and copies of all documents, records and other information relevant to your appealed claim for benefits, which shall be provided to you without charge;

5. If the appeal final adverse benefit determination relied upon any internal rules, guidelines or protocols, a statement that you may request a copy of the rule, guideline or protocol, which will be provided to you without charge;
6. If the appeal final adverse benefit determination was based in whole or in part on Medical Necessity, Experimental/Investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided to you without charge;
7. Notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
8. Notice of the availability of, and contact information for, an applicable office of consumer assistance established under the Public Health Service Act section 2793, if one is available;
9. A description of the Plan's or its designee's applicable appeal procedures;
10. A discussion of the decision; and
11. A statement of your right to bring a civil action under federal law following the denial of a claim upon review, if your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

If the Plan or its designee has not complied with the internal claims appeals process (except for certain de minimis errors), you may choose to initiate the external review process.

Second Level External Review

In accordance with federal law, the Plan or its designee has established an external review process to examine coverage decisions under certain circumstances. The request for External Review must be made within four months from your receipt of the notice of final adverse benefit determination from the internal mandatory appeal. You may be eligible to have a decision reviewed through the external review process if you meet the following criteria:

1. The adverse benefit determination involves medical judgment, as determined by the external reviewer, or a rescission of coverage;
2. You have exhausted the mandatory internal appeal process, unless under federal law you are not required to exhaust the internal appeal process (for example, when your claim is entitled to expedited review and you have simultaneously filed for an internal expedited appeal, or if you do not receive a timely internal appeal decision).
3. You are or were covered under the Plan at the time the service was requested or, in the case of retrospective review, were covered under the Plan when the service was provided;
4. You have provided all of the information and forms necessary to process the external review.

External Review will be conducted by Independent Review Organizations (IROs) accredited by a nationally recognized accrediting organization. You will not be required to pay for any part of the cost of the external review. All IROs act independently and impartially and are assigned to review your claim on a rotational basis or by another unbiased method of selection. The decision to use an IRO is not based in any manner on the likelihood that the IRO will support a denial of benefits.

The Plan is required by law to provide to the IRO conducting the review, a copy of the records that are relevant to your medical Condition and the external review.

The IRO will review the claim without being bound by any decisions or conclusions reached during the internal claim and appeal process.

External Review for Non-Urgent Care Appeals

A request for an external review for a non-expedited or non-urgent claim must be in writing and should be addressed to the address indicated above.

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review. The IRO will notify you and give you ten business days to submit information for its consideration. The IRO will issue a written decision within 45 days after the IRO receives the request for external review. This written decision will include the main reasons for the decision, including the rationale for the decision. The IRO's determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or you. If the IRO reverses the adverse benefit determination, the Plan will provide coverage or payment for the claim.

Expedited External Review for Urgent Care Appeals

A request for an external review for Urgent or Expedited claims may be requested orally by calling 1-800-367-3762 or in writing by contacting Member Appeals at the address listed above.

An expedited review may be requested if your condition, without immediate medical attention, could result in serious jeopardy to your life or health or your ability to regain maximum function; or you have received a final internal appeal denial concerning an admission, availability of care, continued stay, or healthcare item or service for which you received Emergency Services, but you have not been discharged from a facility.

You may request an external review of an urgent care claim at the same time you request an internal appeal of an urgent care claim.

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review. The IRO will issue a decision within 72 hours after the IRO receives the request for external review. If the decision is not in writing, within 48 hours after providing that notice, the IRO will provide a written confirmation. This decision will include the main reasons for the decision, including the rationale for the decision. The IRO's determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or you. If the IRO reverses the adverse benefit determination, the Plan will provide coverage or payment for the claim.

LEGAL ACTION

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

GENERAL PROVISIONS

Foreign Travel

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

Health Care Fraud

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

Plan Amendments

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

Right to Release Claims and Receive Necessary Information

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

Physical Examination

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

Facility of Payment

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

Rescission of Coverage

A rescission of your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf),

performs an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan. Your coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by your employer.

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

Right of Recovery

If the Plan makes any payment which is determined in excess of the Plan's benefits, the Plan shall have the right to recover the amount determined to be in error. The Plan shall have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment to that Provider for this Plan and/or other plans administered by Mutual Health Services. This right does not affect any other right of recovery Mutual Health Services may have with respect to overpayments.

Form or Content of Benefit Booklet

No agent or employee of the Administrator is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through an endorsement authorized and signed by an officer of the Employer.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Administrator, Employer, nor any Provider shall have any further responsibility to pay benefits or provide care for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

The Administrator, on behalf of the Employer, shall make a good-faith effort to arrange for an alternative method of administering benefits. In the event of circumstances not within the control of the Administrator or Employer, including but not limited to: a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Administrator, disability of a significant part of a PPO Network Provider's personnel or similar causes, or the rendering of health care services provided by the Plan is delayed or rendered impractical the Administrator, on behalf of the Employer, shall make a good-faith effort to arrange for an alternative method of administering benefits. In such event,

the Administrator and PPO Network Providers shall administer and render services under the Plan insofar as practical, and according to their best judgment; but the Administrator and PPO Network Providers shall incur no liability or obligation for delay, or failure to administer or arrange for services if such failure or delay is caused by such an event.

Protected Health Information Under HIPR&C

The Health Insurance Portability and Accountability Act of 1996 (HIPR&C), and the Privacy Regulations issued under HIPR&C, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's Group Health Plan has a responsibility under the HIPR&C Privacy Regulations to provide you with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of your information and details about a number of individual rights you have under the Privacy Regulations. As an Administrator of your Employer's Plan, Mutual Health Services has also adopted a number of privacy practices.

Large Case Management

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

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

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

Coordination of Benefits

Applicability

This provision applies when you have health care coverage under more than one Plan. For the purposes of this provision, "Plan" is defined below.

If this provision applies, the Order of Benefit Determination Rules specify whether the benefits of this Plan are determined before or after those of another Plan. The benefits of this Plan:

1. Will not be reduced when, under the Order of Benefit Determination Rules, this Plan determines its benefits before another Plan; but
2. May be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The reduction is described under the heading "Effects on the Benefits of this Plan."

Definitions

Plan - this Plan and any other arrangement providing health care or benefits for health care through:

1. Group insurance or group-type coverage whether insured or uninsured. This includes prepayment group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Individual insurance for individual-type coverage. This includes prepayment, group practice, or individual practice coverage.
3. Coverage under a governmental Plan or coverage required or provided by law except Medicare or Medicaid.
4. Any other coverage which, as defined by the Employee Retirement Income Security Act of 1974, is a labor-management trustee Plan, a union welfare Plan, an employee organization Plan or an employee benefit organization.
5. Any other coverage provided because of sponsorship by or membership in any other association, union, or similar organization.

"Plan" is not any of the following:

1. Group or group-type Hospital indemnity benefits of $100.00 per day or less.
2. School accident-type coverage for grammar, high school, and college students for accidents only, including athletic injuries, either on a 24 hour basis or on a "to and from" school basis.

Primary Plan/Secondary Plan - the Order of Benefit Determination Rules state whether this Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When this Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered a benefit paid.

Order of Benefit Determination Rules

When there is a basis for a claim under this Plan and another Plan, this Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

1. The other Plan has rules coordinating its benefits with those of this Plan; and
2. Both those rules and this Plan's rules require that this Plan's benefits be determined before those of the other Plan.

This Plan determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, Subscriber or Member (that is, other than as a Dependent) are determined before those of the

Plan which covers the person as a Dependent, except that: if the person is also a Medicare beneficiary, and as a result of the rules established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

a. Secondary to the Plan covering the person as a Dependent; and
b. Primary to the Plan covering the person as other than a Dependent (e.g. a retired employee),

Then the order of benefits is reversed so that the Plan covering the person as an employee, Subscriber, Subscriber or retiree is secondary and the other Plan is primary.

2. Dependent Child/Parents not Separated or Divorced. Except as stated in paragraph 3. below, when this Plan and another Plan cover the same child as a Dependent of different parents who are not separated or divorced:
   a. The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; if (1) the parents are married; (2) the parents are not separated (whether or not they ever have been married); or (3) a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage; but
   b. If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

   However, if the other Plan does not have the rule described in a. immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

3. Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
   a. First, the Plan of the parent with custody of the child;
   b. Then, the Plan of the Spouse of the parent with custody of the child;
   c. Then, the Plan of the parent not having custody of the child; and
   d. Finally, the Plan of the Spouse of the non-custodial parent.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the Plan has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent will be the Secondary Plan. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's Spouse does, the spouse's Plan is primary. This subclause does not apply to any Plan year during which any benefits are actually paid or provided before the entity has actual knowledge.

4. Joint Custody. If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the Order of Benefit Determination Rules outlined in paragraph 2.
5. Active/Inactive Subscriber. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's Dependent are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's Dependent. If the other Plan does not have this rule and if, as a result, the plans

do not agree on the order of benefits, this rule 5 is ignored. This rule does not supersede rule 1 above.

6. Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:
    a. First, the benefits of a Plan covering the person as an employee, Subscriber or Member or as that person's Dependent;
    b. Second, the benefits under the continuation coverage. If the other Plan does not have the rule described above and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
7. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered the person longer are determined before those of the Plan which covered that person for the shorter term. If none of the preceding rules determines the Primary Plan, the benefits paid shall be shared equally between the Plans.

Effect on this Plan's Benefits

When a Member is covered under two or more Plans which together pay more than this Plan's benefits, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Plan's benefit payments will not be affected when it is Primary. However, when this Plan is secondary under the Order of Benefit Determination Rules, benefits payable by this Plan will be reduced, if necessary, by the combined benefits of all other Plans covering you or your Dependent that pay prior to this Plan under those Rules.

When the benefits of this Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan. If this Plan is secondary, the combined benefits of this Plan and the other Plan will never exceed what would have been provided by this Plan if primary. No benefits will be provided by this Plan when the amount paid by the other Plan is equal to or greater than the amount this Plan would have paid if Primary.

Worker's Compensation

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to a Member shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under the Plan shall not duplicate any benefits to which Members are entitled, or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

RIGHT OF SUBROGATION AND REIMBURSEMENT

Subrogation

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

Reimbursement

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

Your Duties

You must provide the Plan or its designee any information requested by the Plan or its designee within five (5) days of the request.

You must notify the Plan or its designee promptly of how, when and where an accident or incident resulting in personal injury to you occurred and all information regarding the parties involved.

You must cooperate with the Plan or its designee in the investigation, settlement and protection of the Plan's rights.

You must send the Plan or its designee copies of any police report, notices or other papers received in connection with the accident or incident resulting in personal injury to you.

You must not settle or compromise any claims unless the Plan or its designee is notified in writing at least thirty (30) days before such settlement or compromise and the Plan or its designee agrees to it in writing.

Discretionary Authority

The Plan shall have discretionary authority to interpret and construct the terms and conditions of the Subrogation and Reimbursement provisions and make determination or construction which is not arbitrary and capricious. The Plan's determination will be final and conclusive.

Provisions Applicable to All Coverage

The Plan Sponsor reserves the right to terminate, suspend, withdraw, amend, or modify the Plan at any time. Any such change or termination in benefits (a) will be based solely on the decision of the Plan Sponsor; and (b) may apply to active Employees or present and future retirees as either separate groups or as one group.

Any representations or statements which disagree with the provisions of the Plan as stated herein, which are made by the Plan Sponsor, Plan Administrators, Representatives or Agents, Plan Participants or Providers:

1. Shall not be considered as representations or statements made by, or on behalf of the Plan; Plan Sponsor or Administrator;
2. Shall not bind Plan Administrator for benefits under the Plan.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

In compliance with the requirements of the HIPAA Privacy and Security regulations, herein referred to as the "HIPAA Regulations", the following has been established as the extent to which the Plan Sponsor will receive, use, and/or disclose Protected Health Information.

Permitted disclosure of Individuals' Protected Health Information to the Plan Sponsor

A. The Plan (and any business associate acting on behalf of the Plan), or any health care issuer servicing the Plan will disclose Individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of the HIPAA Regulations.

B. All disclosures of the Protected Health Information of the Plan's Individuals by the Plan's business associate or health care issuer, to the Plan Sponsor will comply with the restrictions and requirements set forth in this document and in 45 C.F.R. §164.504 (the "504" provisions).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Required separation between the Plan and the Plan Sponsor

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

1. Human Resources Department

B. This list reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who may receive or at times access Individuals' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to Individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of Individuals' Protected Health Information in violation of, or noncompliance with, the provisions of this Amendment.

C**.** The Plan Sponsor will promptly report any violation or noncompliance, including any unauthorized use or disclosure of Individuals' Protected Health Information to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

HIPAA Security Standards

Definitions

A. *Electronic Protected Health Information* – The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

B. Plan – The term "Plan" means Southwest General Health Center Consumer-Driven Health Plan.

C. Plan Documents – The term "Plan Documents" means the group health plan's governing documents and instruments (*i.e.*, the documents under which the group health plan was established and is maintained), including but not limited to Southwest General Health Center Consumer-Driven Health Plan Document.

D. Plan Sponsor – The term "Plan Sponsor" means the entity as defined at section 3(16) (B) of ERISA, 29 U.S.C. § 1002(16) (B). The Plan Sponsor is Southwest Community Health System.

E. Security Incidents – The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Plan Sponsor Obligations

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

A. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

B. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f) (2) (iii) of the HIPAA Regulations is supported by reasonable and appropriate security measures;

C. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

D. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

1. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

2. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

Your Duties:

- You must notify the Administrator, on behalf of the Employer, promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the Administrator, on behalf of the Employer, in the investigation, settlement and protection of the Employer's rights of the Administrator, on behalf of the Employer.

- You must not do anything to prejudice the rights of the Administrator, on behalf of the Employer.
- You must send the Administrator, on behalf of the Employer, copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the Administrator, on behalf of the Employer, if you retain an attorney or if a lawsuit is filed on your behalf.

Termination of Employee Coverage

Your coverage under this Plan will terminate automatically without notice as of midnight on the earliest of the following dates:

1. The date the Plan terminates and/or is dissolved; or
2. The last day of the calendar month in which you cease active work with Southwest General Health Center; or
3. The date that you die; or
4. When you cease your contributions toward the Plan; or
5. The date you enter into military service, other than for a duty of less than 30 days, or as specified in the USERRA section of this Plan; or
6. The date you fail to return to work have an approved FMLA leave.

Termination of Dependent Coverage

For a Dependent child, as of midnight on the earliest of the following dates:

1. The last day of the calendar month in which the Employee's coverage terminates; or
2. When the Employee ceases to make the required contribution regarding Dependent coverage; or
3. The date the child becomes eligible and chooses to be covered as an Employee; or
4. The last day of the calendar month the child reached age 26; or
5. When this Plan is terminated and/or discontinued.

For a Dependent Spouse, as of midnight on the earliest of the following dates:

1. The last day of the calendar month in which the Employee's coverage terminates; or
2. When the Employee ceases to make the required contribution regarding Dependent coverage; or
3. The date the Spouse becomes covered as an Employee; or
4. The last day of the calendar month the Spouse is legally separated or divorced from the Employee; or
5. When this Plan is terminated and/or discontinued.

Modifications

This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer, or by mutual agreement between the Administrator and the Employer without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Conformity with Law

Any provision of the Plan which is in conflict with the applicable federal laws and regulations is hereby amended to conform with the minimum requirements of such laws.

Clerical Error

Clerical error, whether of the Administrator or the Employer, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue benefits otherwise validly terminated.

Policies and Procedures

The Administrator, on behalf of the Employer, may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Employer, has authority to waive any conditions or restrictions of the Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Employer's Sole Discretion

The Employer may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Employer, with advice from the Administrator, determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

Direct Access to Obstetricians and Gynecologists

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

Selection of a Primary Care Provider

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

Statement of Rights Under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 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 (e.g., your physician, nurse midwife, or physician assistant), 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan Administrator.

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

Statement of Rights Under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- **All stages of reconstruction of the breast on which the mastectomy was performed;**
- **Surgery and reconstruction of the other breast to produce a symmetrical appearance;**
- **Prostheses; and**
- **Treatment of physical complications of the mastectomy, including lymphedema.**

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. **See the Schedule of Benefits.**

If you would like more information on WHCRA benefits, call your Plan Administrator.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your Spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask your employer or Plan Administrator to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and Alcoholism and Drug Abuse benefits with day/visit limits on medical/surgical benefits. In general, group health plans offering mental health and Alcoholism and Drug Abuse benefits cannot set day/visit limits on mental health or Alcoholism and Drug Abuse benefits that are lower than any such day/visit limits for medical and surgical benefits. A plan that does not impose day/visit limits on medical and surgical benefits may not impose such day/visit limits on mental health and Alcoholism and Drug Abuse benefits offered under the plan. Also, the plan may not impose deductibles, copayment/coinsurance and out of pocket expenses on mental health and Alcoholism and Drug Abuse benefits that are more restrictive than deductibles, copayment/coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in the Plan, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program)

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call the Customer Service telephone number on your ID Card, or contact your Plan Administrator.

Genetic Information Nondiscrimination Act (GINA)

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

Lifetime Dollar Limits

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

No Surprises Act

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

ERISA INFORMATION AND STATEMENT OF ERISA RIGHTS

NOTE: This section is not a part of your Benefit Booklet. The Administrator is not responsible for any statements contained herein that are not set forth in the Administrative Services Agreement or the Benefit Booklet.

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to each participant in an employee benefit Plan. This information is outlined below.

ERISA INFORMATION

Plan Name:	Southwest General Health Center
Maintained By:	Southwest Community Health System
Type of Plan:	Self-Funded Consumer-Driven Health Plan - a Group Health Plan
Plan Administrator:	Southwest General Health Center
Employer Identification:	34-1455141
Plan Number:	503
Agent for Services of Legal Process:	Southwest Community Health System
Name of Claims Administrator:	Mutual Health Services
Claims Administrator Address:	P.O. Box 5700 Cleveland, OH 44101
End of Plan Year:	December 31st

STATEMENT OF ERISA RIGHTS

As a Participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons shall be entitled to:

Receive Information About Your Plan and Benefits

i. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts, and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.
ii. Obtain upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
iii. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
iv. A certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it up to 24 months after losing coverage.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Consumer-Driven Health Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administration.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (i.e. finds your claim is frivolous).

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. The nearest EBSA Office is Cincinnati Regional Office, 1885 Dixie Highway, Suite 210, Ft. Wright, KY 41011-2664.

Multi-Language Interpreter Services & Nondiscrimination Notice

MUTUAL HEALTH SERVICES℠

This document notifies individuals of how to seek assistance if they speak a language other than English.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-367-3762 (TTY: 711).

Chinese

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-800-367-3762 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-367-3762 (TTY: 711).

Arabic

ملحوظة:إذاكنت تتحدث اذكر اللغة،فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-367-3762 رقم هاتف الصم والبكم (711).

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-367-3762 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-367-3762 (телетайп: 711).

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-367-3762 (ATS: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-367-3762 (TTY: 711).

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-367-3762 (TTY: 711).

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-367-3762 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-367-3762 (TTY: 711)번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-367-3762 (TTY: 711).

Japanese

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-800-367-3762 (TTY: 711) まで、お電話にてご連絡ください。

Dutch

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-367-3762 (TTY: 711).

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-367-3762 (телетайп: 711).

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-367-3762 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-367-3762 (TTY: 711).

Please Note: Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MUTUAL HEALTH SERVICES' CUSTOMER CARE DEPARTMENT AT 1-800-367-3762.

Nondiscrimination Notice

Mutual Health Services complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Mutual Health Services does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Mutual Health Services provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Mutual Health Services provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or if you believe Mutual Health Services failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator
Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

- Electronically through the Office for Civil Rights Complaint Portal available at:
  ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW Room 509F
  HHH Building
  Washington, DC 20201-0004
- By phone at:
  1-800-368-1019 (TDD: 1-800-537-7697)
- Complaint forms are available at:
  hhs.gov/ocr/office/file/index.html

Products marketed by Medical Mutual may be underwritten by one of its subsidiaries, such as Medical Health Insuring Corporation of Ohio or MedMutual Life Insurance Company.