Plan Document
and
Summary Plan Description

for

City of Toledo, Ohio
Employee Health Benefit Plan

Local 20, AFSCME – Local 7, 2058, and 3411, UAW – Local 12, Exempt Employees, Municipal Court Judges Division, and Elected Officials

Revision and Re-Statement Date: January 1, 2016

TABLE OF CONTENTS

ADOPTION AGREEMENT

The City of Toledo, Ohio Employee Health Benefit Plan (the "Plan") is established and continued in this document, adopted effective as of January 1, 2016, by the City of Toledo (the "Employer"). On this date, the Employer hereby re-states the health benefits plan providing medical, prescription drug, and other health benefits for eligible employees and their dependents in accordance with the terms and conditions of this plan document and summary plan description ("Plan Document"). The Employer has duly authorized the adoption of this amended and restated Plan Document and the execution thereof.

The benefits provided under this Plan and the general terms and conditions governing the same are contained in this Plan Document, a copy of which is provided to participants in the Plan, and may also be governed by the provisions of certain insurance contracts purchased on behalf of the Plan. The Plan Document and all such insurance contracts, if any, as the same may be amended from time to time, are hereby incorporated herein by this reference and made a part of this Plan.

Under this Plan, the Employer is the Plan Sponsor, and shall also function as the Plan Administrator and Named Fiduciary unless another individual or entity is appointed by the Employer. The Plan Sponsor does hereby certify that the Plan Sponsor has reviewed the Plan Document and that it represents the terms and conditions of the Plan adopted by the Plan Sponsor.

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

City of Toledo

By: _____

Name: _____

Date: _____ Title: _____

PLAN INFORMATION

1. NAME OF THE PLAN

City of Toledo, Ohio Employee Health Benefit Plan

Although The City of Toledo intends to continue the Plan, The City of Toledo necessarily reserves the right to modify, amend, suspend, or terminate the Plan at any time, or to change the amount of contribution required from the Participants.

2. PURPOSE OF THE PLAN

The City of Toledo has established an employee health benefit plan for the exclusive benefit of its Employees and their Dependents, and to grant them legally enforceable rights under this Plan. This Plan Document is a cooperative effort of organized labor and management.

3. NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF THE PLAN SPONSOR

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

4. PLAN SPONSOR IDENTIFICATION NUMBER

34-6401447

5. PLAN NUMBER

501

6. NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF THE PLAN ADMINSITRATOR

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

7. NAME AND ADDRESS OF THE PERSON DESIGNATED AS AGENT FOR THE SERVICE OF LEGAL PROCESS

Benefits Plan Administrator
Department of Human Resources
The City of Toledo
One Government Center, Suite 1920
Toledo, Ohio 43604
Telephone: (419) 245-1500

8. PLAN YEAR (for fiscal record keeping)

January 1st through December 31st

9. UNION PLAN(S):

Upon request, a copy of the collective bargaining agreement(s) is/are available from the Union Office or the Plan Administrator.

10. CLAIMS ADMINISTRATOR

HealthSCOPE Benefits, Inc.

Send Claims to:
HealthSCOPE Benefits, Inc.
P.O. Box 99004
Lubbock, TX 79490-9004

11. ADDRESS AND TELEPHONE NUMBER OF THE OFFICE OF THE DEPARTMENT OF LABOR

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Room N-5644
Washington, D.C. 20210
(202) 565-7500

12. EFFECTIVE DATE OF THE PLAN

The Effective Date of the Plan is June 1, 1994.

The Plan is amended and restated effective January 1, 2016

13. TYPE OF PLAN

Non-ERISA Group health benefits which include medical, prescription drug, dental, and vision.

14. TYPE OF ADMINISTRATION:

The Plan is self-administered by the Plan Administrator. The Plan Administrator has hired a Claims Administrator to provide claims payment and ministerial administration. Health benefits are provided primarily by the Employer with claims being paid on behalf of the Employer by the Claims Administrator from the general assets of the Employer.

15. SOURCES OF CONTRIBUTIONS:

Contributions for Plan expenses are obtained from the Employer and from the participating employees. The Employer evaluates the costs of the Plan based on projected Plan expenses and determines the amount to be contributed by the Employer and the amount to be contributed by the participating employees.

16. GRANDFATHERED HEALTH PLAN

Patient Protection and Affordable Care Act

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

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

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

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

SCHEDULE OF BENEFITS

BASIC COVERAGE FOR HOSPITAL AND PROFESSIONAL SERVICES

GENERAL INFORMATION

Office Visit Rider Benefit	Individual: $300 Family: $600
	Services subject to the Office Visit Rider Benefit are paid at 100% for In-Network Providers and 80% for Out-of-Network providers up to the $300 individual or $600 family calendar year benefit. Once the Office visit Rider Benefit has been exhausted, covered services are subject to the Deductible and coinsurance
Lifetime Maximum Benefit for Surgical Treatment of Morbid Obesity*	$15,000 per Covered Person
	*This Lifetime Maximum Benefit applies to Eligible Expenses paid by the Plan under Basic Coverage and Major Medical Coverage combined starting when the surgery is incurred. Includes any related complications or related services following surgical treatment.

This listing of Covered Services appears in alphabetical order to better assist the Covered Person in locating the different benefit allowances for the specific Covered Services.

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK
Allergy Testing	100%	80%
Anesthesia Services	100%	80%
Birth Control – Insertion of IUDs by physician	100%	80%
	Removal of birth control devices or implants is not covered.	
Birth Control office visit	$10 Co-Pay Office Visit Rider Benefit until exhausted then 80% after deductible	$10 Co-Pay Office Visit Rider Benefit payable at 80% until exhausted then 60% after deductible
Birthing Center Services	100%	80%
Cardiac Rehabilitation Therapy *– Outpatient*	100%	80%
Chemotherapy • Outpatient Services • Associated office visit	100% $10 Co-Pay Office Visit Rider Benefit until exhausted then 80% after deductible	80% $10 Co-Pay Office Visit Rider Benefit payable at 80% until exhausted then 60% after deductible
	Services, drugs and treatments that are deemed Experimental or Investigational will not be covered.	
Consultation Services During Inpatient Confinement *Including Second and Third Surgical Opinions*	100% for First Inpatient Consultation	80% for First Inpatient Consultation
	Additional Inpatient Consultations are covered under Major Medical Coverage	

Consultation- Physicians Office	$10 Co-Pay Office Visit Rider Benefit until exhausted then 80% after deductible	$10 Co-Pay Office Visit Rider Benefit payable at 80% until exhausted then 60% after deductible
Diagnostic Services – *Outpatient*	100%	80%
Durable Medical Equipment – *Billed by Hospital*	100%	80%
Emergency Care in Emergency Department of Hospital – *Medical Emergency* • Facility Charges • Professional Charges	$100 Co-Pay, then 100% 100%	$100 Co-Pay, then 80% 80%
	Co-Pay waived for the following: when Covered Person is admitted to the Hospital; ER visits Monday – Friday between 8PM and 9AM; ER visits Saturday after 12PM; and ER visits anytime on Sunday.	
Emergency Care in Emergency Department of Hospital – *Non-Medical Emergency*	Facility Charges: $100 Co-Pay, then 100% of ancillary charges only Professional Charges: 100%	Facility charges: $100 Co-Pay, then 80% of ancillary charges only Professional Charges: 80%
	Note: The Plan does not cover the ER visit room charge in the case of a non-emergency. Co-Pay waived for the following: ER visit Monday-Friday between the hours of 8PM and 9AM; ER visit Saturday after 12 noon; ER visit anytime on Sunday	
Home Health Care Services	100%	80%
Hospice Services – *Inpatient and Outpatient*	100%	80%
Hospital Services During Inpatient Confinement	100%	80% until Covered Person Reaches $2,000 Coinsurance Maximum per Admission, then 100%
Hospital and Ambulatory Surgical Facility Services – *Outpatient*	100%	80% until Covered Person Reaches $2,000 Coinsurance Maximum per Admission, then 100%
Impotence Treatment • Surgical Treatment • Other services	100% 80% after deductible	80% 60% after deductible
Infusion Therapy/IV Therapy • Facility Charges • Physician Charges	100% 100%	80% 80%
Inhalation Therapy – *Outpatient Hospital*	100%	80%
Kidney Dialysis – *Outpatient*	100% of the Usual and Reasonable Charge after all applicable deductibles and coinsurance. Please refer to Kidney Dialysis Treatment Outpatient Description.	
Maternity Services	100%	80%
	Covered for all female Covered Persons.	
Medical and Surgical Supplies – *Billed by Hospital*	100%	80%

Mental Health or Substance Abuse Services – *Inpatient and Outpatient* • Billed by Hospital • Office Visit • Psychotherapy	100% $10 Co-Pay until Office Visit Rider Benefit is exhausted, then 80% after Deductible 80% after deductible	80% $10 Co-Pay Office Visit Rider Benefit is payable at 80% until exhausted, then 60% after Deductible 80% after Deductible
Occupational Therapy – Outpatient • Billed by Hospital • Professional Charges	100% 80% after deductible	80% 60% after deductible
Patient Education Programs *- Billed by Hospital*	100%	80%
Physical Therapy - Outpatient *- Billed by Hospital*	100%	80%
	Aquatic Therapy is not covered regardless of whether it is performed in conjunction with Physical Therapy.	
Physician Office Visits - *for Non-Routine Care*	Office Visit Rider Benefit $10 Co-Pay until exhausted then 80% after Deductible	Office Visit Rider Benefit: $10 Co-Pay, payable at 80% until exhausted, then 60% after Deductible
Physician Medical Services During Inpatient Confinement	100%	80%
Podiatry Services • Office visit • Diagnostic lab, x-ray & surgery	Office Visit Rider Benefit: $10 Co-Pay, payable at 80% until exhausted, then 80% after Deductible 100%	Office Visit Rider Benefit: $10 Co-Pay, payable at 80% until exhausted, then 60% after Deductible 80%
Pre-Admission Testing Diagnostic Lab and X-ray • Outpatient hospital or Physician's Office	100%	80%
Radiation Therapy – *Outpatient*	100%	80%
Reconstructive Surgery	100%	80%
Routine Preventive/Well Care for Adults *- Age 9 years and older*	100% No Office visit Co-Pay	80% No Office visit Co-Pay
	Includes physical examinations, screenings and immunizations.	
Routine Preventative/Well Care for Children *- Age Newborn through 12 months*	100% No Office visit Co-Pay	80% No Office Visit Co-Pay
	Includes physical examinations, screenings and immunizations.	
Routine Preventative/Well Care for Children *- Age 13 months through 8 years*	100% No office visit Co-Pay	80% No office visit Co-Pay

	Includes physical examinations, screenings and immunizations.	
Skilled Nursing Facility Services	100%	80%
Speech Therapy - *Outpatient*	100%	80%
Sterilizations - *Voluntary & Involuntary*	100%	80%

Surgical Services – *Inpatient and Outpatient*	100%	80%
Transplant Services	100%	80%
Urgent Care Facilities	$10 Co-Pay, then 100%	$10 Co-Pay, then 80%

SCHEDULE OF BENEFITS

MAJOR MEDICAL COVERAGE

GENERAL INFORMATION

PLAN CATEGORY	IN-NETWORK	OUT-OF-NETWORK
Deductible	Individual: $100 Family: $200	Individual: $100 Family: $200
	1. Each $10 office visit Co-Pay goes towards helping to satisfy the $100 individual and the$200 family calendar year deductible. 2. Eligible Expenses applied toward the In-Network Deductible are also applied toward the Out-of-Network Deductible, and vice versa. 3. If two or more family members are injured in the same accident, all family members must satisfy only one individual deductible for all Eligible Expenses incurred by all family members in connection with the accident.	
Coinsurance *Except as Otherwise Specified*	This plan pays 80% and the covered person pays 20%	This plan pays 60% and the covered person pays 40%
Copayments **(For all Office Visits)**	$10 Co-Pay	$10 Co-Pay
Annual Maximum Benefit	Unlimited	Unlimited
Lifetime Maximum Benefit for Surgical Treatment of Morbid Obesity*	$15,000 per Covered Person	$15,000 per Covered Person
	*This Lifetime Maximum Benefit applies to Eligible Expenses paid by the Plan under Basic Coverage and Major Medical Coverage combined starting at the time surgery is incurred. Includes any related complications or related services following surgical treatment.	

COVERED SERVICES

This listing of Covered Services appears in alphabetical order to better assist the Covered Person in locating the different benefit allowances for the specific Covered Services.

COVERED SERVICE	IN-NETWORK	OUT-OF-NETWORK
Allergy Injections	80% after Deductible	60% after Deductible
Allergy Serum	80% after Deductible	60% after Deductible
Ambulance Services **Ground or Air**	80% after Deductible	80% after Deductible
Birth Control • Depo Provera and IUD Device • Birth Control Pills	80% after Deductible Covered under Pharmacy Benefits	60% after deductible Covered under Pharmacy Benefits
	Removal of any Birth Control Device is not covered	

Chiropractic Services • Office Visits and Manipulation • X-rays and Lab	$10 Co-Pay after Deductible, then 80% 100% no deductible	$10 Co-pay after deductible, then 60% 80% no deductible
	$500 maximum per covered person per calendar year for all covered services	
Consultation Services During Inpatient Confinement - *Beyond First Inpatient Consultation Including Second and Third Surgical Opinions*	80% after Deductible	60% after Deductible
Consultation Services in Physician's Office	$10 Co-Pay, then 80% after Deductible	$10 Co-Pay, then 60% after Deductible
Durable Medical Equipment – *Billed by Durable Medical Equipment Provider*	80% after Deductible	60% after Deductible
Inhalation Therapy - *In Physician's office*	80% after Deductible	60% after Deductible
Inhalers for Asthma and Respiratory Disorders	80% after Deductible	60% after Deductible
Medical and Surgical Supplies – *Billed by Provider Other than Hospital*	80% after Deductible	60% after Deductible
Mental Health and Substance Abuse Services - *Physician office visit*	Office Visit Rider Benefit: $10 Co-Pay until exhausted, then 80% after Deductible	Office Visit Rider Benefit: $10 Co-Pay, payable at 80% until exhausted, then 60% after Deductible
Orthotic Devices	80% after Deductible	60% after Deductible
Patient Education Programs – Billed by Physician	80% after Deductible	60% after Deductible
Physical Therapy – *Outpatient, rendered by a Facility or in a Physician's Office*	80% after Deductible	60% after Deductible
	Aquatic Therapy is not covered regardless of whether it is performed in conjunction with Physical Therapy.	
Physician Office Visits for Non-Routine Care	Office Visit Rider Benefit: $10 Co-Pay until exhausted, then 80% after Deductible	Office Visit Rider Benefit: $10 Co-Pay, payable at 80% until exhausted, then 60% after Deductible
Prescription Drug Copayments	80% after Deductible	80% after Deductible
	Required Co-Payments under the Prescription Drug Coverage are considered Eligible Expenses under the Major Medical Coverage.	
Private Duty Nursing Services	80% after Deductible	60% after Deductible
Prosthetic Appliances	80% after Deductible	60% after Deductible
Second and Third Surgical Opinions – *Outpatient*	80% after Deductible	60% after Deductible

MEDICAL BENEFITS

This section describes the Covered Person's Medical Benefits. The Plan will cover the Medical Benefits when services:

1. Are authorized by a Physician;
2. Are rendered and billed by a Provider;
3. Qualify as a Covered Services; and
4. Are Medically Necessary, except as specified.

For Medical Benefits, payment of the Provider's Reasonable Charge, or the actual charge, whichever is less, will be provided for all Covered Services. With respect to the Preferred Providers, the Provider's Reasonable Charge will be based on the Negotiated Rate set forth in the PPO contract, except as provided by the Kidney Dialysis Treatment provision. For a Non-Preferred Providers, the Provider's Reasonable Charge will be the Customary and Reasonable Charge.

All payments will be subject to any applicable Copayments, Deductible, Coinsurance, maximum benefits and other provisions and limitations in this Plan Document and the Schedule of Benefits. All benefit payments will be made based on the procedure code assigned by the Provider for the specific procedure or service rendered and billed by that Provider.

PRE-CERTIFICATION PROVISIONS AND CASE MANAGEMENT

The Plan requires that the Covered Person obtain Pre-Certification in advance of receiving certain services. In addition, the Plan has a separate requirement that requires that the Covered Person provide notification following a Hospital Admission when such admission is not scheduled and occurs through the Emergency Room or Department of a Hospital. These requirements are described in detail in this section of the Plan Document.

The purpose of these Pre-Certification and notification requirements is to assist the Plan in determining the Medical Necessity of the services or procedures and the appropriateness of the planned course of treatment (e.g., appropriate length of stay or the appropriate number of visits or treatments). Compliance with the pre-certification and notification requirements is not a guarantee of benefit payment.

Under the Plan, a Medical Management Company will conduct and manage the Pre-Certification and notification process for a non-scheduled admission. This means that the Covered Person should contact the Medical Management Company at the telephone number appearing on the Identification Card to facilitate this process. In each instance, the Covered Person may satisfy this requirement by having the Hospital, Admitting Physician or a family member contact the Medical Management Company to provide the required Pre-Certification or notification.

Pre-Certification for Scheduled Admissions

Pre-Certification must be obtained for every scheduled Hospital Admission. There are different notification and/or pre-certification requirements for non-scheduled Hospital admissions and Transplant Procedures.

In order to obtain Pre-Certification, the Covered Person should contact the Medical Management Company when there is a scheduled Hospital admission within 3 business days prior to the admission. When Pre-Certification is provided, a certain number of Inpatient Hospital days for the stay will be assigned. If the Covered Person fails to follow the Pre-Certification guidelines as set forth herein, no payment of benefits for Hospital expenses will be made. If services are not Medically Necessary, no benefits are payable at all.

Special Note About Confinements for Maternity Services: Pre-Certification of Hospital admissions for Maternity Services is not required for any Hospital Confinement for such services unless the Confinement exceeds 48 hours for a routine vaginal delivery and 96 hours for a cesarean section delivery.

Pre-Certification for Transplant Procedures

Pre-Certification is also required for all Inpatient and Outpatient Services related to transplant services. Under this provision, all Inpatient and Outpatient Services related to transplant services must be pre-certified within three business days prior to receiving such services in order for Coverage to be provided. Failure to obtain pre-certification a transplant procedure will result in a denial of the claim for said services.

Notification for Non-Scheduled Admission

If a Covered Person is admitted to a Hospital for a non-scheduled admission, notice of the admission must be provided to the Medical Management Company no later than 24 hours after the admission. The admission will be reviewed within one working day of the date notification of the admission has been provided. The review will be performed with the Covered Person's Physician to determine if a continued Hospital stay is Medically Necessary. If notice of a Covered Person's non-scheduled admission is not provided, no payment of benefits will be made.

A non-scheduled admission is an emergency or unplanned admission to the Hospital. Non-scheduled admissions frequently occur through the emergency department of a Hospital.

Transplant Management

Although a Covered Person is free to choose the Hospital that will perform a covered transplant procedure, the Plan will pay a higher benefit when the Covered Person uses a Hospital that is a "Center of Excellence" to receive Transplant Services. This higher benefit level, which is set forth in the Schedule of Benefits, applies to all Covered Services received in connection with the covered transplant procedure when a Center of Excellence performs the actual transplant surgery. To determine which Hospitals are considered a Center of Excellence, the Covered Person or the Covered Person's Physician should contact the Medical Management Company as soon as the Covered Person becomes a candidate for a transplant procedure. The Medical Management Company will be able to direct the Covered Person or the Covered Person's Physician to a list of Hospitals that qualify as a Center of Excellence.

Pre-Certification for Certain Procedures/Services

Pre-Certification is required for the following procedures:

1. Home Health Services
2. Home Infusion Therapy
3. Hospice Services
4. Sleep Studies
5. Magnetic Resonance Imaging (MRI and MRA)
6. Uvulopalatopharyngoplasty
7. Arthroscopy
8. Blepharoplasty and Ptsosis Surgery
9. Foot Surgery (Major Joint Surgery) including: Bunionectomy/Correction, Hallux Valgus, Bone Spur Removal/Ostectomy, Hammertoe/Capsulotomy, Osteotomy Procedures, Ostectomy Procedures
10. Treatment for varicose veins - surgical treatment and sclerotherapy
11. Breast Surgery, other than biopsy procedures and for malignancy
12. Surgical Treatment of Morbid Obesity at least 14 days in advance of surgery.

In order to obtain Pre-Certification, the Covered Person should contact the Medical Management Company when there is a scheduled procedure or service within three business days prior to the procedure or service being rendered. If the Covered Person fails to obtain Pre-Certification, services received will not be covered.

Continued Stay Review and Discharge Planning

During a Covered Person's Hospital stay, a Continued Stay Review will be conducted. This review applies to all Hospital admissions. The purpose of Continued Stay Review is to enable the Health Plan to re-evaluate the Medical Necessity of a continued Hospital stay. It may be necessary to obtain additional information concerning the Covered Person's Hospital stay in order to conduct a Continued Stay Review.

Review for Discharge Planning occurs during Hospitalization Review. The purpose is to identify patients requiring extended care following discharge and determine the most appropriate setting for continued care.

Case Management

Case Management is a voluntary program and it is designed to inform patients of more cost effective settings for treatment. Case Management typically applies when an individual has a chronic or ongoing condition, or a catastrophic condition, that is expected to result in significant claim costs for the Plan. In this event, on an exception basis, benefits may be provided for settings and/or procedures not expressly covered under the Plan, if the setting and/or procedure will assist the Plan Sponsor in managing the Plan's medical costs. All requests for Case Management will be individually reviewed by the Plan.

If a Covered Person requests an alternative setting or procedure under Case Management, the Plan Sponsor has the right to deny Coverage for such setting or procedure and benefits pursuant to the terms of the Plan, exclusive of this provision.

Oncology Program

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

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

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

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

PREFERRED PROVIDER (PPO) ARRANGEMENT

The Plan offers a broad network of providers within the network selected by the Plan Sponsor. The Plan provides the highest level of benefits when Covered Persons utilize Preferred Providers. Preferred Providers are those who are contracted with the network indicated on the Identification Card. Services provided by Non-Preferred Providers will generally be covered at a lower benefit level than services received from an Preferred Provider. Preferred Providers must accept a reduced rate ("Negotiated Rate") as their charge for services rendered and cannot bill for the difference between the charge and the Negotiated Rate.

COVERED SERVICES
UNDER
BASIC COVERAGE

The following is a list of Covered Services under the Plan's Basic Coverage. The list of services appears in alphabetical order.

Abortion Services
The Plan will cover surgical services in relation to the performance of an abortion when such services are rendered and billed by a Physician in a covered setting. In addition, the Plan will cover medical or surgical complications that are the direct result of the Covered Person receiving an abortion.

Acute Rehabilitation Facility
The Plan will cover certain services when the Covered Person is confined as an Inpatient in an Acute Rehabilitation Facility for the care and treatment of an Illness or Injury requiring acute rehabilitation services. The following room and board expenses and ancillary services will be covered:

1. Room and Board. Room and board in a semi-private room, including meals, special diets and nursing services, other than private duty nursing services. Coverage includes a bed in a special care unit approved by the Plan. Use of a private room, will be covered at the facility's semi-private room rate;
2. Ancillary Services. Ancillary Services received during a Confinement in an Acute Rehabilitation Facility include, but are not limited to:
    a. Treatment rooms and equipment used therein;
    b. Prescribed drugs;
    c. Medical and surgical dressings, supplies, casts and splints;
    d. Blood, blood transfusions and other blood-related services;
    e. Diagnostic Services;
    f. Inhalation therapy;
    g. Physical Therapy;
    h. Occupational Therapy; and
    i. Speech Therapy.

Ambulatory Surgical Facility Services
The Plan will cover services rendered and billed by an Ambulatory Surgical Facility in connection with the performance of a covered surgical procedure performed in such facility.

Anesthesia Services
The Plan will cover the administration of anesthesia by a Physician or Other Medical Professional Provider who is not the surgeon or assistant at surgery for surgery performed by a Physician on an Inpatient or Outpatient basis and when such surgery is performed in a covered setting.

Birthing Center Services
The Plan will cover the following services in connection with Maternity Services provided to a Covered Person when such services are rendered and billed by a Birthing Center:

1. Operating room and equipment used therein;
2. Delivery room and equipment used therein;
3. Other treatment rooms and equipment used therein;
4. Prescribed drugs;
5. Anesthesia, anesthesia supplies and services provided by an employee of the Facility;
6. Medical and surgical dressings, supplies, casts and splints;
7. Blood, blood transfusions and other blood-related services; and
8. Diagnostic Services.

Botox Injections
The Plan will cover Botox injections when used for the treatment of migraine headaches.

Cardiac Rehabilitation Therapy – Outpatient
The Plan will cover Cardiac Rehabilitation Programs in connection with the rehabilitation of the Covered Person following a myocardial infarction, coronary occlusion or coronary bypass surgery when such rehabilitation services are rendered under the supervision of a Physician in a Facility.

Chemotherapy – Outpatient
The Plan will cover charges for chemotherapy. The Plan shall refer to the Centers for Medicare & Medicaid Services (CMS) authoritative compendia, including the NCCN Drugs and Biologics Compendium and Thomson Micromedex, in the determination of medically accepted drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen.

Clinical Trial Routine Patient Costs.
The Plan will cover Routine Patient Costs for a Qualified Individual in an Approved Clinical Trial. This benefit does not include: the investigational item, device or service itself; items and services solely for data collection and analysis purposes and not for direct clinical management of the Participant; or any service inconsistent with the established standard of care for the Participant's diagnosis. Routine Patient Costs services, treatment or items provided by an Out-of-Network provider are covered only if the Approved Clinical Trial is only offered outside the Participant's state of residence.

Diagnostic Services - Outpatient
The Plan will cover Outpatient Diagnostic Services rendered in an Outpatient Facility or Physician Office setting when the Covered Person has specific symptoms and such tests and procedures are needed to detect and diagnose an Illness or Injury. Outpatient Diagnostic Services include, but are not limited to, pre-admission testing and allergy testing. Specific services covered under this benefit include:

1. Laboratory examinations;
2. X-ray tests or examinations;
3. EKGs;
4. EEGs; and
5. MRIs, MRAs, and CAT Scans.

Drug Addiction Services
Refer to the Mental Health & Substance Abuse Services.

Durable Medical Equipment
The Plan will cover the rental (or, at the Plan's option, the purchase) of durable medical equipment prescribed by a Physician. Rental costs must not be more than purchase price. This equipment must serve only a medical purpose and be able to withstand repeated use.

Emergency Care in Emergency Department
The Plan will cover treatment of an Illness or Injury that is considered to be a Medical Emergency when such services are rendered in the Emergency Department of a Hospital. Covered Services include those Medically Necessary services and supplies provided by the Hospital following the Covered Person's admission to the Emergency Department for an Illness or Injury and include the services provided by the Physician and Other Medical Professional Providers who are Hospital employees and who are regular staff members of the Emergency Department of the Hospital.

Home Health Care Services
Home Health Care Services may be provided to the Covered Person on a part-time basis in the Covered Person's home as a Medically Necessary alternative to Inpatient care. A Home Health Care Provider must provide the services according to a Physician-prescribed course of treatment that has been previously approved by the Plan. Covered Services include the following:

1. Skilled nursing services
2. Medical social service
3. Nutritional guidance
4. Home health aide service
5. Diagnostic Services
6. Therapy services including home infusion therapy

Home Health Aide visits are limited to eight hours per visit. Custodial care is not a covered service.

Hospice Services

Hospice Services are the following services that are provided to a terminally ill patient with a life expectancy of six months or less. Hospice Services must be provided by a Hospice Provider according to a Physician-prescribed plan of care that has been previously approved by the Plan.

1. Nursing Care
2. Medical Social Services
3. Physical, Speech and Occupational Therapy
4. Inhalation Therapy
5. Home Health Aide Services
6. Dietary Counseling
7. Medical/Surgical Supplies
8. Medical Equipment
9. Lab Services
10. 24-Hour Continuous Nursing Care.

Hospice Services are most often provided in the home and must be agreed to by the Covered Person.

Hospital Services During an Inpatient Confinement

The Plan will cover certain Hospital Services when the Covered Person is hospitalized as an Inpatient in a Hospital. The following room and board expenses and ancillary services are considered covered Inpatient Hospital Services:

1. Room and Board. Room and board in a semi-private room, including meals, special diets and nursing services, other than private duty nursing services. Coverage includes a bed in a special care unit approved by the Plan. The Plan will cover a private room when necessary for isolation purposes but not for the convenience of the Covered Person, or if the Hospital does not provide semi-private rooms.
2. Ancillary Services. Ancillary Services received during a Hospital Confinement include, but are not limited to:
    a. Operating room and equipment used therein;
    b. Delivery room and equipment used therein;
    c. Other treatment rooms and equipment used therein;
    d. Prescribed drugs;
    e. Anesthesia, anesthesia supplies and services provided by an employee of the Facility;
    f. Medical and surgical dressings, supplies, casts and splints;
    g. Blood, blood transfusions and other blood-related services;
    h. Diagnostic Services;
    i. Radiation therapy;
    j. Intravenous chemotherapy;
    k. Kidney dialysis;
    l. Inhalation therapy;
    m. Physical Therapy;
    n. Occupational Therapy; and
    o. Speech Therapy.

Infusion Therapy/Intravenous IV Therapy

The Plan will cover the delivery of prescribed infusion therapy drug medications directly into the blood

stream via a vein, usually located in the arm or hand in managing certain disease processes. Many medications used to treat neurological disorders must be delivered in this manner. Treatment must be rendered in a covered setting.

Inhalation Therapy – Outpatient

The Plan will cover Outpatient Inhalation Therapy services when such services are rendered and billed by a Provider. Inhalation Therapy is a type of therapy that involves the introduction of dry or moist gases into the lungs. Treatment must be rendered in a covered setting.

Impotence Treatment

The Plan will cover penile implants and other Medically Necessary treatments or devices. Prescription drugs for impotence may be available under Prescription Benefits.

Kidney Dialysis Treatment – Outpatient

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

A. Reasons for the Dialysis Program. The Dialysis Program has been established for the following reasons:
   (1) the concentration of dialysis providers in the market in which Plan members reside may allow such providers to exercise control over prices for dialysis-related products and services,
   (2) the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members,
   (3) evidence of (i) significant inflation of the prices charged to Plan members by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan members to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers, and
   (4) the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the Plan members' interests, such as subsidies for other plans and discriminatory profit-taking.

B. Dialysis Program Components. The components of the Dialysis Program are as follows:
   (1) Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").
   (2) Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.
   (3) Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan Administrator shall consider factors including:
      i. Market concentration: The Plan Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.
      ii. Discrimination in charges: The Plan Administrator shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the

charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

(4) In the event that the Plan Administrator's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan Administrator may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan Administrator may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the Plan member, to the following payment limitations, under the following conditions:

i. Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the Plan member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.

ii. Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the Plan's members, upon the Plan Administrator's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.

iii. Maximum Benefit. The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

iv. Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan Administrator shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

v. Additional Information related to Value of Dialysis-Related Services and Supplies. The Plan member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.

vi. All charges must be billed by a provider in accordance with generally accepted industry standards.

(5) Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

(6) Discretion. The Plan Administrator shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law.

Mammography Services - Outpatient

The Plan will cover routine Mammography Services on an Outpatient basis. Coverage includes the following Mammography Services performed on a routine basis.

1. For women age 35 through 39 years, the Plan will cover one baseline mammogram;
2. For women age 40 years or older, the Plan will cover one mammogram every calendar year.

As used in connection with the Coverage for routine mammography screenings, the Provider's Reasonable Charge shall be determined as the lesser of the following:

1. The Provider's billed charge; or
2. 130% of Ohio's Medicare Reimbursement Rate for screening mammography, or if there is more than one Medicare Reimbursement Rate in Ohio for screening mammography or a component of a screening mammography, less than 130% of the lowest Medicare Reimbursement Rate in Ohio. In this event, the Provider's Reasonable Charge for routine mammography screenings shall be increased to equal 130% of Ohio's Medicare Reimbursement Rate for screening mammography or 130% of the lowest Medicare Reimbursement Rate in Ohio if there is more than one Medicare Reimbursement Rate in Ohio for screening mammography or a component of a screening mammography.

In the event a Provider provides a service that is a component of the mammography screen and submits a separate claim from that component, a separate payment shall be made to the Provider in an amount that corresponds to the ratio paid by Medicare in Ohio for that component. Regardless of whether separate payments are made for the benefit, the total benefit for a mammography screening shall equal the maximum benefit as set forth in the preceding paragraph.

As used herein, Medicare Reimbursement Rate means the reimbursement rate paid in Ohio under the Medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

Maternity Coverage

Inpatient Services. Coverage will be provided for the services rendered by a Hospital or Professional Provider in connection with the Maternity Services for a Covered Person. The Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Dependent Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan may pay for a shorter stay if the attending Provider (e.g. the Covered Person's Physician, Certified Nurse Midwife, or Physician Assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, the Plan 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.

In addition, the Plan may not require that a Physician or other Provider obtain authorization for prescribing a length of stay unless the length of stay will exceed 48 hours for a vaginal delivery or 96 hours for a cesarean section.

Routine Nursery Care of Well Newborn. This benefit includes the routine nursery care of the newborn infant and the first Inpatient visit to examine the infant. A Physician other than the Physician who performed the obstetrical delivery must perform the examination. The Plan will provide Coverage for a newborn infant for the first 31 days of the infant's life provided the infant has been enrolled for Coverage under the Plan pursuant to the enrollment requirements described in this Plan Document.

Pre-Natal and Post-Natal Office Visits. Coverage will be provided for Office Visits in connection with pre-natal and post-natal care and treatment of the mother. Pre-natal and post-natal Office Visits will be treated as a Maternity Service and will be covered in the same manner as all other Maternity Services. However, the initial pre-natal Office Visit is covered under the Physician Office Visit benefit (refer to the Schedule of Benefits) if the Physician does not bill the initial Office Visit as part of the overall obstetrical bill.

Medical and Surgical Supplies

The Plan will cover medical and surgical supplies that serve a specific medical purpose and are purchased by

the Covered Person for use in the home. Covered medical and surgical supplies include, but are not limited to, the following:

1. Syringes and needles;
2. Diabetic supplies including glucose monitors, test strips and lancets;
3. Oxygen;
4. Surgical dressings;
5. Surgical stockings, limited to three pairs per calendar year;
6. Casts and splints;
7. Braces;
8. Catheters;
9. Colostomy and ileostomy bags and supplies required for their use;
10. Soft lenses and sclera shells intended for use in the treatment of an Illness or Injury of the eye; and
11. Allergy serum and intravenous solutions unless such serum and IV solutions are obtained from a Pharmacy.

Mental Health and Substance Abuse Services

The Plan will cover Mental Health Services for the care and treatment of a psychiatric condition. Mental Health Services will be covered on Inpatient and Outpatient basis and during a Partial Day Treatment Program. A mental health condition will be treated the same as any other Illness for purposes of determining available Covered Services. In addition, the following additional services are covered:

1. Individual psychotherapy
2. Group psychotherapy
3. Psychological testing
4. Family counseling - Counseling with family members to assist in the Covered Person's diagnosis and treatment, except marriage counseling.
5. Convulsive therapy - Convulsive therapy treatment is limited to Inpatient care. It includes electroshock treatment or convulsive drug therapy.

Mental Health Services will be covered when rendered by a Physician (in an eligible Inpatient setting or office setting), Hospital, Specialized Hospital, or Community Mental Health Facility. Residential treatment facilities will be covered as inpatient treatment when pre-certification is received and treatment is determined to be Medically Necessary.

The Plan will cover Substance Abuse Services for the care and treatment of alcoholism and drug addiction Substance Abuse Services will be covered on an Inpatient and Outpatient basis. In addition, Partial Day Treatment Programs are also covered. Covered Services include those services that would be covered for any other Illness, as set forth in this Plan Document, and also include the following services:

1. Individual psychotherapy
2. Group psychotherapy
3. Psychological testing
4. Family counseling - Counseling with family members to assist in the Covered Person's diagnosis and treatment, except marriage counseling.

Substance Abuse Services will be covered when rendered by a Physician (in an eligible Inpatient setting or office setting), Hospital, Specialized Hospital, Alcoholism Treatment Facility or Community Mental Health Facility. Residential treatment facilities will be covered as inpatient treatment when pre-certification is received and treatment is determined to be Medically Necessary.

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations.

The Plan will provide benefits for intermediate levels of care for mental health conditions and substance abuse disorders in parity with medical or surgical care of the same level. For instance, if the Plan

provides benefits for a skilled nursing or rehabilitation facility for medical or surgical treatment, the Plan will provide equal benefits for intensive outpatient therapy, or partial hospitalization. Contact the customer service number on the back of the member ID card for more information.

Morbid Obesity – Surgical Treatment

For those Covered Persons who are diagnosed as having Morbid Obesity and an illness that is directly caused by Morbid Obesity, the Plan will cover surgical treatment when surgical intervention of Morbid Obesity is recommended by the Covered Person's Physician. The Plan will cover the surgical procedure and the Hospital admission, any related complications, and related services following surgical treatment.

There is a separate lifetime maximum benefit of $15,000 pre Covered Person which applies to all covered surgical procedures, the Hospital admission, any related complications, and related services following surgical treatment. The separate lifetime maximum benefit applies to Eligible Expenses paid by the Plan under Basic Coverage and Major Medical Coverage combined. Coverage for surgical treatment of Morbid Obesity begins at the time in which the surgical expense is incurred. The Plan will not cover services rendered prior to the surgery. The Plan will cover all surgically-related procedures from the point of surgery and Medically Necessary follow-up services after the surgery including but not limited to related services for conditions resulting from the surgery (e.g., surgical removal of excess skin).

Medical Necessity Review requirements must be met to qualify for the procedure.

Occupational Therapy Services - Outpatient

The Plan will cover Outpatient Occupation Therapy when rendered and billed by a Physician or Other Medical Professional Provider in a covered Outpatient setting. As used herein, Occupational Therapy means treatment rendered on an Inpatient or Outpatient basis as a part of a physical medicine and rehabilitation program to improve functional impairments where the expectation exists that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. No benefits are provided for diversional, recreational, and vocational therapies (such as hobbies, arts and crafts).

Organ Transplants

Refer to Transplant Services benefit.

Patient Education Programs

The Plan will cover patient education programs in a covered Inpatient or Outpatient setting, including services performed in an office visit setting, for the following patient education programs:

1. Diabetic education;
2. Dietary and nutritional education when the Covered Person's diagnosis is hypoglycemia, hyperlypidemia, acute or chronic renal failure or liver disease, or hypercholesterolemia; and
3. Ostomy care.

Education for weight control and educational supplies are not covered.

Physical Therapy Services - Outpatient

The Plan will cover Physical Therapy when rendered by a Physician or Physical Therapist in a covered Outpatient setting. As used herein, Physical Therapy means treatment by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following disease, injury, or loss of body part. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or Other Medical Professional Provider are required.

Aquatic Therapy is not inclusive to the Physical Therapy benefit.

Such treatment does not include treatment of the spine which is covered under the chiropractic benefit.

Physician Medical Services During an Inpatient Confinement

The Plan will cover certain Medical Services that are rendered and billed by a Physician when the Covered Person is hospitalized as an Inpatient in a Hospital. The following services are considered covered Medical Services during a Covered Person's Hospital Confinement:

1. Physician In-Hospital Visits. The Plan will cover one Physician visit per day from the Covered Person's treating Physician during a Covered Person's Hospital Confinement.
2. Intensive Care. The Plan will cover the constant care and treatment while the Covered Person is confined in an intensive care unit.
3. Care by Multiple Physicians. When the Covered Person's condition requires the skills of separate Physicians, the Plan will cover the medical care and treatment by two or more Physicians received during the same Hospital Confinement.
4. Other Physician Consultations. When the Covered Person's Physician requests another Physician's consultation, the Plan will provide Coverage for such consultation but will limit Coverage to one such consultation per Hospital admission. Staff consultations required by Hospital rules are excluded from Coverage.

Physician Office Visit for Non-Routine Care

The Plan will cover charges incurred during a visit to the Covered Person's Physician for non-routine care in connection with a specific Injury or Illness. Covered Services includes screening examinations, evaluation procedures, medical care, treatment or services directly related to assist in the diagnosis or treatment of a specific Injury or Illness which is known or reasonably suspected.

Any diagnostic tests requested by the Physician in connection with the office visit will be covered under the "Diagnostic Services – Outpatient" benefit.

After the Maximum Benefit for Physician Office Visits under the Basic Coverage has been exhausted, the Plan will cover the remaining Eligible Expenses under the Major Medical Coverage. Refer to the Schedule of Benefits for the Maximum Benefit under the Basic Coverage.

Physician's Office Visit for Well Care

Refer to Routine/Well Care benefit.

Podiatry Services

The Plan will cover podiatry services rendered by a Podiatrist or a Physician in a covered setting (e.g., Physician's office or Emergency Department of a Hospital). Covered services include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

Radiation Therapy – Outpatient

The Plan will cover radiation therapy when rendered by a Physician or Other Medical Professional Provider in a covered setting on an Outpatient basis.

Reconstructive Surgery

When performed in a covered facility setting, the Plan will cover reconstructive surgery to restore bodily functions or correct deformity. Such surgical procedure will be treated the same as any other surgical procedure. Coverage is limited to problems caused by disease, Injury, birth or growth defects, or previous treatments. In addition, Coverage will be provided for the following services to an individual receiving benefits in connection with a mastectomy:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Routine/Well Care for Adults and Dependent Children Age Nine and Older

Coverage will include charges for all Covered Persons for routine periodic examinations, screening examinations, medical assessments, evaluation procedures, preventative medical care, treatment or services not directly related to the a specific Injury, Illness or pregnancy-related condition which is known or reasonably suspected. Specific services covered under this benefit include:

1. Routine physical examinations, limited to one per calendar year;
2. Routine immunizations – no limitations, including Hepatitis, Flu, Pneumovax, Gardisil and H1N1;
3. Routine gynecological exams limited to one per calendar year and routine Pap smear screenings limited to one per calendar year;
4. Routine prostate (PSA) screenings, limited to one per calendar year; and
5. Routine mammogram screenings for women age 35 and older. Refer to the section entitled Mammography Services – Outpatient.
6. Screening Colonoscopy beginning at age 50
7. Shingles (Herpes Zoster) Vaccine beginning at age 50

Routine/Well Care for Dependent Children – Newborn through Age Eight

Coverage will include charges for a Dependent Child for routine periodic examinations, screening examinations, medical assessments, evaluation procedures, preventative medical care, treatment or services not directly related to the a specific Injury, Illness or pregnancy-related condition which is known or reasonably suspected. Specific services covered under this benefit include:

1. Routine Physician examinations according to the schedule of examinations recommended by the American Pediatric Association for Dependent Children from birth through eight years of age. Thereafter, routine Physician examinations will be limited to one per calendar year;
2. Routine immunizations;
3. All diagnostic laboratory examinations in connection with the Routine Physician Office Visit; and
4. Hearing Screening for newborns from birth through age one.

Second and Third Surgical Opinions – Inpatient

If the Covered Person's Physician recommends that a surgical procedure be performed, the Plan will cover the Covered Person's consultation with another Physician in order to obtain a second surgical opinion. If the second opinion differs from the first opinion, the Plan will cover the Covered Person's consultation with a third Physician to obtain a third surgical opinion. The second and/or third Physician with whom the Covered Person consults must be a specialist in the field of medicine for which the surgery is related.

Skilled Nursing Facility Services

Covered Services for an Inpatient of a Skilled Nursing Facility are the same as those shown in the sections called "Inpatient Hospital Services" and "Inpatient Medical Services."

Coverage is subject to the following requirements:

1. The Covered Person must be admitted to the Skilled Nursing Facility within 24 hours following a Medically Necessary Hospital stay; and
2. Services must be Medically Necessary as a continuation of treatment for the condition for which the Covered Person was hospitalized.

Sleep Disorders

The Plan will cover the diagnosis and treatment of a sleep disorder when services are rendered and billed by a Physician or Other Medical Professional Provider in a covered setting. For purposes of determining what services will be covered in connection with this benefit, a "sleep disorder" will be considered the same as any other Illness under this Plan Document.

Speech Therapy – Outpatient

The Plan will cover Speech Therapy when rendered and billed by a Physician or Speech Therapist in a covered Outpatient setting. As used herein, Speech Therapy means active treatment for improvement of an

organic medical condition causing a speech impairment. Treatment must be either post-operative or for the convalescent stage of an active illness or disease. Treatment for developmental delays, language disorders or articulation is not covered.

Sterilization Procedures

The Plan will cover voluntary and involuntary sterilizations for both male and female Covered Persons. Reversal of any sterilization procedure is not covered.

Surgical Services

Surgery performed by a Physician is covered on an Inpatient or Outpatient basis. Inpatient basis includes surgery performed by a Physician while the Covered Person is an Inpatient in a Hospital. Outpatient basis includes Surgical Services performed in a Facility or a Physician's Office. Surgical services also include:

1. Surgical Assistance. Services of a Physician who helps the Covered Person's surgeon in performing covered major surgery when a house staff member, intern or resident cannot be present. In this instance, the Provider's Reasonable Charge for services of a Physician who assists the surgeon in performing a covered surgery will be determined as 20% of the surgeon's charge for the surgery;
2. Anesthesia Services. Administration of anesthesia by a Physician or other Professional who is not the surgeon or assistant at surgery;
3. Multiple Surgical Procedures. When more than one surgical procedure is performed through the same body opening during one operation, the Covered Person is covered only for the most complex procedure, unless more than one body system is involved or the procedures are needed for the handling of multiple traumas.

When more than one surgical procedure is performed through more than one body opening during one operation, the Covered Person is covered for the most complex procedure and for a portion of the benefit for the less complex procedure(s).

Therapy Services - Outpatient

The following therapy services will be covered when rendered in an Outpatient Facility or Physician Office setting:

1. Chemotherapy;
2. Home infusion therapy;
3. Occupational Therapy;
4. Speech Therapy;
5. Physical Therapy; and
6. Radiation therapy.

In addition, the Plan will cover Cardiac Rehabilitation Programs in connection with the rehabilitation of the Covered Person following a myocardial infarction or coronary occlusion or coronary bypass surgery when such rehabilitation services are rendered under the supervision of a Physician in a Facility.

Transplant Services

The Plan will cover services for in connection with the transplant procedures described in this section when such services are rendered and billed by a Physician and/or Hospital. Such services will be referred to as Transplant Services and include all Covered Services described in this Plan Document as such services would be available for the treatment of any other Illness. In addition, the Plan will cover expenses for the acquisition and transportation of the organ or tissue and will cover travel and lodging expenses in connection with the Covered Person receiving a covered transplant procedure. Travel and lodging expenses will be limited to the travel expenses of the Covered Person receiving the transplant procedure and, if the Covered Person is a minor, the travel and lodging expenses of two adult companions (e.g., the Covered Person's parents). If the Covered Person is an adult, the Plan will cover the travel and lodging expenses of one adult companion.

Under the Plan, a covered transplant procedure includes the following human organ and tissue transplants:

1. Kidney transplant;
2. Pancreas transplant;
3. Cornea transplant;
4. Bone Marrow transplant;
5. Heart transplant;
6. Lung transplant;
7. Heart/lung transplant;
8. Liver transplant;
9. Intestines transplant.

Although a Covered Person is free to choose the Hospital that will perform the transplant procedure, the Plan will pay a higher benefit when the Covered Person uses a Hospital that is a "Center of Excellence" to receive Transplant Services. This higher benefit level, which is set forth in the Schedule of Benefits, applies to all Covered Services received in connection with the covered transplant procedure when a Center of Excellence performs the actual transplant surgery. To determine which Hospitals are considered a Center of Excellence, the Covered Person or the Covered Person's Physician should contact the Medical Management Company as soon as the Covered Person becomes a candidate for a transplant procedure. The name and telephone number of the Medical Management Company serving the Covered Person's Plan is shown on the Identification Card. The Medical Management Company will be able to direct the Covered Person or the Covered Person's Physician to a list of Hospitals that qualify as a Center of Excellence.

Urgent Care Services in Urgent Care Facility

The Plan will cover services rendered by an Urgent Care Facility in connection with the treatment and diagnosis of an Illness or Injury, and include the services provided by the Physician and Other Medical Professional Providers who are Urgent Care Facility employees. Under this benefit, Coverage will be provided for screening examinations, evaluation procedures, medical and surgical care, treatment or services directly related to a specific Injury or Illness which is known or reasonably suspected.

COVERED SERVICES
UNDER
MAJOR MEDICAL COVERAGE

The following is a list of Covered Services under the Plan's Major Medical Coverage. The list of services appears in alphabetical order.

Allergy and Asthma Treatment
The Plan will cover allergy injections when such injections are administered by a Physician in the Physician's office or other covered setting. The Plan will also cover allergy serum and inhalers.

Ambulance Service
Ambulance service is transportation by a vehicle designed, equipped and used only to transport the sick and injured:

1. From the Covered Person's home, scene of accident or medical emergency to a Hospital;
2. Between Hospitals;
3. Between Hospital and Skilled Nursing Facility; or
4. From a Hospital or Skilled Nursing Facility to the Covered Person's home.

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

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

Birth Control
The Plan will cover injectable contraceptives such as Depo Provera and contraceptive devices when rendered by a Physician or Other Medical Professional Provider in a covered Outpatient setting. Removal of any birth control device is not covered.

Chiropractic Services – Outpatient
The Plan will cover Chiropractic Treatment when rendered by a Physician or a Chiropractor on an Outpatient basis and in a covered setting. As used herein, Chiropractic Treatment means treatment of the spine by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following disease or injury. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or Other Medical Professional Provider are required.

Drug Addiction Services
Refer to the Mental Health and Substance Abuse Services benefit.

Durable Medical Equipment
The Plan will cover the rental (or, at the Plan's option, the purchase) of durable medical equipment prescribed by a Physician. Rental costs must not be more than purchase price. This equipment must serve only a medical purpose and be able to withstand repeated use.

Inhalation Therapy - Outpatient
The Plan will cover Outpatient Inhalation Therapy services when such services are rendered and billed by a Provider. Inhalation Therapy is a type of therapy that involves the introduction of dry or moist gases into the lungs. Treatment must be rendered in a covered setting.

Medical and Surgical Supplies

The Plan will cover medical and surgical supplies that serve a specific medical purpose and are purchased by the Covered Person for use in the home. Covered medical and surgical supplies include, but are not limited to, the following:

1. Syringes and needles;
2. Diabetic supplies including glucose monitors, test strips and lancets;
3. Oxygen;
4. Surgical dressings;
5. Surgical stockings, limited to three pairs per calendar year;
6. Prefabricated Post Mastectomy Bras, limited to four bras per calendar year;
7. Breast Prosthesis limited to one prosthesis (two if bilateral) every two years.
8. Casts and splints;
9. Braces;
10. Catheters;
11. Colostomy and ileostomy bags and supplies required for their use;
12. Soft lenses and sclera shells intended for use in the treatment of an Illness or Injury of the eye; and
13. Allergy serum and intravenous solutions unless such serum and IV solutions are obtained from a Pharmacy.

Mental Health and Substance Abuse Services

The Plan will cover Mental Health Services for the care and treatment of a psychiatric condition. Mental Health Services will be covered on Inpatient and Outpatient basis and during a Partial Day Treatment Program. A mental health condition will be treated the same as any other Illness for purposes of determining available Covered Services. In addition, the following additional services are covered:

1. Individual psychotherapy
2. Group psychotherapy
3. Psychological testing
4. Family counseling - Counseling with family members to assist in the Covered Person's diagnosis and treatment, except marriage counseling.
5. Convulsive therapy - Convulsive therapy treatment is limited to Inpatient care. It includes electroshock treatment or convulsive drug therapy.

Mental Health Services will be covered when rendered by a Physician (in an eligible Inpatient setting or office setting), Hospital, Specialized Hospital, or Community Mental Health Facility.

The Plan will cover Substance Abuse Services for the care and treatment of alcoholism and drug addiction Substance Abuse Services will be covered on an Inpatient and Outpatient basis. In addition, Partial Day Treatment Programs are also covered. Covered Services include those services that would be covered for any other Illness, as set forth in this Plan Document, and also include the following services:

1. Individual psychotherapy
2. Group psychotherapy
3. Psychological testing
4. Family counseling - Counseling with family members to assist in the Covered Person's diagnosis and treatment, except marriage counseling.

Substance Abuse Services will be covered when rendered by a Physician (in an eligible Inpatient setting or office setting), Hospital, Specialized Hospital, Alcoholism Treatment Facility or Community Mental Health Facility.

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

Morbid Obesity – Surgical Treatment

For those Covered Persons who are diagnosed as having Morbid Obesity and an illness that is directly caused by Morbid Obesity, the Plan will cover surgical treatment when surgical intervention of Morbid Obesity is recommended by the Covered Person's Physician. The Plan will cover the surgical procedure and the Hospital admission, any related complications, and related services following surgical treatment.

There is a separate lifetime maximum benefit of $15,000 pre Covered Person which applies to all covered surgical procedures, the Hospital admission, any related complications, and related services following surgical treatment. The separate lifetime maximum benefit applies to Eligible Expenses paid by the Plan under Basic Coverage and Major Medical Coverage combined. Coverage for surgical treatment of Morbid Obesity begins at the time in which the surgical expense is incurred. The Plan will not cover services rendered prior to the surgery. The Plan will cover all surgically-related procedures from the point of surgery and Medically Necessary follow-up services after the surgery including but not limited to related services for conditions resulting from the surgery (e.g., surgical removal of excess skin).

Orthotic Devices

The Plan will cover orthotic devices. Under the Plan, orthotic devices are rigid or semi-rigid supportive devices which limits or stops motion of a weak or diseased body part.

Patient Education Programs

The Plan will cover patient education programs in a covered Inpatient or Outpatient setting, including services performed in an office visit setting, for the following patient education programs:

1. Diabetic education;
2. Dietary and nutritional education when the Covered Person's diagnosis is hypoglycemia, hyperlypidemia, acute or chronic renal failure or liver disease, or hypercholesterolemia; and
3. Ostomy care.

Educational supplies and education for weight control is not covered

Physical Therapy Services - Outpatient

The Plan will cover Physical Therapy when rendered by a Physician or Physical Therapist in a covered Outpatient setting. As used herein, Physical Therapy means treatment by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following disease, injury, or loss of body part. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or Other Medical Professional Provider are required.

Such treatment does not include treatment of the spine which is covered under the chiropractic benefit.

Physician's Office Visit for Non-Routine Care

The Plan will cover charges incurred during a visit to the Covered Person's Physician for non-routine care in connection with a specific Injury or Illness. Covered Services includes screening examinations, evaluation procedures, medical care, treatment or services directly related to assist in the diagnosis or treatment of a specific Injury or Illness which is known or reasonably suspected.

Any diagnostic tests requested by the Physician in connection with the office visit will be covered under the "Diagnostic Services – Outpatient" benefit.

After the Maximum Benefit for Physician Office Visits under the Basic Coverage has been exhausted, the Plan will cover the remaining Eligible Expenses under the Major Medical Coverage. Refer to the Schedule of Benefits for the Maximum Benefit under the Basic Coverage.

Prescription Drug Copayments
The required Copayments under the Plan's Prescription Drug Coverage are considered Eligible Expenses under the Major Medical Coverage.

Private Duty Nursing Services
Coverage is provided for services of a practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.) when ordered by a Physician. Nursing services do not include care that is primarily non-medical or custodial in nature such as bathing, exercising, and feeding.

Inpatient Services - Services that are determined to be of such nature or degree of complexity that the Provider's regular nursing staff cannot give them.

Home Services - Services that are determined to require an R.N. or L.P.N.'s continual skills. Benefits are not provided for a nurse who usually lives in the Covered Person's home or is a member of the Covered Person's immediate family.

Prosthetic Appliances
The Plan will cover the purchase, fitting, needed adjustment, repairs, and replacements of prosthetic appliances 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 organ.

Covered prosthetic appliances include prostheses in connection with breast reconstruction following a covered mastectomy procedure. Limited to one prostheses (two if bilateral) every two years.

Second and Third Surgical Opinions – Outpatient
If the Covered Person's Physician recommends that a surgical procedure be performed, the Plan will cover the Covered Person's consultation with another Physician in order to obtain a second surgical opinion. If the second opinion differs from the first opinion, the Plan will cover the Covered Person's consultation with a third Physician to obtain a third surgical opinion. The second and/or third Physician with whom the Covered Person consults must be a specialist in the field of medicine for which the surgery is related.

Skilled Nursing Facility Services
Covered Services for an Inpatient of a Skilled Nursing Facility are the same as those shown in the sections called "Inpatient Hospital Services" and "Inpatient Medical Services."

Coverage is subject to the following requirements:

1. The Covered Person must be admitted to the Skilled Nursing Facility within 24 hours following a Medically Necessary Hospital stay; and
2. Services must be Medically Necessary as a continuation of treatment for the condition for which the Covered Person was hospitalized.

Sleep Disorders
The Plan will cover the diagnosis and treatment of a sleep disorder when services are rendered and billed by a Physician or Other Medical Professional Provider in a covered setting. For purposes of determining what services will be covered in connection with this benefit, a "sleep disorder" will be considered the same as any other Illness under this Plan Document.

Speech Therapy – Outpatient
The Plan will cover Speech Therapy when rendered and billed by a Physician or Speech Therapist in a covered Outpatient setting. As used herein, Speech Therapy means active treatment for improvement of an organic medical condition causing a speech impairment. Treatment must be either post-operative or for the convalescent stage of an active illness or disease.

EXCLUSIONS OR LIMITATIONS FOR YOUR MEDICAL BENEFITS

Some health care services are not covered by the Plan. Excluded services include but are not limited to the following:

1. **Admissions Primarily for Diagnostic Studies**. The Plan will not cover room, board and general nursing care for Hospital admissions mainly for diagnostic studies;

2. **Admissions Primarily for Physical Therapy**. The Plan will not cover room, board and general nursing care for Hospital admissions mainly for Physical Therapy;

3. **Alternative Treatments**. The Plan will not cover treatments that are deemed to be "alternative treatments" including, but not limited to, the following: acupressure, acupuncture, naturopathy, psychosurgery, massage therapy, megavitamin therapy, nutritionally based alcoholism therapy, holistic or homeopathic care including drugs, ecological or environmental medicine, hypnotherapy or hypnotic anesthesia, hippotherapy, and sleep therapy;

4. **Bereavement Counseling**. The Plan will not cover bereavement counseling;

5. **Biofeedback**. The Plan will not cover biofeedback therapy;

6. **Braces and Artificial Limbs**. The Plan will not cover expenses for replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is a sufficient change in the Covered Person's physical condition to make the original device no longer functional;

7. **Certain Counseling Services**. The Plan will not cover marriage counseling, family counseling, pastoral counseling, financial counseling, legal counseling and custodial care counseling, except as specifically set forth in this Plan Document;

8. **Certain Examinations and Services**. The Plan will not cover examinations or medical services the Covered Person receives specifically for the purpose of employment, recreation, insurance, school attendance or licensure;

9. **Cosmetic Services**. The Plan will not cover expenses in connection with or treatment only to improve appearance, except as specifically set forth herein. This exclusion does not include procedures to restore body function or correct deformity from disease, trauma, birth or growth defects or prior therapeutic processes;

10. **Custodial Services**. The Plan will not cover expenses or services for custodial care or for services not needed to diagnose or treat an Injury or Illness and will furthermore not cover Hospital Confinements for custodial care or for custodial treatment for a psychiatric or substance abuse disorder;

11. **Dental Services**. The Plan will not cover expenses for dentistry or dental processes, except as specified;

12. **Dental or Medical Department/Clinic**. The Plan will not cover expenses incurred or services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar persons or group;

13. **Drugs**. The Plan will not cover expenses for over-the-counter or prescription drugs purchased and administered on an Outpatient basis, except as specified herein. Prescription drugs administered while

an Inpatient in a Hospital will be covered under the Plan;

14. **Educational or Training**. The Plan will not cover expenses for services or supplies primarily for educational, vocational or training purposes, except as provided herein;

15. **Exercise Program**. The Plan will not cover expenses for exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by the Plan;

16. **Experimental/Investigative Services**. The Plan will not cover expenses for any services that are Experimental/Investigative;

17. **Eye Glasses**. The Plan will not cover expenses for eye glasses, sunglasses, safety glasses, safety goggles, subnormal vision aids or contact lenses (except for aphakic patients and soft lenses or sclera shells which are intended for use as corneal bandages);

18. **Family Member**. The Plan will not cover expenses or services received from a member of the Covered Persons' household or from an Immediate Family Member. For the purposes of this exclusion, Immediate Family Member means the Covered Employee, his or her spouse, Dependent Child, brother, sister, parent, or brother-in-law, sister-in-law or parent-in-law;

19. **Felony or Illegal Activity**. The Plan will not cover expenses incurred as a result of an Illness or Injury, caused by or contributed to by engaging in an illegal act, by committing or attempting to commit a crime or by participating in a riot or public disturbance;

20. **Genetic Testing**. The Plan will not cover expenses for genetic testing of any kind or for any purpose;

21. **Governmental Unit or Program**. The Plan will not cover expenses to the extent governmental units or governmental programs provide benefits;

22. **Hearing Examinations and Hearing Aids**. The Plan will not cover expenses for hearing examinations or hearing aids or examinations for prescribing or fitting hearing aids, except as provided herein;

23. **Inappropriate Charges**. The Plan will not cover expenses for any charge, expense, service or treatment that has been deemed inappropriate or unnecessary by the AMA or is otherwise deemed inappropriate or unnecessary in accordance with accepted medical standards and practice;

24. **Infertility Services**. The Plan will not cover expenses for in-vitro fertilization, artificial insemination, reversal of sterilization and all other services in connection with an infertility condition except for the covered diagnostic tests in connection with diagnosing the infertility condition. Charges for assisted reproductive technologies including, but not limited to, in vitro fertilization, artificial insemination, GIFT or ZIFT will not be covered;

25. **Legal Obligation to Pay**. The Plan will not cover expenses for which the Covered Person has no legal obligation to pay in the absence of this or like coverage;

26. **Lifestyle Improvement Services**. The Plan will not cover lifestyle improvement services or charges, including, but not limited to, physical fitness programs and equipment, spas, air conditioners, humidifiers, personal hygiene and convenience items, mineral baths, massage and dietary supplements;

27. **Medicare**. The Plan will not cover expenses for which benefits are payable under Medicare Part A, Part B or Part D or would have been payable if a Covered Person had applied for Part A, Part B and/or Part D, except as specified in this Plan Document;

28. **Non-Covered Services**. The Plan will not cover services that are not specified in this Plan Document as Covered Services;

29. **Non-Medically Necessary Services**. The Plan will not cover services or supplies that are not considered to be Medically Necessary as defined herein;

30. **Orthopedic Shoes**. The Plan will not cover orthopedic shoes;

31. **Podiatry Services**. The Plan will not cover expenses for foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular or bone surgery), calluses, toenails, and the like;

32. **Prior to Effective Date or After Termination Date**. The Plan will not cover expenses incurred prior to the Covered Person's Effective Date or after the termination date except as specified in this Plan Document;

33. **Private Room Charges**. The Plan will not cover charges for a private room while the Covered Person is an Inpatient in a Hospital or Skilled Nursing Facility unless such private room is deemed Medically Necessary;

34. **Preventative and Routine Services**. The Plan will not cover preventative services, routine office visits or routine periodical physical examinations for a Covered Person, except as specified in this Plan Document;

35. **Smoking Cessation Programs**. The Plan will not cover expenses for care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung illness such as emphysema or asthma;

36. **Sterilization Reversal**. The Plan will not cover expenses for the reversal of a sterilization procedure;

37. **Telephone Consultations, Missed Appointments, Claim Form Completion**. The Plan will not cover expenses for telephone consultations, missed appointments, or completion of claim forms;

38. **Temporomandibular Joint Dysfunction (TMJ) Devices and Treatment**. The Plan will not cover devices or treatment for TMJ, however, this service may be eligible for coverage through your Dental Plan benefits;

39. **Transplant Services**. The Plan will not cover transplant procedures other than those specified herein;

40. **Transsexual Surgery**. The Plan will not cover expenses for transsexual surgery or any treatment leading to or in connection with transsexual surgery. This exclusion includes gender dysphoria or sexual reassignment or change, medications, implants, hormone therapy, surgery, medical or psychiatric treatment in connection with such surgery or treatment;

41. **Veteran's Administration Facility**. The Plan will not cover services received by veterans for any disease or injury suffered as a result of or while in military service to the extent that such services can be performed by a Veterans Administration Hospital or Facility;

42. **Vision Services**. The Plan will not cover expenses for eye care, including radial keratotomy or other eye surgery to correct refractive disorders, for eye examinations, except as specified herein, including lenses for the eyes and examinations for the fitting of lenses. In addition, eye examinations for any occupational condition, ailment or Injury arising out of or in the course of employment will not be covered. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal

bandages;

43. **War**. The Plan will not cover expenses or charges for Injury or Illness that occurs as a result of any act of war, declared or undeclared;

44. **Weight Control or Related Treatments**. The Plan will not cover exercise programs, dietary products, supplies or treatment for controlling or reducing weight, obesity treatments, including but not limited to any surgical procedures to correct obesity or morbid obesity except as specified in this Plan Document;

45. **Wigs**. The Plan will not cover expenses for care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician;

46. **Workers' Compensation**. The Plan will not cover expenses that are for Injury or Illness arising in the course of employment if whole or partial compensation is available under workers' compensation or any other laws of any governmental unit. This applies whether or not the Covered Person claims such compensation or recovers losses from a third party.

PRESCRIPTION DRUG BENEFITS

The Plan provides prescription drug benefits but such benefits are not administered by HealthSCOPE Benefits, Inc. Contact the Employer for a description of the prescription drug benefits, and all related terms and conditions thereof, that are available under the City of Toledo, Ohio Employee Health Benefit Plan.

DENTAL BENEFITS

The Plan provides dental benefits but such benefits are not administered by HealthSCOPE Benefits, Inc. Contact the Employer for a description of the dental benefits, and all related terms and conditions thereof, that are available under the City of Toledo, Ohio Employee Health Benefit Plan.

VISION BENEFITS

The Plan provides vision benefits but such benefits are not administered by HealthSCOPE Benefits, Inc. Contact the Employer for a description of the vision benefits, and all related terms and conditions thereof, that are available under the City of Toledo, Ohio Employee Health Benefit Plan.

GENERAL EXCLUSIONS

The following exclusions and limitations are the General Exclusions under the Plan and apply to the entire Plan.

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

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

3. **Claims Time Frames**. The Plan will not cover charges for claims not received within the Plan's filing limit deadlines as specified under the section entitled Claims Information;

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

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

6. **Criminal Act**. The Plan will not cover charges for services and supplies incurred as a result of an Illness or Injury, caused by or contributed to by engaging in an illegal act, by committing or attempting to commit a crime or by participating in a riot or public disturbance;

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

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

9. **Experimental/Investigative**. The Plan will not cover charges for services and supplies which are either experimental or investigational or not Medically Necessary, except as provided herein;

10. **Excess of Provider's Reasonable Charge**. The Plan will not cover charges for services and supplies for treatment which are in excess of the Provider's Reasonable Charge (except as otherwise stated herein);

11. **Family Member**. The Plan will not cover expenses or services received from a member of the Covered Person's household or from an Immediate Family Member. For the purposes of this exclusion, Immediate Family Member means the Covered Employee, his or her spouse, brother, sister, parent or the Dependent Child. Immediate Family Member also includes the brother sister, parent or Dependent Child of the employee's spouse;

12. **Government Owned/Operated Facility**. The Plan will not cover charges for services and supplies in a hospital owned or operated by the United States government or any government outside the United States in which the Covered Person is entitled to receive benefits, except for the reasonable cost of services and supplies which are billed, pursuant to Federal Law, by the Veterans Administration or the Department of Defense of the United States, for services and supplies which are eligible herein and which are not incurred during or from service in the Armed Forces of the United States or any other country;

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

14. **Legal Obligation**. The Plan will not cover charges for services and supplies for which the Covered Person has no legal obligation to pay or for which no charge has been made;

15. **Maximum Benefit**. The Plan will not cover charges for services and supplies which exceed the maximum benefit, as shown in the Schedule of Benefits or Eligible Expenses;

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

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

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

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

20. **Professional Medical Standards**. The Plan will not cover charges for services and supplies which are not provided in accordance with generally accepted professional medical standards or for experimental treatment;

21. **Self-Inflicted Injury**. The Plan will not cover charges for attempted suicide or intentional self-inflicted injury, unless the injury was sustained as the result of a medical condition or domestic violence. As used herein, a medical condition includes a physical or mental health condition;

22. **Subrogation Failure**. The Plan will not cover charges for an Illness or Injury suffered by a Covered Person due to the action or inaction of any party if the Covered Person fails to provide information as specified under Subrogation;

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

24. **Travel Expenses**. The Plan will not cover charges for travel, whether or not recommended by a Physician, except as provided herein;

25. **War.** The Plan will not cover charges for services, supplies or treatment related to Illness, Injury, or disability caused by or attributed to an act of war, act of terrorism, riot, civil disobedience, insurrection, nuclear explosion or nuclear accident. “War” means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized military forces;

25. **Work-Related Illness or Injury**. The Plan will not cover charges for services and supplies for any condition, disease, defect, ailment, or accidental Injury arising out of and in the course of employment (for wage or profit) whether or not benefits are available under any Workers’ Compensation Act or other similar law. This Exclusion applies if the Covered Person receives the benefits in whole, part or even if there is no Workers’ Compensation coverage in place. This Exclusion also applies whether or not the Covered Person claims the benefits or compensation.

ELIGIBILITY PROVISIONS

ELIGIBLE EMPLOYEES

Full-Time and Part-Time Employees as defined in the section entitled "Definitions" must meet the following eligibility requirements in order to be considered an Eligible Employee under the Plan:

1. Full-Time Employees must regularly work 30 hours per week or the number of hours per week as stated in their respective collective bargaining agreement and/or the Toledo Municipal Code;
2. Part-Time Employees must regularly work the number of hours per week as stated in their respective collective bargaining agreement and/or the Toledo Municipal Code;
3. The employee cannot be a temporary employee;
4. The employee must be Actively Working; and
5. If applicable, the employee must make the required contribution towards the coverage.

Eligibility for an Eligible Employee who is not Actively Working due to an Employer Approved Leave of Absence for less than 30 days or an unpaid FMLA leave up to 12 weeks will continue in accordance with the section entitled "Continued Coverage Provisions."

Waiver of Coverage – Full-Time Employees covered by another health care plan due to marriage or other reasons may waive Coverage under the City of Toledo's Plan and receive additional life insurance coverage in the amount of $25,000. This Waiver of Coverage option shall also be extended to City of Toledo employees whose Spouses are also employed by the City of Toledo.

ELIGIBLE DEPENDENTS

The following persons are considered to be Eligible Dependents:

1. The spouse of the Covered Employee. As used herein, "spouse" includes an individual of the same or opposite sex to whom the Covered Employee is legally married.

   Spouses who are both employed by the City of Toledo must jointly enroll for Family Coverage under the Plan as an Employee and a Dependent Spouse.

   If the Spouse of a City of Toledo employee is employed by a different employer and coverage is available through his/her employer's plan, the Spouse will not be eligible for coverage under this Plan. Special consideration will be given to cases of demonstrated hardship due to excessive premiums based on spousal income. An "excessive premium" is identified in the following circumstances:

   a. A Spouse whose gross base income is less than $30,000 who is required to pay 30% or more of their premium cost for "employee only" primary coverage;
   b. A Spouse whose gross base income is more than $30,001 but less than $50,000 must accept their employer's plan for "employee only" coverage. However, if the Spouse is required to pay 40% or more of their premium cost for "family" coverage, the eligible dependents may be eligible to enroll in this Plan as primary and the Spouse may be eligible for coverage under this Plan as secondary;
   c. A Spouse whose gross base income is more than $50,001 must accept their employer's plan coverage and must carry any eligible dependents in accordance with the "birthday rule". The Spouse and dependents may be eligible for secondary coverage through this Plan.

2. A Domestic Partner of the Covered Employee. This provision does not apply to employees who are members of Teamsters Local 20, Toledo Patrolman's Association (TPPA), AFSCME Local 7, or AFSCME Local 7 Communication Operators.

   As used herein, "Domestic Partner" includes:

   Individuals who meet the definition of Domestic Partner, have submitted a notarized Domestic Partnership Affidavit, and have provided proof that:

   a. Both the Covered Employee and Domestic Partner share a common residence;
   b. Both the Covered Employee and Domestic Partner have been in an intimate relationship for at least six consecutive months prior to applying for benefits and have allowed six months or more to pass since the termination of any previous domestic partnership (unless termination due to death of domestic partner);
   c. Both the Covered Employee and Domestic Partner share responsibility for each other's common welfare;
   d. Neither the Covered Employee or Domestic Partner is legally married;
   e. Neither the Covered Employee or Domestic Partner is part of an existing domestic partnership with any third party;
   f. The Covered Employee and Domestic Partner are 18 years of age or older; and
   g. The Covered Employee and Domestic Partner are not related to one another by blood.

   The Covered Employee must submit to the Human Resources Department:

   a. A copy of the signed declaration of domestic partnership registered with the Clerk of Council, City of Toledo
   b. A signed, notarized Affidavit of Domestic Partnership for Benefits Coverage
   c. Copy of joint mortgage or joint lease agreement
   d. Signed, completed application/enrollment forms for benefits coverage
   e. Two of the following documents for verification (may include, but is not limited to):
      1. Proof of joint bank account(s)
      2. Proof of joint ownership of a vehicle
      3. Proof that the domestic partner is the primary beneficiary of a life insurance policy or retirement plan
      4. Proof of joint liabilities; such as a bank loan(s) or joint credit card(s)
      5. Other forms of evidence of significant joint financial interdependency as may be acceptable to the Director of Human Resources
      6. Evidence of durable powers of attorney for property or health signed to the effect that we have granted powers to one another
   f. One of the following documents that is dated within 30 days of your application for benefits:
      1. Bank statement, either a joint statement or individual accounts for each partner showing the shared residential address
      2. Paycheck stubs for both partners for showing the shared residential address
      3. Driver's license, State-issued identification or automobile registration for each partner showing the shared residential address
      4. Tax return for each partner listing the shared residential address as address of record

   A Child of a Covered Employee's Domestic Partner. As used herein, "Children of Domestic Partner" include children who meet the following criteria:

   a. The child is not employed and has no benefits available to him or her;
   b. The child is a natural child or child who has been placed under the legal guardianship of the Domestic Partner; and
   c. The child is no older than 26. For children over the age of 26, the Human Resources Department should be contacted at 419-245-1500.

NOTE: The City of Toledo encourages employees seeking to participate in this benefit to consult an attorney and/or tax advisor concerning any possible legal obligations that may be created by the affidavit or receiving benefits. The City makes no representations as to any legal or financial consequences a beneficiary may incur through participation and accepts no responsibility for any legal or financial consequences.

3. A Dependent Child of the Covered Employee. As used herein, "Dependent Child" includes:

   a. An Employee's child, regardless of the child's dependency, residency, student or financial dependence status, who is the natural child, step child, legally adopted child of the employee or spouse or a child who is in the legal guardianship of the employee or employee's spouse pursuant to an interlocutory order of adoption and who is under the age of 26;

   b. A child who is subject of a National Medical Support Notice will be considered a Dependent Child under this Plan. The NMSN entitles such child to Coverage even if (a) such child does not reside with the Covered Employee or is not dependent on the employee for support, and (b) even if the employee does not enroll for Coverage under the Plan or does not have legal custody of the child. If the Eligible Employee has not satisfied the applicable Waiting Period, the Plan must cover the Dependent Child upon the Eligible Employee's completion of such Waiting Period. All other applicable enrollment provisions of the Plan (e.g., Dependent Limiting Age, benefit options, right to continued Coverage, etc.) which are available to Covered Employees or other Covered Dependents shall be made available to the Dependent Child who is eligible pursuant to a National Medical Support Notice; and

   c. An unmarried child who is over the Dependent Limiting Age of the Plan, who is permanently disabled upon attainment of the Dependent Limiting Age and who meets the dependency requirements set forth in this paragraph. The Dependent Child must be incapable of self-sustaining employment by reason of mental retardation or mental or physical handicap and primarily dependent upon the Covered Employee for support and maintenance. The Covered Employee must notify the Employer of the child's disability within 31 days after the Dependent Child reaches the Dependent Limiting Age. Such notification shall include proof satisfactory to the Employer of the Dependent Child's incapacity and dependence upon the Covered Employee. After a two-year period following the date the Dependent Child meets the Dependent Limiting Age, the employee may be required to provide additional proof of the child's continued dependence and incapacity.

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

   The Plan Administrator has the right to request information needed to determine the patient's eligibility when a claim is filed.

   If you acquire a Dependent while you are eligible for coverage for Dependents, coverage for the newly acquired dependent will be effective on the first day of the month following the date the Dependent becomes eligible, provided you make written application for the Dependent and agree to make any required contributions, within 31 days of the date of eligibility.

ELIGIBILITY DETERMINATIONS UNDER HIPAA

Federal Law, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), prohibits the Plan Sponsor from denying Coverage under the Plan based on any of the following health-related factors:

1. Health status;
2. Medical condition (including both physical and mental illnesses);

3. Receipt of healthcare;
4. Medical history;
5. Genetic information;
6. Evidence of insurability (including conditions arising out of acts of domestic violence); and
7. Disability.

APPLYING FOR COVERAGE AND EFFECTIVE DATES

ENROLLMENT PERIOD AND EFFECTIVE DATES - FOR NEW HIRES AND REHIRES

An Eligible Employee shall be eligible to enroll for Coverage under the Plan for himself and any eligible Dependents upon completion of the applicable probationary period, if any, or as of the Eligible Employee's date of hire, date of rehire, or change of eligibility. The Eligible Employee must complete and submit an enrollment application to the Plan. If such application is made within 30 days after the Eligible Employee's date of eligibility, Coverage shall become effective on the date the application was made.

If an Eligible Employee submits an enrollment application for Coverage under the Plan later than 30 days but within 90 days after the Eligible Employee's date of eligibility, Coverage shall become effective on the first day of the month following the Plan's receipt of the application.

If an Eligible Employee submits an enrollment application for Coverage under the Plan later than 90 days after the Eligible Employee's date of eligibility, the Eligible Employee shall be considered a Late Enrollee and, except as provided under the section entitled "Special Enrollment Periods" below, Coverage for the Eligible Employee shall not become effective until the first day of the month following the end of the next Open Enrollment Period.

If an Eligible Employee is not Actively Working on the day Coverage would otherwise become effective, the Effective Date of Coverage will be postponed to the day the Eligible Employee returns to work. This does not apply if the Eligible Employee is not Actively Working due to the existence of a health condition.

SPECIAL ENROLLMENT PERIODS

There are a number of circumstances that qualify as Special Enrollment Periods. The following events qualify as Special Enrollment Periods under the Plan:

1. Loss of Other Coverage: Coverage for Eligible Employees who decline enrollment when initially eligible under the Plan due to existing medical benefits under another health plan and state in writing at such time that this is the reason for declining enrollment, subsequently lose coverage under the other plan, and complete and submit an application within 30 days following the termination of coverage, shall be made effective on the date of the loss of the other coverage, as set forth below. In this event, loss of coverage must be due to:

    a. Exhaustion of COBRA benefits;
    b. Loss of eligibility under the prior coverage; or
    c. Termination of contributions by the employer under the prior plan.

    As used herein, "loss of eligibility" includes but is not limited to the following types of losses:

    a. Loss of eligibility under the other coverage due to divorce, dissolution, legal separation. In this instance, the Eligible Employee and any Dependent Children would be eligible to enroll;
    b. Loss of eligibility under the other coverage due to cessation of dependency status. In this instance, the Eligible Employee, spouse, and any Dependent Children would be eligible to enroll;
    c. Loss of eligibility under the other coverage due to death of the employee. In this instance, the Eligible Employee (whose spouse has died) and any Dependent Children would be eligible to enroll;
    d. Loss of eligibility under the other coverage due to termination of employment or reduction of hours. In this instance, the Eligible Employee, spouse, and any Dependent Children would be eligible to

enroll;

e. Loss of eligibility under the other coverage because the individual no longer resides in the service area. In this instance, the Eligible Employee, spouse, and any Dependent Children would be eligible to enroll;
f. Loss of eligibility under the other coverage because the overall maximum benefit has been reached. In this instance, the Eligible Employee, spouse, and any Dependent Children would be eligible to enroll;
g. Loss of eligibility under the other coverage because the other employer ceases to provide health care benefits to similarly situated individuals. In this instance, the Eligible Employee, spouse, and any Dependent Children would be eligible to enroll.

This Special Enrollment Period also applies to Dependents of Eligible Employees who decline enrollment when initially eligible under the Plan due to existing medical benefits under another health plan and state in writing at such time that this is the reason for declining enrollment, provided application is submitted within the time frame set forth above and loss coverage under the other plan was for one of the reasons set forth above.

2. Birth or Adoption: In the event of a birth of a child or adoption or placement for adoption of a child, the newly acquired child and the Eligible Employee and spouse, if not covered, will be eligible to enroll for Coverage under this provision. In this event, application must be completed and submitted to the Plan within 31 days following the date the dependent child becomes an Eligible Dependent. Coverage shall be made effective on the birth date of the child, or for an adopted child or child placed for adoption, on the date the Dependent Child becomes an Eligible Dependent. In this instance, in addition to the newly acquired Dependent Child under this provision, the Eligible Employee and the spouse, who are otherwise eligible under the Plan, and who did not enroll under the Plan when initially eligible or during a subsequent open enrollment period, if applicable, are permitted to enroll during this Special Enrollment Period.

3. Marriage: Finally, in the event Covered Employee marries after his or her Coverage has become effective, the employee may add his or her spouse to the Coverage by completing and submitting to the Plan an application within 31 days of the event. In this event, Coverage will be effective on the date of the marriage. In this instance, the Eligible Employee who is otherwise eligible under the Plan, and who did not enroll under the Plan when initially eligible or during a subsequent open enrollment period, if applicable, and any Dependent child(ren) who is/are acquired as the result of the marriage, are permitted to enroll during this special enrollment period.

LATE ENROLLMENT

Employees or Dependents who fail to submit an enrollment application during the time periods set forth above will be considered Late Enrollees. Late Enrollees will be permitted to enroll for Coverage during the Plan's Open Enrollment Period.

OPEN ENROLLMENT PERIOD

Open Enrollment Period is the period designated by the Employer during which the Employee may elect Coverage for himself and any eligible Dependents if he is not covered under the Plan and does not qualify for a Special Enrollment as described herein. During this Open Enrollment Period, an Employee and his Dependents who are not covered under this Plan must complete and submit an enrollment form for coverage.

The Open Enrollment Period under this Plan occurs during the month of May each calendar year. Coverage for Employees and Dependents who enroll during this Open Enrollment Period will be effective the first day of June immediately following the last day of the Open Enrollment Period.

EFFECT OF SECTION 125 TAX REGULATIONS ON THIS PLAN

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

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

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

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

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

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

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

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

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

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

Revocation Due to Reduction in Hours: The Participant may revoke coverage under this Plan if he or she

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

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

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

TERMINATION PROVISIONS

TERMINATION OF EMPLOYEE COVERAGE

Coverage will terminate for the Covered Employee and his/her Covered Dependents on the earliest of the following:

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

The employee may be eligible for continued Coverage under COBRA or another Continued Coverage option as described in the section entitled “Continuation of Coverage.”

TERMINATION OF DEPENDENT COVERAGE

Coverage will terminate for Covered Dependents on the earliest of the following:

1. The date the Plan terminates;
2. The date the Employee’s Coverage terminates;
3. The last day of the month of the Employee’s death;
4. The date a Dependent loses dependency status under the Plan;
5. The date of a legal separation or divorce in the case of a Spouse of a Covered Employee who is legally separated or divorced from the Covered Employee. Such Spouse must have met all legal requirements;
6. For a Dependent of a Part-Time Employee, the end of the period for which any required contribution by the Employer or Employee has been made if payment of any required contribution for Coverage has not been submitted when due;
7. For a Domestic Partner on the last day of the month of the date of the Termination Notice was filed in the Clerk of Council Office. Note: Employee must wait at least six months from the date on the Termination Notice before registering again for domestic partnership benefits, unless the former domestic partnership was dissolved due to death of the Domestic Partner;
8. Immediately after a Covered Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

The Dependent may be eligible for continued Coverage under COBRA or another Continued Coverage option as described in the section entitled “Continuation of Coverage.”

NOTICE REGARDING YOUR RIGHTS UPON TERMINATION OF COVERAGE

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

PROHIBITION ON RESCISSION

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

CONTINUED COVERAGE PROVISIONS

CONTINUED COVERAGE DURING UNPAID EMPLOYER-APPROVED LEAVE OF ABSENCE (OTHER THAN FMLA)

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

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

CONTINUATION COVERAGE FOR DOMESTIC PARTNERS

Domestic Partners and/or their dependents may be eligible for Domestic Partner Continuation Coverage. Employees should:

a. Ensure that eligible Domestic Partners and/or any eligible children apply for Domestic Partner Continuation Coverage within 60 days of the date that eligibility for benefits coverage ends. If electing Domestic Partner Continuation Coverage, benefit payments must continue to be made to the City of Toledo to prevent a lapse in benefits coverage.
b. Upon election and determined eligibility of Domestic Partner Continuation Coverage, payments must be made within the grace period (by the 15th of the month in which the coverage is incurred) for Domestic Partner Continuation Coverage benefits to continue.
c. Note that failure to notify HR within the 60-day time frame or failure to provide timely payments will result in forfeiture of Domestic Partner Continuation Coverage.

CONTINUED COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

Under the Family and Medical Leave Act of 1993 ("FMLA"), an employer who is subject to FMLA requirements must provide to the employee unpaid leave of absence for 12 weeks during each 12-month period in certain circumstances.

During an FMLA leave of absence, Health Care Coverage under the Plan will continue for the FMLA period. Once the Covered Employee has exhausted the 12 weeks of continued Coverage under this section, he/she may be eligible for additional continued Coverage under COBRA.

If the Covered Employee requires additional details concerning FMLA, the Covered Employee should contact the Employer or Plan Sponsor.

CONTINUED COVERAGE FOR EMPLOYEES IN UNIFORMED SERVICES

In the event the Covered Employee is required to be absent from work as the result of service in the Uniformed Services, Coverage for Medical Benefits may be continued for the Covered Employee in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended.

As used herein, Uniformed Services means the Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Period of Continued Coverage Under the USERRA Provision

Coverage may be continued for the Covered Employee and his or her covered Dependents for a period which shall equal the lesser of the following:

1. The 24-month period beginning on the date on which the employee's absence begins; or

2. The period beginning on the date on which the employee's absence begins and ending on the day after the date on which the employee fails to apply for or return to a position of employment.

Notification and Election

The Covered Employee must notify the Employer in writing and submit to the Employer the entire monthly payment, as such may be applicable, if he or she wishes to continue Coverage. The Covered Employee's election and first month's monthly payment is due at the earliest of the following:

1. If the Employer notifies the Covered Employee of his or her right to continue Coverage before Coverage would otherwise end, then the Covered Employee's election and monthly payment must be submitted to the Employer no later than 31 days after the date the Covered Employee's Coverage would have otherwise terminated; or

2. If the Employer notifies the Covered Employee of his or her right to continue Coverage after Coverage has terminated, then the Covered Employee's election and monthly payment must be submitted within 31 days following the date of notification by the Employer.

Cost of Continued Coverage

The Employer may require the Covered Employee or Dependent to pay the full cost of the continued Coverage. The monthly payment may not exceed 102% of the monthly payment being charged by the Employer for similarly situated employees. However, if the employee performs service in the Uniformed Services for less than 31 days, such employee may not be required to pay more than 100% of the monthly payment being charged by the Employer for similarly situated employees.

Termination of Continued Coverage

The continuation of Coverage ends at the earliest of the following:

1. When the Covered Person becomes covered under another group health plan without pre-existing condition limitation;
2. Upon the expiration of the continued period of Coverage as set forth herein;
3. When the required payments are not received on a timely basis; or
4. When the health plan is terminated and not replaced by the Employer with another health plan.

COBRA CONTINUATION COVERAGE

A federal law commonly referred to as COBRA requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of benefit ("COBRA Continuation Coverage") at group rates in certain instances where Coverage under the Plan would otherwise end. This notice is intended to inform the Covered Person, in a summary fashion, of the rights and obligations under the COBRA Continued Coverage provisions of the law. If the Covered Person does not choose COBRA Continuation Coverage, the Coverage under the Plan will end.

COBRA Continuation Coverage applies to the medical benefits under the Plan and also applies to any dental and/or vision coverage if covered under the Plan prior to the Qualifying Event. The Covered Person will only be entitled to receive COBRA Continuation Coverage for the coverage(s) (s)he elects to continue during the election process as described herein.

Qualified Beneficiaries

As used herein, a Qualified Beneficiary is a Covered Person who loses Coverage under the Plan as the result of a Qualifying Event.

Qualifying Events

Qualifying Events are any one of the following events, which would normally result in termination of Coverage. These events will qualify a Covered Person to continue coverage as a Qualified Beneficiary beyond the termination date described in the Plan Document. The Qualifying Events are listed below.

1. Death of the Covered Employee.
2. The Covered Employee's termination of employment (other than termination for gross misconduct) or reduction in work hours to less than the minimum required for Coverage under the Plan. This includes Covered Employees whose employment has terminated following the last day of leave under the Family Medical Leave Act.
3. Divorce or legal separation from the Covered Employee.
4. The Covered Employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan.
5. A Dependent child no longer meets the eligibility requirements of the Plan.
6. A covered Retiree and their covered Dependents whose benefits were substantially reduced within one year of the Employer filing for Chapter 11 bankruptcy.

Notification Requirements

There are a number of notification requirements under COBRA. First, the Claims Administrator must be alerted to a Qualifying Event in order to offer COBRA Continuation Coverage to Qualified Beneficiaries. This notice must be submitted in writing to the Claims Administrator, either by the Employer, or by the Covered Employee or a Dependent. The nature of the Qualifying Event determines which party must notify the Claims Administrator. Second, once the Claims Administrator is notified of a Qualifying Event, the Claims Administrator will provide notices to the COBRA Beneficiary. The notification requirements established under COBRA are described in this COBRA Continuation Coverage section.

Notification by Covered Employee or Dependent

The Covered Employee or Dependent must notify the Claims Administrator when eligibility for COBRA Continuation Coverage results from one of the following events:

1. Divorce or legal separation from the Covered Employee; or
2. A Dependent child no longer meets the eligibility requirements of the Plan.

The Covered Employee or Dependent must provide this notice to the Claims Administrator within 60 days of either the Qualifying Event or date of loss of Coverage, as applicable to the Plan.

For individuals who are requesting an extension of COBRA Continuation Coverage due to a disability, the individual person must submit proof of the determination of disability by the Social Security Administration to the Employer within the initial eighteen month COBRA Continuation Coverage period and no later than 60 days after the Social Security Administration's determination. When the Social Security Administration has determined that a person is no longer disabled, Federal law requires that person to notify the Claims Administrator within 30 days of such change in status.

These notification requirements also apply to an individual who, while receiving COBRA Continuation Coverage, has a second or subsequent Qualifying Event. Refer to the section entitled Period of Continued Coverage for additional information.

The Covered Employee or Dependent, or their representative, must deliver this notice in writing to the Claims Administrator. The notice must identify the Qualified Beneficiaries, the Plan, the Qualifying Event, the date of the Qualifying Event, and include appropriate legal documentation to confirm the Qualifying Event. The Claims Administrator shall require that any additional information be provided, when necessary to validate the Qualifying Event, before deeming the notice to be properly submitted. If the requested information is not provided within the time limit set forth above the Plan Administrator reserves the right to reject the deficient notice, which means that the individual has forfeited their rights to COBRA Continuation Coverage.

To protect their rights, it is very important that Covered Employees and Dependents keep the Claims Administrator informed of their current mailing address. Any notices will be sent to individuals at their last known address. It is the responsibility of Covered Employees and Dependents to advise the Claims of any address changes in a timely manner, in order to ensure that notices, such as those regarding their rights under COBRA, are deliverable.

Failure to provide notice to the Claims Administrator in accordance with the provisions of this notice requirement will result in the person forfeiting their rights to COBRA Continuation Coverage under this provision.

Notification by Employer

The Employer is responsible for notifying the Claims Administrator when eligibility for COBRA Continuation Coverage results from any events other than divorce or legal separation, or a Dependent becoming ineligible.

The Employer shall provide this notice to the Claims Administrator within 30 days of either the Qualifying Event or date of loss of coverage, as applicable to the Plan. The Employer must include information that is sufficient to enable the Claims Administrator to determine the Plan, the Covered Employee, the Qualifying Event, and the date of the Qualifying Event.

The Employer must deliver this notice in writing to the Claims Administrator. The notice must identify the Qualified Beneficiaries, the Plan, the Qualifying Event, the date of the Qualifying Event, and include appropriate legal documentation to confirm the Qualifying Event. The Claims Administrator shall require that any additional information be provided, when necessary to validate the Qualifying Event, before deeming the notice to be properly submitted.

Notification by Plan Administrator

Election Notice: Once the Claims Administrator receives proper notification that a Qualifying Event has

occurred, COBRA Continuation Coverage shall be offered to each of the Qualified Beneficiaries by means of a COBRA Election Notice. The time period for providing the COBRA Election Notice shall generally be fourteen days following receipt of notice of the Qualifying Event. This time period may be extended to 44 days under certain circumstances where the Employer is also acting as the Plan Administrator.

Notice of Ineligibility: In the event that the Plan Administrator determines that the Covered Employee and/or Dependent(s) are not entitled to COBRA coverage, the Claims Administrator shall notify the Covered Employee and/or Dependent(s). This notice shall include an explanation of why the individual(s) may not elect COBRA Continuation Coverage. A notice of ineligibility shall be sent within the same time frame as described for a COBRA Election Notice.

Notice of Early Termination: The Claims Administrator shall provide notice to a Qualified Beneficiary of a termination of COBRA Continuation Coverage that takes effect on a date earlier than the end of the maximum period of COBRA Continuation Coverage that is applicable to the Qualifying Event. The Claims Administrator shall notify the Qualified Beneficiary as soon as possible after determining that coverage is to be terminated. This notice shall contain the reason coverage is being terminated, the date of termination, and any rights that the individual may have under the Plan, or under applicable law, to elect alternative group or individual coverage.

Election Of Coverage

Upon receipt of Election Notice from Claims Administrator, a Qualified Beneficiary has 60 days from the date the notice is sent to decide whether to elect COBRA Continuation Coverage. Each person who was covered under the Plan prior to the Qualifying Event has a separate right to elect COBRA Continuation Coverage on an individual basis, regardless of family enrollment. For example, the employee's spouse may elect COBRA Continuation Coverage even if the employee does not select the coverage. COBRA Continuation Coverage may be elected for one, several or all dependent children who are Qualified Beneficiaries and a parent may elect COBRA Continuation Coverage on behalf of any dependent child.

In considering whether to elect COBRA Continuation Coverage, the Qualified Beneficiary should take into account that a failure to continue coverage may affect future rights under federal law. For example, the Covered Person may lose the right to be provided with a reduction in a pre-existing condition limitation if the gap in coverage is greater than 63 days. The Covered Person also has special enrollment rights under HIPAA which allow him or her to enroll in another group health plan for which (s)he is otherwise eligible when Coverage under this Plan terminates due to a Qualifying Event. The Covered Person also has the same special enrollment rights at the end of the COBRA Continuation Coverage if (s)he receives continued coverage for the maximum period available under COBRA.

If the Qualified Beneficiary chooses to have continued coverage, (s)he must advise the Claims Administrator in writing of this choice. This is done by submitting a written COBRA Election Notice to the Claims Administrator. The Claims Administrator must receive this written notice no later than the last day of the 60 day period. If the election is mailed, the election must be postmarked on or before the last day of the 60 day period. This 60 day period begins on the later of the following:

1. The date coverage under the Plan would otherwise end; or
2. The date the notice is sent by the Plan Administrator notifying the person of his or her rights to COBRA Continuation Coverage.

Period of Continued Coverage

The law requires that a Qualified Beneficiary who elects COBRA Continuation Coverage be afforded the opportunity to maintain COBRA Continuation Coverage for 36 months unless (s)he loses Coverage under the Plan because of a termination of employment or reduction in hours. In that case, the required COBRA Continuation Coverage period is 18 months.

This 18-month period may be extended if a subsequent or second Qualifying Event (for example, divorce, legal separation, an employee becoming entitled to Medicare or death) occurs during that 18-month period. A second event may be a valid Qualifying Event only if it would have been a valid first Qualifying Event. That is, a second Qualifying Event shall qualify only if it would have caused a Covered Person to lose Coverage under the Plan if the first Qualifying Event had not occurred. A second or subsequent Qualifying Event is therefore limited to the following Qualifying Events:

1. Death of a Covered Employee;
2. Divorce or legal separation between the spouse and the Covered Employee; and
3. Dependent Child's loss of Dependent status under the Plan.

The Covered Employee's Medicare entitlement may also be considered a subsequent or second Qualifying Event for any Dependents who are Qualified Beneficiaries following the first Qualifying Event, but only if the Medicare entitlement would have resulted in loss of Coverage under the Plan had the first Qualifying Event not occurred.

Under no circumstances, however, will Coverage last beyond 36 months from the date of the event that originally made the Covered Person eligible to elect Coverage. Only a person covered prior to the original Qualifying Event or a child born to or Placed for Adoption with a Covered Employee during a period of

COBRA continuation is eligible to continue coverage beyond the original 18-month period as the result of a subsequent Qualifying Event. Any other Dependent acquired during COBRA Continuation Coverage is not eligible to continue coverage beyond the original 18-month period as the result of a subsequent Qualifying Event.

Period Of Continued Coverage For Disabled Person

A person who is totally disabled may extend COBRA Continuation Coverage from eighteen months to 29 months. Non-disabled family members may also elect to extend COBRA Continuation Coverage even if the disabled individual does not elect to extend his coverage.

The disabled person must be disabled for Social Security purposes at the time of the Qualifying Event or within 60 days thereafter. The disabled person must submit proof of the determination of disability by the Social Security Administration to the Employer within the initial eighteen month COBRA Continuation Coverage period and no later than 60 days after the latest of the following:

1. the date of the Social Security Administration's determination;
2. the date of the Qualifying Event;
3. the date the Qualified Beneficiary would lose Coverage under the plan; or
4. the date the Qualified Beneficiary is informed of the obligation to provide the disability notice, either through this Plan Document or the initial COBRA Notice provided by the Employer.

Refer to the guidelines set forth in the subsection Notification Requirements.

When the Social Security Administration has determined that a person is no longer disabled, Federal law requires that person to notify the Claims Administrator within 30 days of such change in status.

Cost Of Coverage and Payments

The Employer requires that Qualified Beneficiaries pay the entire costs of their COBRA Continuation Coverage, plus a two percent administrative fee. This must be remitted to the Employer or the Employer's designated representative, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.

The premium for an extended COBRA Continued Coverage period due to a total disability may also be higher than the premium due for the first 18 months. If the disabled person elects to extend coverage the Employer may charge 150% of the contribution during the additional 11 months of COBRA Continuation Coverage. If only the non-disabled family members elect to extend coverage the Employer may charge 102% of the contribution.

For purposes of determining monthly costs for continued coverage, a person originally covered as an Employee or as a spouse will pay the rate applicable to a Covered Employee if Coverage is continued for himself alone. Each child continuing Coverage independent of the family unit will pay the rate applicable to a Covered Employee.

Timely payments must be made for the continued Coverage. The initial payment must be made within 45 days after the date the person notifies the Employer that he has chosen to continue Coverage. The initial payment must be the amounts needed to provide Coverage from the date continued benefits begin, through the date of election.

Thereafter, payments for continued Coverage are to be made monthly. These monthly payments are due on the first day of each month. If the premium is not received by the first day of the month, the Employer will consider that Coverage has been allowed to terminate until the monthly payment has been received. However, a 30 day grace period is allowed for receipt of this monthly payment before the termination becomes final. Claims will be denied until the monthly premium payment is received.

There shall be no grace period for making payments, other than the grace period described above.

If the initial payment, or any subsequent monthly payment, received is short by an insignificant amount (the lesser of $50 or 10% of the premium), the Covered Person will be sent a notice at the Covered Person's last known address stating that the remaining amount due must be sent within 30 days to continue Coverage under COBRA if the Plan Administrator requires the payment to be made in full. The Plan Administrator may also choose to accept the payment, which was short by an insignificant amount, as payment in full. Should you have any questions in regards to how payment short by an insignificant amount will be handled under this Plan, please contact the Plan Administrator.

When Continuation Coverage Begins

When COBRA Continuation Coverage is elected and the contributions paid within the time period required coverage is reinstated back to the date of the Qualifying Event or loss of coverage, as applicable to the Plan, so that no break in Coverage occurs. Coverage for Dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

Dependents Acquired During Continuation

A spouse or Dependent child newly acquired during COBRA Continuation Coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during COBRA Continuation Coverage. A Dependent acquired and enrolled after the original Qualifying Event, other than a child born to or Placed for Adoption with a Covered Employee during a period of COBRA Continuation Coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of Coverage.

End Of COBRA Continuation Coverage

COBRA Continuation Coverage will end on the earliest of the following dates:

1. 18 months from the date continuation began because of a reduction of hours or termination of employment of the Covered Employee.

2. 36 months from the date continuation began for Dependents whose coverage ended because of the death of the Covered Employee, divorce or legal separation from the Covered Employee, the child's loss of Dependent status, or Medicare entitlement.
3. The end of the period for which contributions are paid if the Covered Person fails to make a payment on the date specified by the Employer or by the end of the grace period.
4. The date coverage under this Plan ends and the Employer offers no other group health benefit plan.
5. The date the Covered Person first becomes entitled to Medicare after the COBRA election.
6. The date the Covered Person first becomes covered under any other group health plan without regard to a pre-existing condition after the COBRA election. If the replacing group health plan has a pre-existing condition limitation, the Covered Person may remain covered under the Plan until he or she has satisfied the pre-existing condition limitation under the new group health plan, or until he or she is no longer eligible under the COBRA Continuation Coverage, as set forth herein.
7. The date the Covered Person is terminated from the Plan for cause, provided an active Covered Employee would be terminated under the Plan for the same cause.
8. 36 months from the date continuation began for the surviving spouse and Dependent children of a Retiree who dies, when the Retiree's Qualifying Event was the Employer's bankruptcy filing.

The Claims Administrator shall provide notice of any early termination. Refer to subsection Notification Requirements, Claims Administrator.

The COBRA law also requires that an individual who has elected COBRA Continuation Coverage be permitted to enroll in any individual conversion health plan which is provided under the Plan. Contact the Plan Administrator about the availability of a conversion policy.

The Plan Administrator and Contact Information

An employee may obtain additional information about his or her COBRA Continuation of Coverage rights from the Plan Administrator. If the employee has any questions concerning his or her COBRA Continuation of Coverage rights, or if (s)he wants a copy of the Plan Document, (s)he should contact the Plan Administrator.

Finally, in order to protect the employee's and his or her family's rights, the Covered Person should keep the Plan Administrator informed of any changes to his or her address and the addresses of family members. The employee should also keep a copy, for his or her records, of any notices sent to the Plan Administrator.

The name, address and telephone number of the Plan Administrator is: The City of Toledo, One Government Center, Suite 1920, Toledo, Ohio, 43604, Telephone: (419) 245-1500.

CLAIMS INFORMATION

When the Covered Person receives Covered Services, a claim must be filed on the Covered Person's behalf to obtain benefits. In some cases, the Provider will file the claim for the Covered Person. If the Covered Person submits the claim, (s)he should use a claim form. It is in the Covered Person's best interest to ask the Provider if the claim will be filed on his or her behalf by the Provider.

CLAIM FORMS

When the Covered Person is submitting the claim on his or her own behalf, (s)he may obtain a claim form from the Employer or Plan Sponsor. If forms are not available, send a written request for claim forms to HealthSCOPE Benefits. Written notice of services rendered may also be submitted to HealthSCOPE Benefits without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

1. Name of patient
2. Patient's relationship to the Covered Employee
3. Identification number
4. Date, type and place of service
5. Name of Provider
6. The Covered Person's signature and the Provider's signature

TIMEFRAME FOR SUBMITTING CLAIM

The claim form must be submitted within 12 months of receiving Covered Services and must have the data needed to determine benefits. An expense is considered incurred on the date the service or supply is given. Failure to submit the claim form within 12 months will not reduce any benefit if the Covered Person shows that the claim was submitted as soon as reasonably possible. No claim may be submitted later than one year after the usual 12-month filing period ends. The claim form should be submitted to the address shown on the Covered Person's Identification Card.

In the event of termination of the agreement between the Claims Administrator and the Plan Sponsor, all notices of claims for Covered Services received after the termination of such agreement should be provided to the Plan Sponsor.

CLAIMS REVIEW PROCEDURE

This section describes the claims review procedures under the Plan. A claim is defined as any request for a benefit made by a Covered Person or by a Provider on behalf of the Covered Person that complies with the Plan's reasonable procedure for making a claim for benefits. The times shown in this section are maximum times only. A period of time begins at the time the claim is filed. The days shown in this section are counted as calendar days.

Under the Plan, the Covered Person can check on the status of a claim at any time by contacting the Customer Service number appearing on the Covered Person's Identification Card.

There are different time frames for reviewing a claim and providing notification concerning the claim. The time frames are based on the category of the claim. For the purpose of this provision, there are three categories of claims: Pre-Service Claims, Post-Service Claims and Urgent Care Claims.

Pre-Service Claims - Pre-Service Claims are those claims that require prior notification and approval of the

benefit prior to receiving the service. These are services, for example, that are subject to pre-certification, pre-authorization or pre-determination. For Pre-Service Claims (other than Urgent Care Claims), the following time frames apply concerning review and notification of the benefit determination:

1. Notification Concerning Failure to Follow Procedure - In the event the Covered Person, or Provider on behalf of the Covered Person, fails to follow the proper procedure for providing notification of a Pre-Service Claim, the Covered Person or Provider will be notified within five days.

2. Benefit Determination Period – The Covered Person will be notified of the benefit determination within 15 days following receipt of notification concerning the Pre-Service Claim.

3. Extension of Benefit Determination Period - If a benefit determination cannot be made within the standard 15-day benefit determination period due to matters beyond the Plan Administrator's control, the period may be extended by an additional 15 days, provided the Covered Person is notified of the need to extend the period prior to the end of the initial 15-day benefit determination period. Only one extension is permitted for each Pre-Service Claim.

   If a benefit determination cannot be made within the standard 15-day benefit determination period due to the Covered Person's failure to provide sufficient information to make the benefit determination, the benefit determination period may be extended, provided the Covered Person is notified of the need to extend the period. The Covered Person must be notified prior to the end of the initial 15-day benefit determination period. The notification must include a detailed explanation of the information needed in order to make the benefit determination. The Covered Person has 45 days following the receipt of the notification to provide the requested information.

Post-Service Claims - Post-Service Claims are those claims for services, other than Pre-Service and Urgent Care Claims, that have been rendered by a Provider. For Post-Service Claims, the following time frames apply concerning review and notification of the benefit determination:

1. Benefit Determination Period - The Covered Person will be notified of the benefit determination within 30 days following receipt of notification concerning the Post-Service Claim.

2. Extension of Benefit Determination Period - If a benefit determination cannot be made within the standard 30-day benefit determination period due to matters beyond its control, the period may be extended by an additional 15 days, provided the Covered Person is notified of the need to extend the period prior to the end of the initial 30-day benefit determination period. Only one extension is permitted for each Post-Service Claim.

   If a benefit determination cannot be made within the standard 30-day benefit determination period due to the Covered Person's failure to provide sufficient information to make the benefit determination, the benefit determination period may be extended, provided the Covered Person is notified of the need to extend the period. The Covered Person must be notified prior to the end of the initial 30-day benefit determination period. The notification must include a detailed explanation of the information needed in order to make the benefit determination. The Covered Person has 45 days following the receipt of the notification to provide the requested information.

Urgent Care Claims - Urgent Care Claims are those pre-service claims in which the time periods for making claim determinations for non-Urgent Care Claims could seriously jeopardize the Covered Person's life, health or ability to regain maximum function or when a Physician with knowledge of the Covered Person's medical condition determines that the Covered Person would be subject to severe pain that cannot be adequately managed or controlled without the treatment that is the subject of the claim. For Urgent Care Claims, the following time frame applies concerning review and notification of the benefit determination:

1. Notification Concerning Incomplete Claim - In the event the Covered Person, or Provider on behalf of the Covered Person, fails to submit complete information in connection with an Urgent Care Claim, the

Covered Person or Provider will be notified of the specific information needed to complete the claim within 24 hours.

2. Benefit Determination Period – The Covered Person will be notified of the benefit determination concerning an Urgent Care Claim within 72 hours following receipt of notification concerning the Urgent Care Claim.

3. Extension of Benefit Determination Period - In the event additional information is needed in order to make a benefit determination, the Covered Person must be notified within 24 hours following receipt of notification concerning the Urgent Care Claim. Notification of the extension will include a detailed explanation of the information needed to make the benefit determination. Upon receipt of the notification of the required extension, the Covered Person has 48 hours to provide the requested information. The determination will be made within 48 hours following receipt of the requested information from the Covered Person. If the Covered Person fails to provide the requested information, the benefit determination will be made within 48 hours following the end of the period allowed for providing said information.

4. Benefit Determination Period For Request of Continuation of Treatment - Any request to continue the course of treatment that is an Urgent Care Claim, shall be decided as soon as possible. The Covered Person will be notified of the benefit determination within 24 hours of the receipt of the claim, provided that such claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

INTERNAL CLAIMS APPEAL PROCESS

The Plan has a claims appeal process. The claims appeal process and the time limits associated with requesting and responding to a request for Claims Appeal are described in this section.

Under the Plan, the Covered Person can check on the status of a claim appeal at any time by contacting the Customer Service number appearing on the reverse side of the Identification Card.

Requesting a Claims Appeal - The Plan has a claims appeals process that allows the Covered Person to submit a request for appeal to the fiduciary who has been named by the Plan Administrator to review a claims appeal (“Named Fiduciary”). Under the Plan, the Plan Administrator will serve as the Named Fiduciary, unless the Plan Administrator has specifically delegated this responsibility to another party. The Named Fiduciary has the sole responsibility for making the decision on an appeal of an adverse benefit determination.

Under the claims appeal process, the Covered Person will be provided with a full and fair review of an adverse benefit determination. This review of an adverse benefit determination must be done by an individual who is neither the individual who made the original adverse benefit determination nor the subordinate of such individual. In addition, if the adverse benefit determination is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not Medical Necessary, the Named Fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

In the event the covered person disagrees with a claims decision concerning the denial of a benefit or scope of benefits, the covered person or the covered person’s authorized representative may submit a request for appeal within 180 days from receipt of the notice of denial or adverse benefit determination. Absent an express written authorization by the covered person providing otherwise, the authorized representative includes a medical provider only for an Urgent Care Claims Appeal.

Under the claims appeal process:

1. The Covered Person is permitted to submit written documents, comments, records and other information

relating to the claim;
2. The Covered Person is allowed reasonable access to any copies of documents, records and other information relevant to the claim;
3. The Covered Person is permitted to request the name of the medical provider used in making the initial adverse benefit determination; and
4. All comments, documents, records and other information submitted without regard to whether such information was submitted or considered in the initial determination will be taken into account.

The Covered Person's request for an appeal of an adverse benefit determination for Pre-Service and Post-Service Claims must be submitted in writing and should be submitted to the:

Named Fiduciary c/o HealthSCOPE Benefits, Inc.
P.O. Box 2860
Little Rock, AR 72203

For appeal of an Urgent Care Claim, the request for appeal may also be submitted verbally to the Named Fiduciary by contacting 1-800-882-9889.

If the Covered Person's request for appeal is not submitted to the Named Fiduciary in the manner described in this section, it will not be considered a "claims appeal" under the Plan.

Under this Plan, HealthSCOPE Benefits, Inc. is not the Named Fiduciary for purposes of reviewing claims appeals under the Plan, but is instead acting strictly at the request of the Plan Administrator to coordinate receipt of appeals on behalf of the Plan.

Time Frame for Claims Appeal Review For Pre-Service Claim - All Pre-Service Claim Appeals will be reviewed and written notification of the Named Fiduciary's decision will be prepared and mailed to the

Covered Person who submitted the claim appeal within 30 days of receiving the request for appeal of a Pre-Service Claim. As used in this section, a Pre-Service Claim Appeal is an appeal for any adverse claims determination in connection with a Pre-Service Claim.

Time Frame for Claims Appeal Review For Post-Service Claim: All Post-Service Claim Appeals will be reviewed and written notification of the Named Fiduciary's decision will be prepared and mailed to the Covered Person who submitted the claims appeal within 60 days of receiving the request for appeal of a Post-Service Claim. As used in this section, a Post-Service Claim Appeal is an appeal for any adverse claims determination in connection with a Post-Service Claim.

Time Frame for Claims Appeal Review for Urgent Care Claim – An Urgent Care Claim Appeal will be reviewed immediately and the Covered Person will be notified of the Named Fiduciary's decision within 72 hours of receiving the request for appeal. Because of the urgency related to Urgent Care Appeals, all notifications concerning an appeals decision may be made verbally. As used in this section, an Urgent Care Claim Appeal is an appeal for any adverse claims determination in connection with an Urgent Care Claim.

Information Included in an Adverse Appeal Determination - All adverse appeal determinations will include the following information:

1. The reason for the determination;
2. The reference to the specific plan provision(s) on which the benefit determination is based;
3. A statement that the Covered Person is entitled to receive free of charge access to and copies of documents and records pertinent to the claim;
4. A statement of the Covered Person's right to obtain free of charge, internal rules, guidelines, protocols, or other similar criterion used in making the adverse determination; and
5. Either an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan, or a statement that such explanation may be obtained free of charge upon request if the claim was denied on the basis of Medical Necessity or Experimental/Investigative grounds.

With the exception of appeals eligible for the external review process, the decision of the Named Fiduciary with regard to an appeal is final.

STANDARD EXTERNAL CLAIM REVIEW PROCEDURE

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

Requesting a Standard External Review. Covered Persons are permitted to request an external review with the Plan, provided the request is filed within four months after the date of receipt of the adverse benefit determination. If there is not a corresponding date that is four months after receipt of the benefits denial notice, the external review request must be filed by the first of the 5th month following receipt of the notice. The external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Covered Person or beneficiary fails to meet the requirements for eligibility under the terms of the Plan.

The external review process applies only to:

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

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

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

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

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

The IRO is required to provide the Covered Person with written notice of the eligibility and acceptance for

external review. The notice must inform Covered Persons that they can submit additional written information to the IRO within ten business days following receipt of the notice and that that the IRO must consider the additional information in its external review. The IRO may also accept and consider additional information that is submitted after ten days, though it is not required to do so.

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

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

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

In addition to documents and information provided by the Covered Person, the IRO will consider the following items in reaching its decision:

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

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

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

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

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

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

EXPEDITED EXTERNAL REVIEW PROCESS

Requesting an Expedited External Review. An expedited external review process must be made available when the Covered Person receives:

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

Immediately upon receiving the external review request, the Plan must assess whether the request meets the reviewability requirements and send the Covered Person a notice regarding the Plan's reviewability assessment.

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

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

IRO's Final External Review Decision. The IRO must provide notice of its final external review decision. The notice must meet the requirements that apply in the context of a standard external review process and response. The notice must be provided as expeditiously as the Covered Person's medical condition or circumstances require, but in no event, more than 72 hours after the IRO receives the request for an expedited external request. If the IRO fails to provide written notice within 48 hours after it provides notice of its decision, the IRO must provide written confirmation of the decision to both the Covered Person and the Plan.

PAYMENT OF BENEFITS

The Covered Person may request that payments be made directly to a Provider; however, the Plan reserves the right to make payments to the Provider or directly to the Covered Person. The Covered Person cannot request that payment be directed to anyone else. Once a Provider renders a Covered Service, the Plan will not honor the Covered Person's request to withhold payment of the claims submitted.

If a benefit is owed when the Covered Person is not able to handle his or her affairs, the benefit may be paid to a relative by blood or marriage. This would happen if the Covered Employee had died or become mentally incompetent. The Plan will make payment to a relative whom it judged to be entitled in fairness to the money. Any such payment would discharge any obligation to the extent of such payment.

RIGHTS TO AN ITEMIZED BILL

The Covered Person has the right to receive a copy of an itemized bill. This bill would identify the services and supplies rendered to the Covered Person. To receive a copy of the bill, send a written request to the Provider that rendered services. It is in the Covered Person's best interest to exercise this right so that (s)he has a copy of the bill for his or her personal files.

COORDINATION OF BENEFITS
AND
ORDER OF BENEFITS DETERMINATION

COORDINATION OF BENEFITS PROVISION

All benefits provided as described in this Plan Document are subject to Coordination of Benefits (COB). COB determines when a benefit plan is primary or secondary when a Covered Person is covered by more than one benefit plan.

This coordination of benefits provisions ("COB") applies when the Covered Person is also covered by an Other Benefit Plan. When more than one coverage exists, one plan will pay its benefits in full according to the terms of that plan. This plan is considered the primary plan. Any Other Benefit Plan is referred to as the secondary plan and pays a reduced benefit to prevent duplication of benefits.

By coordinating benefits under this provision, the total benefits payable by all Other Benefits Plans and this Plan will not exceed 100% of Allowable Expenses, as defined herein. A common set of rules is used to determine the order of benefits determination Other Benefit Plan.

When the Plan is primary, the Plan will pay benefits without regard to any Other Benefit Plan. When this Plan is secondary, the benefits payable under this Plan will be reduced so that the sum of benefits paid by all Other Benefit Plans and this Plan do not exceed 100% of total Allowable Expenses. As secondary plan, this Plan would base its payment on the difference between the total amount of the Allowable Expense and the amount that has been paid by the Other Benefit Plan(s) as the primary plan(s). If the amount paid by the primary plan equals or exceeds the amount that would have been payable this Plan if were the primary plan, then no further benefit payments will be made by the Plan in connection with that claim. Any applicable Deductible, Copayment or Coinsurance requirement under the Other Benefit Plan and this Plan will not be considered an Allowable Expense.

In no event shall the Covered Person recover under this Plan and all Other Benefit Plans more than the total Allowable Expenses under this Plan and all Other Benefit Plans. Nothing contained in this section shall entitle the Covered Person to benefits in excess of the total Maximum Benefits of this Plan. The Covered Person agrees to refund to the Employer any excess benefits the Plan may have paid.

The Plan may exchange information with any Other Benefit Plans without the consent of or notice to any person, while coordinating benefits for a Covered Person. Any person claiming benefits under this Plan must furnish to the Employer the information necessary to coordinate benefits.

DEFINITIONS

As used in this section, the following terms are defined as:

Other Benefit Plan means any arrangement providing health care benefits or services, including but not limited to: group, blanket, or franchise insurance coverage; group or individual practice or other prepayment coverage; labor management trusteed plans; union welfare plans; employer organization plans, or employee benefit organization plans; or any tax supported or governmental program (not including Medicare).

Allowable Expenses means any Eligible Expenses incurred while the Covered Person is covered under this Plan, except that any Eligible Expenses incurred that apply toward the Covered Person's copayment, deductible or coinsurance requirement under this Plan or any Other Benefit Plan will not be included as an Allowable Expense.

ORDER OF BENEFITS DETERMINATION (OTHER THAN MEDICARE)

Which plan provides primary or secondary Coverages will be determined by using the first of the following rules that applies:

1. No COB. If the Other Benefit Plan contains no COB provision, it will always be primary.

2. Employee or Member. The benefit plan covering the Covered Person as an employee, member or subscriber (other than a Dependent) is primary.

3. Medicare Eligible. If a Covered Person is eligible for Medicare, benefits will be coordinated with Medicare as set forth in the section entitled "Order of Benefits Determination for Medicare."

4. Dependent Child of Parents (Not Divorced or Legally Separated). When a Dependent is covered by more than one plan of different parents who are not separated or divorced, the coverage of the parent whose birthday falls earlier in the calendar year (excluding year of birth) is primary. If both parents have the same birthday, the plan that covered the parent longer will be primary. If a Dependent is covered by two benefit plans and the Other Benefit Plan does not have coordinate benefits based on the birthday of the parent (e.g., benefits are coordinated based on the gender of the parents), the rule of the Other Benefit Plan will determine the primary and secondary contract.

5. Dependent Child of Parents Divorced or Legally Separated. When a Dependent is covered by more than one plan of different parents who are not separated or divorced, the following rules apply:

    a. if the parent with custody has not remarried, his or her coverage is primary;

    b. if the parent with custody has remarried, his or her coverage is primary, the parent without custody is secondary and the stepparent's coverage pays last;

    c. if a court decree specifies the parent who is financially responsible for the Child's health care expenses, the coverage of that parent is primary.

6. Active Employees vs. Laid Off or Retired Employees. When a plan covers the Covered Person as an active employee or a Dependent of such employee and the Other Benefit Plan covers the Covered Person as a laid-off or retired employee or as a Dependent of such person, the plan that covers the Covered Person as an active employee or Dependent of such employee is primary.

7. Above Rules Do Not Apply. When the rules above do not apply, the plan that has covered the Covered Person longer is primary.

8. Special Note About Continued Coverage. If the Covered Person is covered under an Other Benefit Plan that is primary but also has continued Coverage this Plan (e.g., COBRA) due to the Other Benefit Plan's pre-existing condition exclusion, then this Plan will be primary for expenses incurred in connection with such pre-existing condition only.

ORDER OF BENEFITS DETERMINATION FOR MEDICARE

If, in addition to the Plan, the Covered Person is covered by Medicare, the order of benefits payments will be determined in the following manner:

Medicare Eligibility On The Basis of Age

Under Medicare, Medicare is the secondary payor for the Working Aged. As used herein, the Working Aged include an employee age 65 or over and the employee's spouse who is age 65 and over, who have coverage under a group health plan because of the employee's or spouse's employment. This provision applies to

employer-sponsored health plans that have 20 or more full time or part-time employees for each working day in each of 20 more calendar weeks in the current calendar or preceding calendar year. Based on this provision, the Covered Employee's Plan will be considered primary for the employee and his/her spouse as long as such employee remains Actively Working, and the Plan will not reduce or terminate Coverage of such employees and their spouses because of their entitlement to Medicare.

Medicare allows the Covered Employee or spouse to choose Medicare as primary. In this event, the employee and spouse will lose Coverage under the Plan for any benefits that would be considered Medicare eligible expenses. Additionally, an employee or spouse who elects Medicare as the primary payor may purchase a Medicare supplement plan from a source other than the Employer. The Employer may not purchase or subsidize an individual Medicare supplement plan for the employee or spouse.

This provision does not apply if the Covered Employee or Spouse is a COBRA beneficiary. In this instance, Medicare will be the primary payer and the Plan will be the secondary payer.

Medicare Eligibility Due to Kidney Failure

Medicare is the secondary payer if the Covered Person has Medicare due to permanent kidney failure for the first 30 months following the date of eligibility or Medicare entitlement, as such date is determined by Medicare.

After a period of up to 30 months following this date expires, Medicare will become the primary payer. Once Medicare becomes primary, the benefits of the Plan will be applied only to any unpaid balance after the Covered Person receives Medicare benefits. In this event, Medicare benefits available to the Covered Person will be subtracted whether or not a Medicare claim is filed.

This provision will also apply if the Covered Person is a COBRA beneficiary.

Medicare Eligibility Due to Other Disability

Medicare is the secondary payer for people under age 65 who have Medicare because of a disability (other than those with permanent kidney failure) and who are covered under a Large Group Health Plan as an employee or Dependent of such person. To be eligible under this provision, the employee must be Actively Working in spite of the disability.

Generally, a Large Group Health Plan is a health plan that has 100 or more full time, part time or seasonal employees. However, the Covered Employee or spouse should contact the Plan Sponsor to determine whether or not Coverage is being provided under a Large Group Health Plan.

This provision does not apply if the Covered Person is a COBRA beneficiary. In this instance, Medicare will be the primary payer and the Plan will be the secondary payer.

Medicare Eligibility for Other Covered Persons

For all other Covered Persons eligible for Medicare (e.g. retirees if eligible under the Plan), Medicare will be determined the primary payer and the Plan will be considered the secondary payer. This means that Medicare benefits will be determined first and the benefits under the Plan will be applied only to any unpaid balance after Medicare benefits are received. If the Covered Person is eligible for Medicare, but has not enrolled for Medicare or filed a Medicare claim, Plan benefits will be reduced by any benefits that would have been paid under Medicare had the person enrolled for Medicare or filed a Medicare claim.

RIGHT TO RECOVERY

RIGHT OF SUBROGATION

The Covered Person automatically assigns to the Plan any rights the Covered Person may have to recover all or part of any payments made by the Plan from any other party, including an insurer or another group health program. Therefore, the Plan Administrator may act as the Covered Person's substitute in the even of any payment made by this Plan for medical benefits, including any payment for a Pre-existing Condition, is or becomes the responsibility of another party. Such payments shall be referred to as Reimbursable Payments.

The Plan Administrator will be subrogate to all rights of recovery of the Covered Person who receive such benefits under the Plan, or any individual who received a payment of funds on behalf of the Covered Person, against any insurance carrier(s) or any third party(ies). All rights of recovery will be limited to the amount of any payments made under this Plan.

This assignment allows the Plan to pursue any claim that the Covered Person may have, whether or not the Covered Person chooses to pursue that claim. Any Covered Person claiming benefits under the Plan shall execute and deliver such documents as may be required, and do whatever else is necessary to secure such rights to the Plan.

RIGHT TO REIMBURSEMENT

The Plan shall be reimbursed for payments made by the Plan from any funds paid by a third party to a Covered Person or paid to another for the benefit of the Covered Person. This right applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the Covered Person constitute a full or partial recovery, and even applies to funds paid for non-medical charges, attorney fees, or other costs and expenses.

Any Covered Person claiming benefits under the Plan shall execute and deliver such documents as may be required, and do whatever else is necessary to secure such rights to the Plan.

EQUITABLE LIEN

The Plan shall have an equitable lien against any rights the Covered Person may have to recover any payments made by the Plan from any other party, including an insurer or another group health program or plan. Recovery shall be limited to the amount of Reimbursable Payments made by the Plan. The equitable liens also attaches to any right to payment for workers' compensation, whether by judgment or settlement, where the Plan has paid expenses otherwise eligible as Covered Services prior to a determination that the Covered Services arose out of and in the course of employment. Payment by Workers' Compensation insurers or the employer will be deemed to mean that such a determination has been made.

This equitable lien shall also attach to the first right of recovery to any money or property that is obtain by anybody (including, but not limited to, the Covered Person, the Covered Person's attorney, and/or a trust) as a result of an exercise of the Covered Person's rights of recovery. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such monies or properties. At the discretion of the Plan Administrator, the plan may reduce any future Eligible Expenses for Covered Services otherwise available to the Covered Person under the Plan by an amount up to the total amount of Reimbursable Payments made by the Plan that is subject to the equitable lien.

GENERAL PROVISIONS

The following provisions shall apply to the Plan's rights of subrogation, reimbursement and creation of an equitable lien:

1. The Plan Administrator has elected a "pay and pursue" in connection with the subrogation, reimbursement and equitable lien rights. Pursuant to the election of "pay and pursue", the Plan Administrator has the right to make benefit payments under the Plan prior to pursuing the subrogation, reimbursement and equitable lien rights under the Plan. All benefit payments under the Plan shall be reduced by any amounts that were paid by any other party as described in this section.
2. The subrogation, reimbursement and equitable lien rights apply to any benefits paid by the Plan on behalf of the Covered Person as a result of the Injuries sustained, including, but not limited to:
    a. Any no-fault insurance;
    b. Medical benefits coverage under any automobile liability plan. This includes the Covered person's plan or any third party's policy under which the Covered Person is entitled to benefits;
    c. Under-insured and uninsured motorist coverage;
    d. Any automobile medical payments and personal injury protection benefits; and
    e. Any third party's liability insurance.
3. The Plan may make total payments that exceed the maximum amount to which the Covered Person is entitled at any time under the Plan. In the event of such payments, the Plan shall have the right to recover the excess amount from any persons to, or for, or with respect to whom such excess payments were made.
4. The Plan provides that recovery of excess amounts may include a reduction from future benefit payments available to the Covered person under the Plan of any amount up to the aggregate amount of Reimbursable Payments that have not been reimbursed to the Plan.
5. The provisions of the Plan concerning subrogation, reimbursement, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule, to the extent permitted by Ohio law.
6. The reimbursement required under this provision will not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation unless separately agreed to, in writing, by the Plan Administrator in the exercise of its sole discretion.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The Plan is administered through the City of Toledo. The City of Toledo is the Employer and Plan Sponsor and also functions as the Plan Administrator, unless another individual or entity is appointed by the Employer. The Plan Administrator shall have full charge of the operation and management of the Plan. The Employer has retained the services of HealthSCOPE Benefits to administer the benefits described in this Plan Document.

The Employer is the Plan Sponsor, and shall also function as the Plan Administrator and Named Fiduciary unless the Employer appoints another individual or entity to act in this capacity. Refer to the section entitled to Operation and Administration of the Plan for more details concerning the administration of the Plan.

ALTERATION OF APPLICATION

An enrollment application may not be altered by anyone other than the applicant unless the applicant has given his or her written consent allowing alterations.

AMENDMENT OF THE PLAN

Amendment: The Employer reserves the right to amend this Plan at any time by an instrument duly executed by an authorized officer. Such amendment shall be binding upon the Employer and all Covered Persons. The Employer shall furnish to each Covered Employee a summary, written in a manner calculated to be understood by the average Covered Employee, of any modification to the Plan or change in the information required to be included in the Plan Document.

Retroactive Amendments: An amendment to this Plan may be made retroactively effective so long as it does not adversely affect the rights of Covered Persons to benefits under this Plan for covered health care expenses which are incurred after the effective date of the amendment but before the amendment is adopted.

Material Reduction: Amendments that are a material reduction in Covered Services or benefits shall be furnished not later than 60 days after the date of adoption of the modification or change. A “material reduction in covered services or benefits” means any modification to the plan or change in the information required to be included in the Plan Document that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average Covered Employee to be an important reduction in Covered Services or benefits under the Plan. A “reduction in covered services or benefits” generally would include any Plan modification or change that: eliminates benefits payable under the Plan; reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations; increases premiums, Deductibles, Coinsurance, Copayments, or other amounts to be paid by a Covered Employee.

APPLICABLE LAW

This Plan shall be construed in accordance with the laws of the State of Ohio and of the United States of America. Any provision of this Plan that is in conflict with applicable law is amended to conform with the minimum requirements of that law.

ASSIGNMENT OF BENEFITS

No assignment of the Plan, or any rights or benefits under the Plan, shall be valid unless permitted under the terms of the Plan or the Plan Sponsor has consented to such assignment in writing.

The Plan will pay benefits under this Plan to the Employee unless payment has been assigned to a Hospital,

Physician, or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the Plan unless the Claims Administrator is notified in writing of such assignment prior to payment hereunder.

BENEFITS NOT TRANSFERABLE

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

COUNTERPARTS

This Plan may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which together constitute one instrument, which may be sufficiently evidenced by any counterpart.

EFFECTIVE DATE

Except where specifically stated otherwise in this Plan, the provisions of this amended and restated Plan are effective January 1, 2016 and this Plan Document shall supersede and replace all prior versions of the Plan as of that date.

EMPLOYMENT RIGHTS

The establishment of the Plan and the Covered Employee's participation in the Plan does not affect in any way the employee's employment rights. Nor does the establishment of or employee's participation in such Plan confer any right upon any employee to be retained in the service of the Employer.

ERRONEOUS INFORMATION

If any information pertaining to any Covered Person is found to have been reported erroneously to the Plan Sponsor or to HealthSCOPE Benefits, as the claims administrator, and such error affects his or her Coverage, the facts will determine to what extent, if any, the Covered Person was or is covered under the Plan.

EXEMPTION FROM ATTACHMENT

To the full extent permitted by law, all rights and benefits under the Plan are exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any Covered Employee or other Covered Person.

FINAL AUTHORITY OF THE PLAN DOCUMENT

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

FRAUD

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

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

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this Plan shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to make a free choice to select a Hospital, Professional Provider or other Provider of health care services. However, benefits will be paid in accordance with the provisions of this Plan, and the Covered Person may have higher out-of-pocket expenses if the Covered Person uses the services of Non-Preferred Provider.

INCONTESTABILITY

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

INTEREST IN PLAN ASSETS

Except with respect to the right of a Covered Person to receive benefits under this Plan, no employee or any other person shall have any right, title or interest in or to the assets of the Plan or in or to any contributions thereto, such contributions being made to and held by the Plan for the sole purpose of providing benefit payments under the Plan in accordance with its terms. The Claims Administrator, nor the Employer in any way guarantees the Plan from loss or depreciation, nor guarantees the payment of any benefits that may be or become due to any person under the Plan. The liability of the Employer for payment of benefits under the Plan as of any date is limited solely to the then assets of the Plan. The liability of the Claims Administrator for the administration of claims under the Plan as of any date is limited solely to the funds that have been provided by the Plan for the express purpose of funding claims as of that date. Any unclaimed property will remain an asset of the Plan and will not be forfeited to the state.

INTERPRETATION OF PLAN PROVISIONS

All provisions of this Plan shall be interpreted and administered in accordance with the provisions of applicable law in a non-discriminatory manner and in a manner that will assure compliance of the Plan's operation therewith. All persons in similar circumstances shall receive uniform, consistent, and non-discriminatory treatment hereunder.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the Plan prior to the expiration of 60 days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the Plan. No such action shall be brought after the expiration of 3 years from the date the expense was incurred.

LIABILITY AND LIMITATION OF ACTION

This Plan will not give the Covered Person any claim, right, action or cause of action against any person or entity other than the Provider rendering Covered Services to the Covered Person for acts or omissions of such Provider.

Except with respect to the right of a Covered Person to receive benefits under this Plan, no Covered Person shall have any right to or interest in the assets of or contributions to the Plan. Such contributions are being made to and held by the Plan for the sole purpose of providing benefit payments under the Plan in accordance with its terms.

The Plan Sponsor and HealthSCOPE Benefits do not actually furnish health care services as described in this Plan Document. Rather, Coverage will be provided for the health care services covered under the Plan when rendered by a Provider to the Covered Person.

PHYSICAL EXAMINATION AND AUTOPSY

By accepting Coverage, as described in this Plan Document, the Covered Person agrees that (s)he may be required to have one or more physical examinations. Performance of an autopsy may also be required in the case of death where it is not forbidden by law. These examinations and/or autopsy will help to determine what benefits will be payable, particularly when there are questions concerning services on a claim.

PLAN RIGHT TO RECOVERY

Whenever payments have been made from the Plan in excess of the maximum amount of payment necessary, according to the terms of the Plan, the Plan will have the right to recover these excess payments. Whenever payments have been made from the Plan that should not have been made, according to the terms of the Plan, the Plan will have the right to recover these incorrect payments. The Plan has the right to recover any such overpayment or incorrect payment from the person or entity to whom payment was made, or from any other appropriate party, whether or not such payment was made due to the Plan Administrator's own error.

REVERSION OF ASSETS

No part of the Plan assets shall revert to the Employer, or be used for, or diverted to, purposes other than the provision of welfare benefits as described herein for the exclusive benefit of Covered Employees.

RIGHTS OF PLAN

To the full extent permitted by law, all rights and benefits under the Plan are exempt from attachment or garnishment or other legal process for the debts or liabilities of any Covered Person.

RIGHT TO ENFORCE PLAN PROVISIONS

Failure by the Plan Sponsor or HealthSCOPE Benefits to enforce any provision of the Plan provision shall not affect the Plan Sponsor's or HealthSCOPE Benefits' right thereafter to enforce such provision or any other provisions of the Plan.

SECONDARY COVERAGE

Covered Persons who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Covered Person incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such costs are payable in any event by the Plan.

A provider that accepts the payment from the Plan will be deemed to consent and agree that (i) such payment shall be for the full amount due for the provision of services and supplies to a Covered Person and (ii) it shall not "balance bill" a Covered Person for any amount billed but not paid by the Plan.

SOURCE OF BENEFITS

All benefits under the Plan shall be provided solely from the Plan and applicable insurance contracts, if any, and neither the Employer nor its officers, directors, or agents (including, but not limited to, the Claims Administrator) shall have any liability or responsibility therefore. The Claims Administrator shall not be liable in any manner should there be insufficient funds in the Plan to provide for the payment of any benefit under the Plan.

TERMINATION OF THE PLAN

Right to Terminate: It is the intention of the Employer to continue this Plan indefinitely. However, the Plan Sponsor reserves the right to terminate this Plan at any time by an instrument duly executed by it.

Effect of Termination: Unless otherwise provided, upon the effective date of Plan termination, the Coverage of all Covered Persons shall cease and no person shall become entitled to any benefits hereunder for any expenses incurred after the effective date of Plan termination. The Plan shall remain liable to pay benefits for expenses incurred prior to the effective date of Plan termination, but only to the extent of the assets set aside for that purpose.

TITLES ARE FOR REFERENCE ONLY

The titles used in the Plan are for reference only. In the event of a conflict between a title and the content of a Section, the content of the Section shall control.

WORKER'S COMPENSATION COVERAGE

The Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

WORD USAGE

Whenever words are used in this document in the singular or masculine form, they shall, where appropriate, be construed so as to include the plural, feminine or neuter form.

OPERATION AND ADMINISTRATION OF THE PLAN

PLAN ADMINISTRATOR RESPONSIBILITIES

Plan Sponsor and Plan Administrator: The Plan is administered through the City of Toledo which has been established and shall be maintained for the exclusive benefit of the employees. The City of Toledo is the Employer and Plan Sponsor and also functions as the Plan Administrator, unless another individual or entity is appointed by the Employer. The Plan Administrator shall have full charge of the operation and management of the Plan. The Employer has retained the services of HealthSCOPE Benefits, Inc. ("HealthSCOPE Benefits") to administer the benefits described in this Plan Document.

Named Fiduciary: The Employer is the Plan Sponsor, and shall also function as the Plan Administrator and Named Fiduciary unless the Employer appoints another individual or entity to act in this capacity. The Plan Fiduciary shall have maximum legal discretionary authority to construe and interpret the terms and conditions of the Plan, to review all denied claims for benefits under the Plan with respect to which it has been designated named fiduciary, including, but not limited to, the denial of certification of the Medical Necessity of Hospital or medical services, supplies and treatment, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Employer and Plan Administrator will be final and binding on all interested parties. Every fiduciary and other person who handles funds or other property of this Plan shall be bonded as required by law.

Discretion: Any discretion or judgment to be exercised by the Employer shall be exercised in the Employer's sole and absolute discretion.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable. Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Plan member is entitled to them.

Funding: All costs of this Plan are provided from the contributions made by the Employer and by Covered Employees in the Plan. All such contributions shall be paid to the Plan or used to pay premiums due on insurance policies held by the Plan. Benefits under this Plan shall be paid from such policies or from the contributions paid to the Plan. Contributions paid to the Plan for the payment of incurred claims shall be paid for directly by the Employer. For this reason, the Plan is considered to be self-funded, meaning an insurance company is not liable to pay benefit claims.

Administrative Duties: The following responsibilities shall be performed in the administration of the Plan. These duties may be performed by the Employer or by a committee of individuals appointed by the Employer to assist in the administration of the Plan:

1. Maintaining all Plan records;

2. Filing tax returns and reports required under federal and state law and complying with all other governmental reporting and disclosure requirements;

3. Authorizing payments and resolving questions concerning the Plan and interpreting, in its discretion, the Plan's provisions related to benefits and eligibility;

4. Hiring outside professionals to assist with Plan Administration and render advice concerning the responsibility they have under the Plan, including but not limited to hiring a claims administrator, actuaries, attorneys, accountants, brokers, consultants;

5. Establishing policies, interpretations, practices and procedures of the Plan;

6. Receiving all disclosures required of fiduciaries and other service providers under any federal or state law;

7. Acting as the Plan's agent for service of legal process;

8. Administering the Plan, including but not limited to the Plan's claims procedures as set forth in this Plan Document;

9. Paying benefits under the Plan, by drawing checks, or instructing others to draw checks, against the Plan established for this purpose. With respect to claims that are administered by the claims administrator, HealthSCOPE Benefits, this responsibility includes instructing the claims administrator to withdraw monies from the funding account for the purpose of administering claims incurred under the Plan; and

10. Performing all other responsibilities allocated to the Plan Administrator.

Resolutions by the Employer: All resolutions or other actions taken by the Employer that has been appointed to assist with the administration of the Plan at any meeting shall be handled as set forth in the Plan Document.

Delegation of Responsibilities: The Employer may delegate its responsibilities hereunder to other persons or entities. Such delegation shall be effective only if the proposed delegate executes an instrument acknowledging acceptance of the delegated responsibilities.

Employment of Advisers. The Employer may employ third party administrators, such as the Claims Administrator, actuaries, attorneys, accountants, brokers, consultants, and other specialists to render advice concerning any responsibility they have under the Plan.

Bonding. Every fiduciary and other person who handles funds or other property of this Plan shall be bonded as required by law.

Written Directions. Whenever a person must or may act upon the written direction of another, he shall not be required to inquire into the propriety of such direction, and he shall follow the direction unless it is clear on its face that the actions to be taken under that direction are prohibited by law or the terms of this Plan. Moreover, such person shall not be responsible for failure to act without such written direction.

Costs and Expenses: The costs and expenses incurred in the administration of this Plan shall be paid from the Plan, unless paid by the Employer. In addition, the Employer may require that Covered Employees contribute toward the cost of the Plan. Such contributions shall be paid to the Plan or used to pay premiums due on insurance policies held by the Plan. Benefits under this Plan shall be paid from such policies or from the contributions paid to the Plan. In addition, administrative expenses, including but not limited to expenses for claims, administration fees and costs, fees, accountants, legal counsel and consultants and advisers, bonding expenses, and other costs of administering the Plan shall be included in such contributions.

Compensation of Certain Employees: Fiduciaries who are employees of the Employer shall not receive compensation under the Plan for services to the Plan; however, they may receive reimbursement for expenses actually incurred in the performance of such services.

CLAIMS ADMINISTRATOR RESPONSIBILITIES

Under the Plan, HealthSCOPE Benefits, Inc. (“HealthSCOPE Benefits”) has agreed to provide certain administrative services on behalf of the Plan Sponsor according to the terms and limitations of the Plan. The responsibilities of HealthSCOPE Benefits are spelled out in an agreement between the Plan Sponsor and HealthSCOPE Benefits (“Administrative Agreement”) and include but are not limited to the administration of

claims on behalf of the Plan Sponsor. Claims for benefits under the Plan shall be filed, processed, reviewed, and, if denied, appealed in accordance with the procedures set forth in this Plan Document and the Plan Administrator's Plan Document.

Except as otherwise provided by law, the appeal procedures set forth in this Plan Document shall be the sole and exclusive remedy.

HealthSCOPE Benefits does not furnish health care services and is not liable for the quality of health care services received by a Covered Person. HealthSCOPE Benefits does not provide insurance coverage or benefits nor does HealthSCOPE Benefits underwrite the liability of this Plan. HealthSCOPE Benefits will not act nor assume the responsibility to act as the Plan Administrator or Named Fiduciary on behalf of the Plan Sponsor. HealthSCOPE Benefits is merely providing assistance with the administration of this Plan by adjudicating claims in accordance with the terms of the Plan. In the event the Administrative Agreement is terminated, HealthSCOPE Benefits will cease to process claims as of the termination of the Administrative Agreement.

DEFINITIONS

Actively Working/Actively At Work - Means the employee is performing his/her regular duties on behalf of, and in the regular business of the Plan Sponsor for the hours as listed in the Eligibility and Effective Date of Coverage section and is reasonably being compensated by the Plan Sponsor on a regular basis for such duties.

Administrative Agreement - Means the contract between the Plan Sponsor and HealthSCOPE Benefits, Inc. (HealthSCOPE Benefits) pursuant to which HealthSCOPE Benefits has been contracted to process claims on behalf of the Plan Sponsor.

Alcoholism Treatment Facility - Means a facility that is primarily engaged in the treatment of alcoholism. The facility must have in effect plans for utilization and peer review and programs for rehabilitation or rehabilitation and detoxification of alcoholism. The facility must also be approved by the Joint Commission on the Accreditation of Health Care Organizations or certified by the Department of Health.

Ambulatory Health Facility - Means a facility which is organized and operated to provide medical care to Outpatients. The facility must provide preventive, diagnostic, therapeutic or rehabilitative services under the direction of a Physician. The facility must not be part of a Hospital.

Ambulatory Surgical Facility - Means a facility, with an organized staff of Physicians, which:

1. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;

2. provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;

3. does not provide Inpatient accommodations; and

4. is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other Professional.

The facility must be accredited by the Joint Commission on the Accreditation of Health Care Organizations or by the American Osteopathic Association.

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

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

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

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of

care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's Network area unless out-of network benefits are otherwise provided under the Plan.

Benefit Period - Means the period beginning on January 1st and ending on December 31st of each year.

Cardiac Rehabilitation Therapy - Means those Medically Necessary services that are rendered under the supervision of a Physician in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery. Therapy must be initiated within 12 weeks after being discharged from an Inpatient Confinement for the medical condition and must be rendered in a Facility covered by the Plan.

Chiropractic Treatment - Means treatment of the spine by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following disease, injury, or loss of body part. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or other Professional are required.

Coinsurance - Means a fixed percentage the insured person pays of the cost of medical care after the deductible has been paid.

Community Mental Health Facility - Means a facility that is primarily engaged in the treatment of mental illness, including substance abuse. The facility must have in effect utilization and peer review plans. The facility must also be approved by the Joint Commission on Accreditation of Health Care Organizations or certified by the Department of Health.

Confinement - Means an Inpatient stay in a Hospital or other Facility. Two successive Confinements will be considered one Confinement if readmission is for the same or related condition for which the Covered Person was previously confined and the readmission occurs within 90 days.

Copayment - Means the dollar amount payable by the Covered Person for a service, treatment or procedure rendered. The Copayment is applicable on a per occurrence basis.

Coverage - Means the payment for Covered Services as specified and limited by this Plan Document.

Covered Dependent Child(ren) – Means a Dependent Child(ren) who is/are covered under the Plan.

Covered Employee - Means the employee of the Employer who has satisfied the eligibility requirements under the Plan and has enrolled for Coverage under the Plan.

Covered Persons - Means the Covered Employee and, under Family Coverage, the Covered Employee's spouse and any unmarried Dependent Children who are eligible for Coverage.

Covered Services - Means services or supplies which are considered eligible for payment under this Plan.

Covered Spouse – Means a Spouse who is covered under the Plan.

Creditable Coverage - Means coverage under any of the following:

a. Group health plan
b. Health insurance coverage, group or individual
c. Medicare
d. Medicaid
e. Medical and dental coverage for member and certain former members of Uniformed Services, and

their dependents (Title 10 U.S.C. Chapter 55)

f. Medical care program of the Indian Health Services or a tribal organization
g. State health benefits risk pool;
h. Public health plan;
i. Federal Employees Health Benefits Program
j. Health benefit plan under Peace Corps Act
k. State Children's Health Insurance Program

Customary and Reasonable Charge –Customary and Reasonable is the name for the method used by the Plan for determining the maximum amount of charges to consider in determining benefit payments for Providers under the Plan. The Customary and Reasonable fee is the fee assessed by a Non-Preferred Provider for a service, treatment or supply which shall not exceed the general level of charges assessed by Providers rendering the same type of service, treatment or supplies. The Customary and Reasonable fee is established using historical data collected for charges by Providers within specific geographic areas for the same or similar services, treatment or supplies. The data may be supplemented with information provided by independent research firms who specialize in the collection of Provider charge data. Unusual circumstances that reasonably require additional time, skill or experience for a Provider's service, are taken into consideration by the Plan and may result in reimbursement of an amount above the Customary and Reasonable maximum but not exceeding the actual charge. The Customary and Reasonable charge does not apply to Preferred Providers, except as provided by the Kidney Dialysis Treatment provision.

Deductible - Means the amount a Covered Person must pay for Eligible Expenses incurred in a Benefit Period before benefits begin to be paid for that person under the Plan.

An Individual Deductible is the amount that each Covered Person must pay during a Benefit Period before benefits begin to be paid for that person.

A Family Deductible is the maximum amount that two or more family members covered under the same Family Coverage must pay in Deductible expense in a Benefit Period. Under the Family Deductible, Eligible Expenses for all family members will be used to satisfy the Family Deductible. Once the Family Deductible is reached, the Deductible will be considered satisfied for all family members under that Family Coverage during the remainder of the Benefit Period.

Dependent – Means the Spouse, Domestic Partner and/or Dependent Child(ren).

Dependent Child – Means:

a. An Employee's child, regardless of the child's dependency, residency, student or financial dependence status, who is the natural child, step child, legally adopted child of the employee or spouse or a child who is in the legal guardianship of the employee or employee's spouse pursuant to an interlocutory order of adoption and who is under the age of 26;

b. A child who is subject of a National Medical Support Notice will be considered a Dependent Child under this Plan. The NMSN entitles such child to Coverage even if (a) such child does not reside with the Covered Employee or is not dependent on the employee for support, and (b) even if the employee does not enroll for Coverage under the Plan or does not have legal custody of the child. If the Eligible Employee has not satisfied the applicable Waiting Period, the Plan must cover the Dependent Child upon the Eligible Employee's completion of such Waiting Period. All other applicable enrollment provisions of the Plan (e.g., Dependent Limiting Age, benefit options, right to continued Coverage, etc.) which are available to Covered Employees or other Covered Dependents shall be made available to the Dependent Child who is eligible pursuant to a National Medical Support Notice; and

c. An unmarried child who is over the Dependent Limiting age of the Plan, who is permanently disabled upon attainment of the Dependent Limiting Age and who meets the dependency

requirements set forth in this paragraph. The Dependent Child must be incapable of self-sustaining employment by reason of mental retardation or mental or physical handicap and primarily dependent upon the Covered Employee for support and maintenance. The Covered Employee must notify the Employer of the disability within 31 days after the Dependent Child reaches the Dependent Limiting Age. Such notification shall include proof satisfactory to the Employer of the Dependent Child's incapacity and dependence upon the Covered Employee. After a two-year period following the date the Dependent Child meets the Dependent Limiting Age, the employee may be required to provide additional proof of the child's continued dependence and incapacity.

Note: Grandchildren are not eligible for Coverage under the Plan and are not considered as Dependent Children. In the event a dependent daughter gives birth a newborn infant, the infant will only be covered while the dependent daughter remains in the Hospital for the obstetrical delivery. The newborn infant is not eligible for Coverage following the dependent daughter's discharge from the Hospital.

Dependent Limiting Age - Means the age limit for Dependent Children under the Plan. The Dependent Limiting Age is the end of the month in which the child reaches age 26.

Diagnostic Services - Means tests and procedures performed when the Covered Person has specific symptoms to detect or to monitor the Covered Person's disease or condition. Diagnostic Services include, but are not limited to, the following: X-ray and other radiology services; laboratory and pathology services; cardiographic, encephalographic and radioisotope tests.

Domestic Partner – Means an adult of the same or different sex, who shares a common residence with an Employee and affirms that he or she and the Employee share responsibility for each other's common welfare, and have signed and filed a Declaration of Domestic Partnership with the City of Toledo.

To be eligible for benefits under the Plan, the Employee and his or her Domestic Partner must meet the requirements set out in the Eligibility section. Domestic Partner benefits are not available to members of Teamsters Local 20, Toledo Patrolman's Association (TPPA), AFSCME Local 7, or AFSCME Local 7 Communication Operators.

Effective Date - Means the date on which Coverage begins.

Eligible Employee – Means an employee of the Employer who satisfies the eligibility criteria set forth in this Plan Document.

Eligible Expenses - Means expenses for Covered Services which are incurred by a Covered Person. Eligible Expenses do not include expenses in excess of the Provider's Reasonable Charge.

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

Emergency Services – means with respect to an emergency medical condition:

- A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including

ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Enrollment Date - Means the first day of coverage, or if there is a waiting period, the first day of the waiting period. As used in this definition, the waiting period means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the Plan can become effective. This definition replaces any other definition that appears in your current Plan Document.

Essential Health Benefits – Means under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitation 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 - Means any treatment, procedure, facility, equipment, drug, device or supply which is not recognized by the Plan as accepted medical practice or which did not have required governmental approval when the Covered Person received it.

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

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or
4. In the treatment of cancer, the National Comprehensive Cancer Network's Drugs and Biologics Compendium or Thomson Micromedex DRUGDEX.

Family Coverage - Means Coverage for the Covered Employee and one or more Dependents.

Family or Medical Leave of Absence - Means an unpaid leave of absence to care for a newborn, newly adopted Dependent Child, a sick Dependent Child, spouse or parent, or an unpaid leave of absence due to a serious health condition pursuant to the Family and Medical Leave Act.

Full-Time Employee – Means an individual who is employed with and is compensated for services by the City of Toledo and who is regularly scheduled to work a minimum of 30 hours per week. The work performed by the Full-Time Employee may occur either at the usual place of business of the City of Toledo or at a location to which the business of the City of Toledo requires the Full-Time Employee to travel.

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

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

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

The term “genetic information” includes participating in clinical research involving genetic services.

Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes.

Therefore, this Plan will not discriminate in any manner with its participants on the basis of such genetic information.

Health Breach Notification Rule – Means 16 C.F.R. Part 318.

Health Plan (also Plan) - Means a self funded health coverage program provided and sponsored by the Plan Sponsor.

Home Health Care Provider - Means a facility which provides skilled nursing and other services on a visiting basis in the Covered Person’s home, and is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician. A Home Health Care Provider must be certified by Medicare or accredited by the Joint Commission on the Accreditation of Health Care Organizations.

Hospice Provider - Means a facility that provides medical, social, psychological and spiritual care as palliative treatment for terminally ill patients in the home and/or as an Inpatient using an interdisciplinary team of professionals. A Hospice Provider must be approved by the Joint Commission on Accreditation of Health Care Organizations or certified by Medicare.

Hospital - Means an institution licensed by the jurisdiction in which it is located; approved by the Joint Commission on the Accreditation of the Health Care Organizations or certified under Medicare. It must provide Inpatient medical care and treatment, a staff of physicians and nurses, facilities for diagnosis and major surgery, but cannot be mainly a place for the aged or for treatment of alcoholism or drug addiction.

Illness - Means any physical disease or mental illness. Pregnancy, premature birth, congenital anomalies and birth anomalies are considered to be Illnesses.

In-Network - Refers to Covered Services rendered by a Preferred Provider.

Individual Coverage - Means Coverage for the Covered Employee only.

Inhalation Therapy – Means a type of therapy that involves the introduction of dry or moist gases into the lungs.

Injury - Means an accidental bodily injury caused by external and violent means. Injury to the teeth as a result of biting and chewing is not considered an accidental bodily Injury.

Inpatient - Means a Covered Person who is admitted to a Hospital or Other Medical Facility Provider as a registered Inpatient and who remains in the Hospital or Other Medical Facility Provider for 24 or more hours.

Laboratory - Means a facility which is maintained to perform diagnostic tests and which is approved for Medicare reimbursement.

Maternity Services - Means services for normal pregnancy, complications of pregnancy, miscarriage and therapeutic abortions.

Maximum Benefit – Means the maximum amount the Plan will pay for a given benefit. The Maximum Benefit can be stated as a dollar amount or the maximum number of days or visits for a specific benefit. Refer to the Schedule of Benefits for maximum benefit amounts.

Medical Benefits Means the medical Covered Services described in the section entitled "Medical Benefits" and the payment made by the Plan for such services as set forth in this Plan Document.

Medical Emergency – Means the sudden and unexpected onset of severe symptoms of a life-threatening Illness or Injury that requires medical care or treatment immediately after the onset of such Illness or Injury.

Medically Necessary (or Medical Necessity) - Means the criteria used by the Plan to determine the Medical Necessity of Health Care services under this Plan Document.

To be Medically Necessary, Covered Services must:

1. Be rendered in connection with an Injury or Illness;
2. Be consistent with the diagnosis and treatment of the Covered Person's condition;
3. Be in accordance with the standards of good medical practice;
4. Not be considered Experimental or Investigative; and
5. Not be for the Covered Person's convenience or the convenience of the Covered Person's Physician.

To be Medically Necessary, Covered Services must also be provided at the most appropriate level of care or in the most appropriate type of health care facility. Only the Covered Person's medical condition (not the financial status or family situation, the distance from a Facility or any other non-medical factor) is considered in determining which level of care or type of health care facility is appropriate.

In order for Covered Services to be paid, the services must be Medically Necessary. Any service failing to meet the Medical Necessity criteria may be the Covered Employee's liability.

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

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

MHPAEA – Means the Mental Health Parity and Addiction Equity Act of 2008 which requires a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

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

connection with such a plan).

Morbid Obesity – Means the following:

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

Negotiated Rate – Means the rate established by the contract in effect between the PPO Network and the Preferred Provider. Under this contract, the Preferred Provider has agreed to accept a reduced rate ("Negotiated Rate") as their charge for services rendered and cannot bill for the difference between the charge and the Negotiated Rate.

Network Service Area – Means the geographical area in which Preferred Providers are located and that services the Covered Persons under this Plan.

Non-Preferred Provider - Means a Provider who is not participating in the [name of network]

Occupational Therapy - Means treatment rendered on an Inpatient or Outpatient basis as a part of a physical medicine and rehabilitation program to improve functional impairments where the expectation exists that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. No benefits are provided for diversional, recreational, and vocational therapies (such as hobbies, arts and crafts).

Ophthalmologist - Means a licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.) legally qualified to practice medicine, including diagnosis, treatment and prescribing of medications and lenses related to conditions of the eye.

Other Benefit Plan - Refers to COB and means any arrangement providing health care benefits or services, including but not limited to: group, blanket, or franchise insurance coverage; group or individual practice or other prepayment coverage; labor management trusteed plans; union welfare plans; employer organization plans, or employee benefit organization plans; or any tax supported or governmental program.

Out-of-Network - Refers to Covered Services rendered by an Non-Preferred Provider.

Outpatient - Means a Covered Person who receives medical care or treatment when he or she is not an Inpatient.

Part-Time Employee – Means an individual who is employed with and is compensated for services by the City of Toledo and who is regularly scheduled to work the number of hours per week as stated in the applicable collective bargaining agreement and/or the Toledo Municipal Code. The work performed by the Part-Time Employee may occur either at the usual place of business of the City of Toledo or at a location to which the business of the City of Toledo requires the Part-Time Employee to travel.

Partial Day Treatment Program (or Partial Day Treatment) - Means is a psychiatric and/or substance abuse program involving the following Covered Services which is accredited by the Joint Commission of Accreditation of Health Care Organizations or in compliance with equivalent standards for patients who require skilled level of care in a Hospital or Other Medical Facility Provider but who do not need treatment for an acute or life threatening condition. A Partial Day Treatment Program is provided in a treatment setting that is less than a 24-hour residential setting.

Pharmacy - Means a facility which is a licensed establishment where prescription drugs are dispensed by a pharmacist under applicable state laws.

Physical Therapy - Means treatment by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and tests of measurements required to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following disease, injury, or loss of body part. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or other Professional are required.

Physician - Means one of these professionals licensed under the applicable state laws:

1. Doctor of Medicine (M.D.)
2. Doctor of Osteopathy (D.O.)
3. Podiatrist (D.P.M.) or Surgical Chiropodist (D.S.C.)
4. Dental Surgeon or Dentist (D.D.S.)
5. Chiropractor (D.C.)
6. Doctor of Optometry (O.D.)
7. Psychiatrist
8. Psychologist
9. Opthalmalogist

Plan Administrator – Means the person designated to administer the Plan and whose responsibilities are set forth in the section of the Plan Document entitled "Operation and Administration of the Plan."

Plan Document - Means the governing document for the Health Plan that has been adopted and sponsored by the Plan Sponsor.

Plan Fiduciary – Means the Employer or person designated by Employer to act as the Plan Fiduciary. The Plan Fiduciary is identified and designated in the section of entitled "Operation and Administration of the Plan."

Plan Sponsor – Means the person designated to sponsor the Plan. The Plan Sponsor is identified and designated in the section of the Plan Document entitled "Operation and Administration of the Plan."

PPO Network – Means the network of Preferred Providers to which the Covered Persons will have access under this Plan.

Preferred Provider - Means a Provider who is a member of the PPO Network indicated on the Covered Person's identification card.

Primary Care Physician ("PCP") – Means a Physician in Family Medicine, General Medicine, Internal Medicine, Pediatrics, and Obstetrics and Gynecology.

Protected Health Information - Means information that is created or received by Plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Personal health information includes information of persons living or deceased. The following components of a member's information also are considered personal health information: a) names; b) street address, city, county, precinct, zip code; c) dates directly related to a member, including birth date, health facility admission and discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary

numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code. Protected Health Information includes Electronic Protected Health Information as defined at 45 C.F.R. §160.103 that is received from, or created or received on behalf of the Plan.

Provider - Means for Medical Benefits, the Facility Providers or Professional Providers listed below which are licensed and are operating within the scope of that license:

Facility Provider – Means a Hospital and an Other Medical Facility.

Other Medical Facility - Means a Facility Provider other than a Hospital and includes the following:

1. Ambulatory Health Facility
2. Ambulatory Surgical Facility
3. Home Health Care Provider
4. Hospice Provider
5. Skilled Nursing Facility
6. Community Mental Health Facility
7. Alcoholism Treatment Facility
8. Specialized Hospital

Professional Provider – Means a Physician and an Other Medical Professional .

Other Medical Professional - Means a Professional Provider other than a Physician and includes the following:

1. Physical Therapist
2. Speech Therapist
3. Registered Nurse Anesthetist (C.R.N.A.)
4. Registered Nurse (R.N.)
5. Licensed Practical Nurse (L.P.N.)
6. Licensed Occupational Therapist (O.T.)
7. Pharmacy
8. Certified Nurse Midwife (C.N.M.)
9. Laboratory (must be Medicare approved)
10. Professional Ambulance Service
11. Licensed Social Worker

Provider's Reasonable Charge – Means the method used by the Plan for determining the maximum amount of charges to consider in determining benefit payments under the Plan. Payment will be subject to any applicable Deductible, Coinsurance and other applicable Plan provisions, the Plan will determine the Provider's Reasonable Charge for all Providers. With respect to the Preferred Providers, the Provider's Reasonable Charge will be based on the Negotiated Rate set forth in the PPO contract, except as provided by the Kidney Dialysis Treatment provision. For Non-Preferred Providers, the Provider's Reasonable Charge will be the Customary and Reasonable Charge.

Qualified Medical Dependent Child Support Order (QMCSO) – Means a medical child support order which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan. An Eligible Employee may obtain a copy of such procedures from the Plan Sponsor.

Rehabilitation Facility – Means a facility that is primarily engaged in the Inpatient treatment and rehabilitation of the Covered Person as the result of an acute Illness or Injury, not including the rehabilitation of a condition resulting from substance abuse. The facility must also be approved by the Joint Commission on the Accreditation of Health Care Organizations or certified by the Department of Health.

Schedule of Benefits - Means a separate schedule showing vital information with respect to the Coverage under this Plan.

Significant Break - Means a period of 63 consecutive days during each of which the individual does not have creditable coverage.

Skilled Nursing Facility - Means a facility which mainly provides Inpatient skilled nursing and related services to patients requiring convalescent and rehabilitative care. Such care is given by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides minimal custodial care, ambulatory or part time care or that provides treatment for mental illness, alcoholism, drug abuse or tuberculosis. The Skilled Nursing Facility must be certified by the Medicare program.

Special Enrollment Period – Means a period during which an enrollment application may be submitted following an event that qualifies the employee or dependent for a Special Enrollment Period. The events that qualify an employee or dependent for a Special Enrollment Period and the time periods during which an Enrollment Application must be submitted during such period is addressed in the section entitled Applying for Coverage and Effective Dates.

Specialized Hospital - Means a facility that is primarily engaged in providing diagnostic and therapeutic services for the Inpatient treatment of mental illness. Such services must be provided by or under the supervision of an organized staff of Physicians. Continuous nursing services must also be provided under the supervision of a registered nurse.

Speech Therapy - Means active treatment for improvement of an organic medical condition causing a speech impairment. Treatment must be either post-operative or for the convalescent stage of an active illness or disease.

Spouse – Means an individual of the same or opposite sex to whom the Covered Employee is legally married.

Substance Abuse – Means any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The DSM-IV definition is applied as follows:

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

spouse about consequences of intoxication, physical fights);

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

Summary Health Information - Means information, that may be individually identifiable health information, and a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and b) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.

Summary Plan Description – Means the document that is provided by the Plan Administrator and that describes, in understandable terms, the Covered Person's rights, benefits and responsibilities under the Health Plan. This document serves as the Summary Plan Description for the Health Plan administered by the Plan Administrator and sponsored by the Plan Sponsor.

Totally Disabled - Means a condition resulting from disease or injury in which, as certified by a Physician:

1. the Covered Person is unable to perform substantial duties of any occupation or business for which (s)he is qualified and is not in fact engaged in any occupation for wage or profit; or

2. the Covered Person is substantially unable to engage in the normal activities of an individual of the same age and sex.

REQUIRED PROVISIONS UNDER GROUP HEALTH PLANS

1. **Coverage for Dependent Children Due to Adoption.** Notwithstanding any Plan provision to the contrary, the Plan will provide benefits to dependent children placed for adoption with Covered Persons or beneficiaries as required. This provision is described in more detail in the section entitled "Eligibility Provisions".

2. **QMCSO Rules.** Notwithstanding any Plan provision to the contrary, the Plan will provide benefits in accordance with the applicable requirements of any such qualified medical support order ("QMSCO"). This provision is described in more detail in the section entitled "Eligibility Provisions".

3. **Standards Relating to Benefits for Newborns and Mothers.** The Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the group health plan or issuer may pay for a shorter stay if the attending Provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not, under federal law, require a Physician or other health care Provider to obtain authorization for prescribing a length of stay of up to 48 or 96-hours. This provision is described in more detail in the section entitled "Medical Benefits".

4. **Coverage for Reconstructive Surgery In Connection With Mastectomy.** The Plan is required to provide Coverage for certain services to an individual receiving benefits in connection with a covered mastectomy pursuant to the Women's Health and Cancer Rights Act, signed into law on October 21, 1998. The law contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The new Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

   As required by law, you are being provided this notice to inform you about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:

   a. Reconstruction of the breast on which the Mastectomy has been performed;
   b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
   c. Prostheses and physical complications from all stages of Mastectomy, including lymphedamas;

   in a manner determined in consultation with the attending Physician and the patient.

   The specific services that will be provided in connection with a mastectomy are described in the section entitled "Medical Benefits."

5. **COBRA Rights.** The Plan is required to provide continuation of coverage in accordance with the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). The specific provisions, including but not limited to, the required COBRA notices that will be provided by the Employer, the extent of COBRA continuation coverage, the qualifying COBRA events and the permitted cost of such coverage, are set forth in this Plan Document.

6. **The Mental Health Parity and Addiction Equity Act (MHPAEA).** Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity

between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. MHPAEA which requires a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

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

HIPAA PRIVACY

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Plan Participants. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Plan Participant's PHI, and inform him/her about:

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

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

How Health Information May be Used and Disclosed

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

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

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

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

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. Establish safeguards for information, including security systems for data processing and storage;

4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;

5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;

7. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

8. Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);

9. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);

10. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);

11. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);

12. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;

13. Train employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;

14. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

15. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

    (a) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

        (i) Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

    (b) In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

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

Disclosure of Certain Enrollment Information to the Plan Sponsor

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

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

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

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Plan Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Participant's information.

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

Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.

2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

    (a) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;
    (b) report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
    (c) locate and notify persons of recalls of products they may be using; and
    (d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

3. The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by (5) above, when required or authorized by law, or with the Plan Participant's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Plan Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.

4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.

5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Plan Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Plan Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.

6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Plan Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.

7. Decedents: The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law.

8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.

9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.

10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

11. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

1. Disclosures to Plan Participants: The Plan is required to disclose to a Plan Participant most of the PHI in a Designated Record Set when the Plan Participant requests access to this information. The Plan will disclose a Plan Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law.

Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

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

2. Disclosures to the Secretary of the U.S. Dept of Health and Human Services: The Plan is required to disclose the Plan Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Rights to Individuals

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

1. Request Restrictions: The Plan Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Plan Participant may request the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.

2. Right to Receive Confidential Communication: The Plan Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Plan Participant would like to be contacted. The Plan will accommodate all reasonable requests.

3. Copy of this Notice: The Plan Participant is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.

4. Accounting of Disclosures: The Plan Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Plan Participant is entitled to such an accounting for the six (6) years prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Plan Participant of the basis of the disclosure, and certain other information. If the Plan Participant wishes to make a request, please contact the Privacy Compliance Coordinator.

5. Access: The Plan Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Plan Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Compliance Coordinator. In very limited circumstances, the Plan may deny the Plan Participant's request. If the Plan denies the request, the Plan Participant may be entitled to a review of that denial.

6. Amendment: The Plan Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Plan Participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request.

Questions or Complaints

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

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

Contact Information:

Privacy Compliance Coordinator Contact Information:

Calvin W. Brown
City of Toledo
One Government Center #1920
Toledo, OH 43604
(p) 419-245-1500
(f) 419-245-1511
calvin.brown@toledo.oh.gov

HIPAA SECURITY

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

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

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

Definitions;

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

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

Plan Sponsor Obligations

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

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.

3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate report to the Plan any security incident of which it becomes aware.

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

Notification Requirements in the Event of a Breach of Unsecured PHI

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

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

1. Notify the individual whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach.

2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered.

3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each calendar year.

4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected individuals may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

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