LUCAS COUNTY

EMPLOYEE HEALTH BENEFIT PLAN

AS AMENDED AND RESTATED

EFFECTIVE MARCH 1, 2011

Incorporating all changes made through the Third Amendment, effective March 1, 2014.

(Benefits provided through the Frontpath Network)

Board of County Commissioners, Lucas County, Ohio
Employee Benefits
One Government Center, Suite 440
Toledo, Ohio 43604-2259

LUCAS COUNTY HEALTH PLAN

AS AMENDED AND RESTATED
EFFECTIVE MARCH 1, 2011

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PURPOSE OF THE PLAN

The Board of County Commissioners, Lucas County, Ohio adopts this document, including any addenda, to establish a health benefit plan for the exclusive benefit of its Eligible Employees and their Eligible Dependents and the Eligible Employees and their Eligible Dependents of eligible designated entities.

PLAN ADMINISTRATION

The Plan is self-administered by the Plan Administrator; however, the Plan Administrator has engaged the services of the Claims Administrator to handle the day-to-day operation of the Plan and has purchased stop-loss insurance to pay large, single claims incurred in any Plan Year in which the claim(s) may exceed an expected amount. The Plan's administrative costs are borne by the Plan Sponsor.

ERISA COMPLIANCE

This plan is a 'governmental plan' as defined by ERISA Section 29 USC §1002 (32) and is exempt from the provisions of United States Code Title 29, Chapter 18, Subchapter I (29 USC §1001 through 29 USC §1191(c). Adoption or use of a term or procedure in the Plan that is identical or substantially similar to a term or procedure contained in 29 USC §1001 through 29 USC 1191(c) shall not cause the plan to lose its 'governmental plan' exemption.

GENERAL COMMENTS PERTAINING TO ELIGIBLITY

Non-Bargaining Unit Employees. The Plan Sponsor reserves the right at its sole discretion to modify, suspend, or terminate the eligibility rules contained in Article 2.0, herein and/or any or all provisions contained herein with or without notice. The Plan Administrator is the sole arbiter of the eligibility rules. The eligibility rules are not a contract, express or implied. No representative of the Plan Sponsor, or any other Lucas County agency, board, department or official, has the authority to enter into an agreement with an employee or employee representative that provides any benefit greater than the benefits set forth in these rules. There is no guarantee of eligibility or coverage for any agreement made contrary to these rules.

Collective Bargaining Unit Employees. The eligibility rules contained in Article 2.0, herein shall be subject to labor contract negotiations between the Plan Sponsor and the various unions representing Lucas County, Ohio employees. It is in the best interest of all parties that there be only one health insurance benefit package for all Lucas County, Ohio employees. Therefore, these eligibility rules shall be discussed and reviewed at meetings of the Lucas County Health Care Cost Containment Board.

ARTICLE 1.0

DEFINITIONS

The following terms used in this Plan document shall have the following meanings. Use of a term in this document that is identical to, or having substantially the same meaning as, the same term in 29 USC §1002 shall not constitute, or be interpreted as, either a waiver or other revocation of the Plan's status as a 'governmental plan' as defined under 29 USC §1002(32), or a waiver or other revocation of the Plan's 29 USC §1003(b)(1) exemption from the provisions of ERISA contained in United States Code Title 29, Chapter 18, Subchapter I (29 USC §1001 through 29 USC §1191c).

1.01 **"Actively at Work".** An Employee's actual engagement in employment at an Employer's business establishment, or at other locations that the Employer may require the Employee to travel to and work at, for which the Employee is eligible to receive, or actually receiving, Pay.

1.02 **"Active Pay Status".** The conditions under which an Employee is receiving Pay from his Employer.

1.03 **"Active Work Status".** Conditions under which an Employee is employed by an Employer but not actually receiving Pay.

1.04 **"Adopting Employer".** Any of the following entities (other than the Plan Sponsor) which have adopted this Plan for the benefit of their Employees:

Board of Lucas County Commissioners (Human Resources, Support Services, OMB, Administration, Commissioners, Facilities, Building Regulations, Child Support Enforcement Agency, Dog Warden, Emergency Services, Job and Family Services, Maumee River Wastewater Treatment Plant, Sanitary Engineer, Solid Waste Management and Workforce Development.)
Criminal Justice Coordinating Council
Lucas County Auditor
Lucas County Board of Developmental Disabilities
Lucas County Board of Elections
Lucas County Children Services
Lucas County Clerk of Courts
Lucas County Common Pleas Court
Lucas County Coroner
Lucas County Domestic Relations Court
Lucas County Engineer

Lucas County Family Council
Lucas County Juvenile Court
Lucas County Land Bank
Lucas County Law Library
Lucas County Mental Health & Recovery Services Board
Lucas County Probate Court
Lucas County Prosecutor
Lucas County Recorder
Lucas County Sheriff
Lucas County Soil & Water Conservation District
Lucas County Treasurer
Lucas County Veteran Service Commission
Metropolitan Park District of Toledo Area
Olander Park District
Toledo-Lucas County Health Department

1.05 **"Allowable Expenses".** The submitted charges that are considered Covered Expenses under Article 4.0, "Schedule of Benefits", subject to Reasonable and Customary limitations.

1.06 "**Alternate Care".** Medical treatment or care that is provided in lieu of the benefits specified in this Plan, because it may be provided in a less comprehensive setting or because it is less expensive. Alternate care must be:

(A) recommended by Case Management for a Participant whose condition(s) would otherwise require Hospital care; and

(B) Medically Necessary; and

(C) approved by the Claims Administrator.

1.07 "**Appeals Committee".** The entity established by the Claims Administrator to review and rule on appeals of the Claims Administrator's denial of benefits and/or coverage submitted by Participants and/or Providers. The address of the Appeals Committee is:

NFP Benefit Alliance
701 Adams, Suite 850
Toledo, OH 43604-6600
Phone: (419) 244-0135 1-877-934-4272
FAX: (419) 244-5743
E-mail: info@nfpba.org

1.08 “**Authorized Medical Leave of Absence”.** An Employee’s leave of absence for medical reasons as approved by the Employee’s Employer. An Authorized Medical Leave of Absence does not include a leave of absence granted for workers’ compensation purposes.

1.09 **“Benefit Percentage”.** That portion of Covered Expenses in excess of any applicable Co-payment that is to be paid in accordance with Section 4.03, “Schedule of Benefits”, hereinbelow subject to the Plan’s designated maximum benefit amounts.

1.10 **“Benefit Period”.** An annual time period commencing on March 1 of each Plan Year. The Benefit Period will terminate on the earliest of the following dates:

(A) the last day of February of the same Plan Year in which the Benefit Period commenced; or

(B) the day the Participant ceases to be a Participant under this Plan.

1.11 **“Case Management”.** The process described in Section 3.08, herein.

1.11.1 **"Center of Excellence"**. A facility that may or may not be in a Primary Network, as defined by each such Primary Network or Plan Administrator and described in the following list:

Akron Children’s Hospital
Arthur James Cancer Center
Cincinnati Children’s Hospital
Cleveland Clinic
Doctor’s Hospital (Columbus, OH)
Glenbeigh Hospital (Rock Creek, OH)
Grant Medical Center (Columbus, OH)
Karmanos Cancer Center (Detroit, MI)
Mayo Clinic, The
Medical City Dallas Hospital
Nationwide Children’s Hospital
Northshore University Hospital
Ohio State University Hospital
Providence Hospital (MI)
Riverside Methodist Hospital (Columbus, OH)
University Hospitals of Cleveland (Includes UHC Rainbow Children’s Hospital)
University of Michigan Medical Center (Regents U of M)

University of Pittsburgh Medical Center
Weisburg Cancer Center (Farmington Hills, MI)
Williams County Hospitals and Wellness Centers (Archbold, Montpelier, and Bryan, OH)

1.12 **“Certification" or “Certified”.** The process by which the designated utilization review organization has:

(A) reviewed the pertinent medical data; and

(B) concurred with the plan of treatment of the Participant’s attending Physician; and

(C) approved the Hospital admission and the length of the Hospital stay, or authorized designated services.

1.13 “**Child” or “Children”.** An individual who is a:

(A) biological child of the Employee;

(B) stepchild of the Employee (except in the case of the child of a domestic partner who is a Spouse);

(C) legally-adopted child of the Employee; or

(D) a child not described in Section 1.13(A), (B) or (C) hereinabove, but for whom the Employee and/or his Spouse is/are the court-ordered guardian(s) or court-ordered custodian(s) provided the court-ordered custody or guardianship has not been granted solely for the purpose of qualifying the child for coverage under the Plan.

The Plan Administrator may require the Employee to submit Documentation demonstrating, to the sole satisfaction of the Plan Administrator, that the individual claimed to be the Employee’s and/or Spouse’s Child meets the requirements of paragraph (A), (B), (C) or (D), of this Section 1.13.

1.14 **“Claim Determination Period”.** A Plan Year or that portion of a Plan Year during which the Participant for whom a claim is made has been covered under this Plan.

1.15 **“Claims Administrator”.** The individual or business entity, if any, selected and retained by the Plan Administrator to supervise the administration, consideration,

investigation and settlement of claims, maintain records, submit reports and other such duties as may be set forth in a written administration agreement. If no Claims Administrator is appointed or retained (as a result of the termination or expiration of the administrative agreement or other reason) or if the term is used in connection with a duty not expressly assigned to and assumed by the Claims Administrator in writing, the term will mean the Plan Administrator.

The entity retained by the Plan Administrator to serve as the Claims Administrator of the Plan is:

NFP Benefit Alliance
701 Adams, Suite 850
Toledo, OH 43604-6600
Phone: (419) 244-0135 1-877-934-4272
FAX: (419) 244-5743

1.16 **"Close Relative".** The Spouse, parent, brother, sister, or Child of an Employee-Participant or the parent, brother, sister or Child of an Employee-Participant's Spouse.

1.17 **"COBRA".** The health insurance continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 added to Title XXII of the Public Health Service Act at 42 USC §300bb-1 et.seq. as amended from time to time.

1.17.1 **"Cohabitate", "Cohabitating", "Cohabitation".** An Eligible Employee or an Employee-Participant and Spouse dwelling together or sharing the same living quarters.

Periods of time during which the Eligible Employee or Employee-Participant and Spouse are not dwelling together or sharing the same living quarters for reasons OTHER THAN Separation, Legal Separation, divorce, annulment of marriage, dissolution of marriage or termination of domestic partnership (e.g. being away on business, vacation or military duty) shall not be considered in determining whether an Eligible Employee or Employee-Participant and Spouse are no longer Cohabitating.

1.18 **"Coinsurance" or "Co-insurance".** That portion of Covered Expenses in excess of any applicable Co-payment that is to be paid by the Participant.

1.19 **"Convalescent/Skilled Nursing Facility".** An institution, or distinct part, thereof, operating under applicable law:

(A) that is licensed to provide, and is engaged in providing, on an Inpatient basis, professional nursing services by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse and physical restoration services to individuals convalescing from Injury or Illness to assist those individuals reach a degree of body functioning that permits self-care in essential daily activities; and

(B) whose services are rendered for compensation from its clients or patients and are under the full-time supervision of a Physician or Registered Nurse; and

(C) which maintains a complete medical record on each client or patient; and

(D) which has an effective utilization review plan; and

(E) which is not, other than incidentally, a place for: rest or Respite Care, the aged, drug addicts, alcoholics, individuals with mental retardation, custodial or educational care, or care of mental illness or disorders.

1.20 "**Convalescent Period".** A period of time commencing with the initial date of a Participant's confinement at a Convalescent/Skilled Nursing Facility. Such confinement must meet both of the following conditions:

(A) the confinement must have lasted for a period of not less than three (3) consecutive days (unless Prior Authorized); and

(B) the confinement commences no later than twenty four (24) hours (unless otherwise Prior Authorized) after the Participant is discharged from a Hospital; provided both the Hospital and Convalescent/Skilled Nursing Facility confinements were for the care and treatment of the same Illness or Injury. Alternatively, the Convalescent/Skilled Nursing Facility confinement must be an alternative to hospitalization. The Plan Administrator may require that a Physician certify that the convalescent care is rendered as an alternative to hospitalization(s).

A Convalescent Period will terminate when the Participant has been free of confinement in any and all institutions providing Hospital or convalescent care for a period of ninety (90) consecutive days. A new Convalescent Period shall not commence until a previous Convalescent Period has terminated unless there is a second, separate occurrence.

1.21 **“Co-payment” or “Co-pay”.** A dollar amount determined under Section 4.03, hereinbelow, that must be paid at the time Covered Expenses are incurred by a Participant.

1.22 **“Cosmetic Procedure”.** A procedure performed primarily for the improvement of a Participant’s appearance rather than for the improvement or restoration of bodily function(s).

1.23 **“Covered Expense”, “Covered Expenses”.** Expenses incurred by a Participant for any Medically Necessary procedures, drugs or treatments, services, or supplies that are not specifically excluded from coverage elsewhere in this Plan.

1.24 **“Custodial Care”.** That type of care or service, wherever furnished and by whatever name, that is designed primarily to assist a Participant, whether or not Totally Disabled, in the activities of daily living including, but not limited to: bathing, dressing, feeding, preparation of meals or special diets, housekeeping, assistance in walking or in getting in and out of bed, and supervision over medication that can normally be self-administered.

1.25 **“Dependent-Participant”.** An Eligible Dependent who has met the requirements of Section 2.02, herein and (if applicable) for whom all required Plan contributions are paid.

1.26 **“Disability Separated” or “Disability Separation”.** The voluntary or involuntary termination of an Employee from his Employer due to that Employee’s inability to perform the essential functions of his position because of a disabling Illness, or Injury. Disability Separated or Disability Separation shall be determined by the Employee’s Employer; however, for the purposes of a Participant obtaining Employer-Paid coverage in the event of unpaid medical leave, layoff or disability described under Section 2.09, herein, the Plan Administrator may, in accordance with the provisions of Section 2.09.3, herein, overrule an Employer’s determination that an Employee has been Disability Separated.

1.27 **“Documentation”.** Written information to be provided by an Employee upon the request of the Plan Administrator, the Appeals Committee or their authorized representatives, as may be deemed necessary by the Plan Administrator and/or the Appeals Committee, to ensure compliance with the provisions of the Plan. The type of written information that may be required by the Plan Administrator and/or the Appeals Committee will depend on the situation and/or provision of the Plan

in question; however, with respect to the following specific situations, the required written information may include, **but is not limited to**, the following:

(A) **Evidence an individual is a Spouse:** Photocopy of marriage certificate identifying both the Employee and his Spouse; and/or, photocopy of the page(s) of the Employee's most recently filed Federal Tax Return (Form 1040, 1040-A or 1040-EZ) that identifies the Spouse to the sole satisfaction of the Plan Administrator. (The submitter may redact the income totals if they choose.)

(B) **Evidence an individual is an Employee's dependent Child:**

(1) **Employee's Biological or Adopted Child:** Photocopy of a birth certificate identifying the Employee as a birth parent; or, photocopy of the court order or decree finalizing the adoption of the Child by the Employee; or photocopy of the page(s) of the Employee's most recently filed Federal Tax Return (Form 1040, 1040-A or 1040-EZ that identifies that individual as the Employee's dependent Child (according to IRS rules and regulations) to the sole satisfaction of the Plan Administrator (the submitter may redact the income totals if they so choose); or, any combination of the above listed information; or any additional documentation requested by the Plan Administrator or voluntarily provided by the Employee that adequately evidences dependent child eligibility.

(2) **Employee's step-child:** A photocopy of a birth certificate, court order or decree identifying the relationship of the Employee or his Spouse, to the child; or photocopy of the page(s) of the Employee's or Spouse's most recently filed Federal Tax Return (Form 1040, 1040-A or 1040-EZ that identifies that individual as the Employee's or the Spouse's Child (according to IRS rules and regulations) to the sole satisfaction of the Plan Administrator (the submitter may redact the income totals if they so choose); or, any combination of the above listed information; or any additional documentation requested by the Plan Administrator or voluntarily provided by the Employee that adequately evidences a child's eligibility for Plan participation.

(3) **Child for Whom an Employee is the guardian:** Copy of court order or decree that establishes the Employee's guardianship over the child.

1.28 **“Doctor of Dental Surgery, (D.D.S.)”.** A legally licensed dental surgeon who, within the scope of his/her license, performs services for which coverage is provided in this Plan.

1.29 **“Durable Medical Equipment”.** Devices which are:

(A) able to withstand repeated use; and

(B) primarily and customarily used to serve a medical purpose; and

(C) not generally useful for a person in the absence of Illness or Injury.

1.30 **“Elective Admission”.** An Inpatient Hospital admission for a health care condition that is not life threatening and for which there is flexibility in making Hospital arrangements.

1.31 “**Effective Date”.** The Plan was originally adopted and effective March 1, 1999. This amendment and restatement is effective March 1, 2011.

1.32 **“Elective Surgery”.** A non-emergency surgical procedure which may be scheduled at the convenience of the patient without jeopardizing the patient’s life or causing serious impairment to the patient’s bodily functions.

1.33 **“Eligible Dependent”.** Except as otherwise indicated or described herein, an Eligible Employee's or Employee-Participant's:

(A) Spouse; and/or

(B) Child; and/or

(C) child who is determined by the Plan Administrator (in its sole discretion) to be an 'alternate recipient' entitled to Plan coverage pursuant to a Qualified Medical Child Support Order.

The Plan Administrator reserves the right to require the Eligible Employee or Employee-Participant to submit Documentation satisfactory to the Plan Administrator, as it deems necessary, as to an Eligible Dependent’s dependency status. This evidence of dependency status includes, but is not expressly limited to, whether a child can be considered an Eligible Dependent.

A person who is covered under this Plan as an individual Participant shall not qualify as an Eligible Dependent. See also Section 2.08, hereinbelow.

1.34 **Eligible Employee".** An Employee or former Employee, who is not an Intermittent Employee.

1.35 **"Emergency".** The sudden and unexpected onset of severe symptoms of a life-threatening Illness or Injury of an individual that requires medical care or treatment immediately after the onset of such Illness or Injury or when the lack of immediate treatment will jeopardize the individual's life or cause serious impairment to the individual's bodily functions.

1.36 **"Emergency Room Co-payment".** The amount to be paid by the Participant for treatment in a Hospital's emergency room before any other benefit provisions are applied. The Emergency Room Co-payment does not apply towards the Out-of-Pocket Maximum.

1.37 **"Employee".** An individual employed by the Plan Sponsor or an Adopting Employer.

1.38 **"Employee-Participant**". An Eligible Employee who has met the requirements for Plan participation under Section 2.01, herein.

1.39 **"Employer".** The Plan Sponsor and/or an Adopting Employer as the context may require.

1.40 **"Employer Identification Number" or "EIN".** The taxpayer identification number issued to the Plan Sponsor by the Internal Revenue Service. The Plan Sponsor's EIN is 34-6400806.

1.41 "**Enrollment Date".** The first day of a Participant's coverage under this Plan or, if earlier, the beginning of any applicable waiting period.

1.42 **"ERISA".** The Employee Retirement Income Security Act of 1974 codified at 29 USC §1001 *et. seq*.

1.43 **"Experimental/Investigational".** Any treatment, procedure, facility, equipment, drug, device or supply which is not recognized as an accepted medical practice or which did not have required governmental approval when received by the Participant.

1.44 **"Family".** An Employee-Participant and his Dependent-Participant(s).

1.45 **"Genetic Testing".** Testing prescribed by a Physician because of, or due to, Family history which indicates the Participant is at risk to develop a hereditary disease and whose results could help the Participant's Physician recommend or prescribe treatment options that could reduce the risk that the Participant will develop that hereditary disease.

1.46 **RESERVED.**

1.47 **"Health Insurance Portability and Accountability Act of 1996" or "HIPAA".** The law codified at 42 USC §1320-d *et.seq.*

1.48 **"Home Health Care Agency".** A public or private agency or organization that specializes in providing medical care and treatment in the home and which:

(A) is primarily engaged in providing skilled nursing and other therapeutic services and, if licensing is required, is licensed by the appropriate authority or authorities to provide such services; and

(B) establishes and maintains policies developed by a 'professional group' associated with the agency or organization. This 'professional group' must include at least one Physician and at least one Registered Nurse to govern the services provided and must provide for full-time supervision of such services by a Physician or Registered Nurse; and

(C) maintains a complete medical record on each individual to whom it provides medical care and/or treatment; and

(D) has a full-time administrator.

1.49 **"Home Health Services".** Services furnished by a Home Health Care Agency consisting of, but not limited to:

(A) part-time or intermittent skilled nursing services provided by a nurse under the supervision of a Registered Nurse;

(B) part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a Registered Nurse;

(C) a physical therapist; a speech therapist, or an occupational therapist;

(D) medical supplies, drugs and medicines prescribed by a Physician; and/or

(E) related pharmaceutical services and laboratory services to the extent that charges or costs would have been covered under this Plan if the Covered Person had been hospitalized.

1.50 **"Hospice".** A health care program providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Participants suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel, which includes at least one Physician and one Registered Nurse, and it must maintain the standards of the National Hospice Organization (NHO) as well as applicable state licensing requirements.

1.51 **"Hospice Benefit Period".** A specified amount of time during which the Participant undergoes treatment by a Hospice. A Hospice Benefit Period begins on the date the attending Physician of a Participant certifies a prognosis of 'terminally ill', and the Participant is accepted into a Hospice program. The Hospice Benefit Period shall end on the earlier of:

(A) the day which is six (6) months from the date the Participant's 'terminally ill' prognosis is certified;

(B) the date of the Participant's death; or

(C) the date on which the Participant's attending Physician certifies that the Participant no longer requires Hospice care.

Following the expiration of a Hospice Benefit Period, a new Hospice Benefit Period may begin if the Participant's attending Physician certifies that the Participant is still terminally ill; however, the Plan Administrator may require the submission of additional proof of the Participant's 'terminally ill' status before a new Hospice Benefit Period can begin.

1.52 **"Hospital".** An institution which:

(A) is engaged primarily in providing medical care and treatment to ill and injured individuals on an Inpatient basis at the individual's expense; and

(B) is constituted, licensed, and operated in accordance with the laws which pertain to Hospitals in the jurisdiction in which it is located; and

(C) maintains on its premises the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or an Injury; and

(D) provides treatment of an Illness or Injury for compensation by and under the supervision of Physicians with continuous twenty-four (24) hour nursing services by Registered Nurses; and

(E) qualifies as a hospital and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO); and

(F) is not, other than incidentally, a place for: rest or Respite Care, Custodial Care or educational care.

1.53 **"Illness".** A bodily disorder, disease, physical sickness, mental infirmity, functional nervous disorder, mental illness or disorder or Pregnancy of a Participant. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously, which are due to the same or related causes, shall be considered one Illness.

1.54 **"Injury".** A condition caused by accidental means from an external force or event which results in damage to the Participant's body.

1.55 "**Inpatient".** The classification of a Participant upon admission to a Hospital, Hospice, or Convalescent/Skilled Nursing Facility for treatment, where charges are made for Room and Board to the Participant as a result of such admission.

1.56 **"Intensive Care Unit".** A section of a Hospital which is segregated from other Hospital facilities and:

(A) is operated exclusively for the purpose of providing professional medical treatment for critically ill individuals; and

(B) has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and

(C) provides observation and treatment by Registered Nurses or other highly trained Hospital personnel.

1.57 **"Intermittent Employee".**

(A) An Employee who is required to work less than one thousand (1000) hours in a calendar year and whose work schedule is generally irregular and fluctuating based on work needs; or

(B) a "seasonal Employee" who works for an Employer during a certain regular season or period of each calendar year performing some work or activity limited to that season or period of the calendar year; or

(C) a "temporary Employee" who works for a limited period of time established by the Employer and whose employment is limited to no more than one hundred twenty (120) calendar days unless the reason for hiring the "temporary Employee" is due to an Authorized Medical Leave of Absence of another Employee in which case the "temporary Employee" can work for the duration of such Authorized Medical Leave of Absence.

1.57.1 **"Seasonal appointment".** For purposes of Section 1.57, an Employee who works a certain regular season or period of each calendar year performing some work or activity limited to that season or period of the year notwithstanding the requirements of Section 1.57(A).

1.58 **"Legal Separation"**. Separation (as defined under Section 1.99, herein) pursuant to a decree or order issued by a court of competent jurisdiction.

1.59 **"Licensed Practical Nurse".** An individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services as a licensed practical nurse by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

1.60 **"Medical Management Company".** The contracted entity (as may be changed from time-to-time at the Plan Administrator's sole discretion) responsible for providing medical management services to the Plan including, but not limited to, Prior Authorization, utilization management, large case management, and pre-admission certification.

As of the Effective Date of this Plan, the Medical Management Company is:

Health Design Plus
1.800.877.5762.

1.61 **“Medically Necessary”.** A service, medicine, or supply which is necessary and appropriate for the diagnosis or active treatment of an Illness or Injury, as determined by the Plan Administrator, based on generally accepted current medical practice.

A service, medicine, or supply will NOT be considered Medically Necessary if it:

(A) is provided only as a convenience to the Participant or provider;

(B) is not appropriate treatment for the Participant’s diagnosis or symptoms;

(C) exceeds (in scope, duration, or intensity) that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment;

(D is part of a plan of treatment that is considered to be Experimental/Investigational or for research purposes in the diagnosis or treatment of an Illness or Injury;

(E) involves the use of a drug or substance not formally approved by the United States Food and Drug Administration; provided, however, that even if such approval is not required, the fact that any particular Physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary; or

(F) involves the use of a drug or substance not normally utilized under generally accepted current medical practice, as determined in the sole discretion of the Plan Administrator.

1.62 “**Medicare”.** The health insurance for the aged program established under Public Law 89-97 as subsequently amended from time to time.

1.63 **“Multiple Surgical Procedure(s)”.** A secondary surgical procedure or procedures performed at the same time and in the same setting as a primary surgical procedure which is (are) not an ‘incidental procedure’ or an ‘integral part’ of the primary surgical procedure.

1.63.1 **“Incidental Procedure”.** For purposes of Section 1.63, an ‘incidental procedure is a medical procedure considered to be not medically

necessary, but is routinely performed at the time of another procedure, usually as a preventative measure.

1.63.2 **"Integral Part".** For purposes of Section 1.63, a surgical procedure is considered to be an "integral part" of another procedure if it may be performed independently but, when performed in conjunction with certain other specific procedures, is considered to be part of the other specific surgical procedure and is not treated separately for claim reporting and reimbursement purposes.

1.64 **"Network Provider".** A duly licensed healthcare provider that provides, within the scope of its authority, services that are covered under this Plan and which has directly or indirectly entered into a contract with the Plan Administrator to provide those services to Participants at a contracted rate.

1.65 **"Newborn".** The status of an infant from the time of the infant's birth until the earlier of :

(A) the infant's initial Hospital discharge; or

(B) the time at which the infant becomes seven (7) days old.

1.66 **"Non-Network Provider".** A duly licensed healthcare provider that provides, within the scope of its authority, services that are covered under this Plan, but which has not directly or indirectly entered into a contract with the Plan Administrator to provide those services at a contracted rate.

1.67 **"Occupational Therapy".** The treatment rendered on an Inpatient or Outpatient basis as a part of a physical medicine and rehabilitation program to improve function impairments where the expectation exists that the therapy will result in practical improvement in the level of functioning within a reasonable period of time.

1.68 **"Office Visit Co-payment".** The Co-payment to be paid by the Participant for a Physician office visit before any other benefit provisions are applied.

1.69 **"Open-Enrollment Period".** An annual period of time established by the Plan Administrator during which:

(A) an Eligible Employee who has initially met the Plan's eligibility requirements may enroll in the Plan along with any Eligible Dependents; and/or

(B) an Employee-Participant may change Plan coverage for himself and/or his Eligible Dependents; and/or

(C) an Employee-Participant may add or drop Eligible Dependents from Plan coverage.

1.70 **"Orthotic Appliance".** An external device intended to correct a defect in the form or a function of the human body.

1.71 **"Other Coverage".** Any and all plans, insurance or other scheme that may pay, in whole or in part, for health care provided to a Participant OTHER THAN plans sponsored by the Plan Sponsor. Solely for purposes of Section 2.02.3, herein, 'Other Coverage' shall also include 'single', 'primary' prescription drug coverage, if such coverage offered or provided.

1.72 **"Out-of-Pocket Maximum".** The Plan Year limit on the total payments made for Covered Expenses under this Plan (e.g. Co-payments and Coinsurance) that a Participant is responsible to pay as described in Section 4.03, "Schedule of Benefits", herein. When payments reach the Out-of-Pocket Maximum, benefits will increase to pay for 100% of a Participant's Network Provider Covered Expenses for the remainder of the Plan Year or benefit period in which the Out-of-Pocket Maximum is reached. Payments for:

(A) Non-Covered Expenses such as amounts over annual benefit maximums or amounts in excess of Reasonable and Customary allowances; and

(B) non-Emergency expenses incurred through Non-Network Providers

do <u>not</u> apply to the Out-of-Pocket Maximum.

Furthermore, Co-payments paid in a given Plan Year shall not apply toward satisfying the Out-of-Pocket Maximum for that Plan Year. Co-payments will continue to apply regardless of whether the Out-of-Pocket Maximum has been met.

1.73 **"Outpatient"**. The status of a Participant who receives medical care, treatment, services or supplies at a clinic, a Physician's office, a Hospital (if not a registered bed patient at that Hospital), an outpatient psychiatric facility or an outpatient alcoholism treatment facility.

1.74 **"Participant".** An Employee-Participant and/or a Dependent-Participant, as the context may require.

1.75 **"Pay".** The remuneration an Employee receives from an Employer.

1.76 **"Pharmacy".** A duly-licensed facility where Prescription Drugs are dispensed by a pharmacist pursuant to applicable federal and state laws.

1.77 **"Physical Therapy".** Treatment by physical means including (but not limited to) modalities such as whirlpool and diathermy; procedures such as massage, ultrasound and manipulation; and test of measurement required to determine the need and progress of treatment. Physical Therapy must be given to relieve pain, restore maximum function, and/or prevent disability following disease, Injury, or loss of a body part. Physical Therapy must be supplied for acute conditions where rehabilitation potential exists and the skills of a Physician or other professional are required.

1.78 **"Physician".** A duly licensed medical doctor, dentist or surgeon, chiropractor, osteopath, chiropodist, podiatrist, optometrist, certified consulting Psychologist or limited licensed Psychologist, who, within the scope of their licenses, are permitted to perform services for which coverage is provided in this Plan.

1.79 "**Plan".** The Lucas County Employee Health Benefit Plan, as amended and restated effective March 1, 2011. The Plan was originally effective March 1, 1999.

1.80 **"Plan Administrator".** The Plan Sponsor, which is responsible for the day-to-day functions and management of the Plan. The Plan Administrator has engaged the services of the Claims Administrator to process claims and perform other Plan-related services and may engage or utilize the services of other persons or firms to assist in the administration of the Plan, as it may deem necessary.

1.81 **"Plan Number".** The Plan Number is 100LC1A.

1.82 **“Plan Sponsor”.** The Board of County Commissioners, Lucas County Ohio, One Government Center, Suite 800, Toledo, Ohio 43604-2259, (419)213-4500**.**

1.83 **“Plan Year”.** The twelve (12) consecutive month period commencing March 1 and ending the immediately following February 28/29.

1.84 **“Pregnancy”**. That physical state which results in childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state.

1.85 **“Precertification”, or “Precertified”.** Shall have the same definition as under Section 1.12, hereinabove.

1.86 **“Prescription Drug”.** Any medicinal substance which is required to bear the label: “Caution: Federal law prohibits dispensing without prescription” (including compounded medications which contain at least one Prescription Drug), injectable insulin and contraceptive medications.

1.87 **“Primary Care Physician”.** A duly licensed medical doctor who maintains a practice in general medicine, family medicine, internal medicine, obstetrics/ gynecology and/or pediatrics, and, within the scope of his/her license, is permitted to perform services for which coverage is provided under this Plan.

1.87.1. **"Primary Network".** Medical facilities and Physicians retained by the Plan Administrator to provide medical care paid in accordance with the Network Provider schedule of benefits. The Plan Administrator may contract with more than one Primary Network.

1.88 **“Prior Authorization or “Prior Authorized”.** The process whereby the Participant or the Participant’s Physician has notified the designated utilization review organization in advance of services to be rendered; and whereby the utilization review organization has reviewed the pertinent medical data, concurred with the decision of the attending Physician, and authorized the designated services.

1.89 **“Prosthesis”.** Any device (including a surgically-implanted device) which replaces all or part of a body/limb in order to prevent or correct a physical deformity or malfunction.

1.90 **"Protected Health Information" or "PHI".** Any individually identifiable information that is created or received by a HIPAA covered entity and which relates to the past, present or future physical or mental health or condition of an individual, the providing of health care to an individual or the past, present or future payment for the provision of health care to an individual. PHI can be oral or recorded in any form or medium.

1.91 **"Psychiatric Care" or "Psychoanalytic Care".** Treatment for a mental illness or disorder, a functional nervous disorder, compulsive disorder, and/or chemical dependency/substance abuse.

1.92 **"Psychologist".** An individual holding the degree of Ph.D. in the science of the mind and behavior (Psychology) who is duly licensed by the jurisdiction in which he/she practices and is acting within the scope of his/her license.

1.93 **"Qualified Medical Child Support Order".** A court order, as defined and provided under ERISA Section 609, that directs the Plan to provide, or continue providing benefits under the Plan for the Child of a Participant who is the noncustodial parent of the Child, and which has been deemed 'qualified' by the Plan Administrator. In making its determination as to whether a medical support order is 'qualified' the Plan Administrator may (if deemed necessary in its sole discretion) seek clarification and/or modification of the order up to and including the right to seek a hearing before the court that issued the order.

1.94 **"Reasonable and Customary".** The designation of a charge as being the usual charge made by a Physician or other provider of health care services and supplies, medication, or equipment that does not exceed the general level of charges made by other providers rendering or furnishing the same care, services, supplies medication and/or treatment within the same 'Area'. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances that require additional time, skill or expertise.

1.94.1 **"Area"**. For purposes of Section 1.94, 'Area shall mean a county or other geographical territory determined by the Plan Administrator, in its sole discretion.

1.95 **"Registered Nurse".** An individual who has received specialized nursing training, is authorized to use the designation of "R.N.", and is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

1.96 **“Respite Care”**. Short-term care provided to a Participant at home or an appropriate facility on an Inpatient or Outpatient basis for the purpose of giving the Participant’s primary caregiver temporary relief from the care of the Participant.

1.97 **“Room and Board”.** All charges, by whatever name, which are made by a Hospital, Hospice, or Convalescent/Skilled Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians or intensive nursing care by whatever name called.

1.98 **“Semi-private” or “Semiprivate”.** A class of accommodations in a Hospital or Convalescent/Skilled Nursing Facility in which at least two (2) patient beds are available per room.

1.99 **“Separation” or “Separated”**. A determination made by the Plan Administrator in its sole discretion that an Eligible Employee or an Employee-Participant and his Spouse have ceased Cohabitation.

1.100 **“Speech Therapy”.** 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.

1.101 **“Spouse”.**

(A) Except as otherwise provided under Sections 1.101.1 and 1.101.2, herein, an individual who:

(1) is legally married to an Employee-Participant or Eligible Employee; and

(2) is a resident of the United States; and

(3) legally resides in the United States.

(B) A Participant may have only one (1) Spouse at a time.

1.101.1 **Special Rules Regarding Spouses in Common Law Marriages.**

(A) An individual seeking the status of Spouse through a claim of a common law marriage with an Employee in the state of Ohio on and after October 10, 1991, shall not qualify as a Spouse for purposes of this Plan.

(B) An individual who has entered into a common law marriage in the state of Ohio with an Employee prior to October 10,1991, or who has at any time entered into a common law marriage in any other jurisdiction that allows common law marriages, shall qualify as a Spouse; provided

(1) Documentation of the common law marriage is submitted to the Plan Administrator; and

(2) such Documentation is deemed by the Plan Administrator (in its sole discretion) as satisfactorily substantiating the existence of the common-law marriage; and

(3) the common law marriage is recognized as valid by the state of Ohio.

1.101.2 **Special Rule Regarding Domestic Partners.** A same-sex, domestic partner of an Employee, who is not otherwise an Eligible Employee, shall be deemed to be the Employee's Spouse provided the Employee and his domestic partner meet the requirements for domestic partnership as described under Lucas County Board of Commissioners Resolution 09-1266.

1.102 **"Timely Application".** An application for initial participation or continued participation in the Plan:

(A) made by an Eligible Employee or (in the case of mandatory re-enrollment) Employee-Participant on his own behalf and/or on behalf of his Eligible Dependent(s) or (in the case of mandatory re-enrollment) Dependent-Participants; and

(B) that is received and approved by the Plan Administrator:

(1) within thirty-one (31) days (plus any extensions granted by the Plan Administrator) of the date on which the Eligible Employee and/or his Eligible Dependent(s) met the

Plan's participation requirements under Sections 2.01 and/or 2.02, herein; or,

(2) within thirty-one (31) days (plus any extensions granted by the Plan Administrator) of the date on which the Eligible Employee and/or his Eligible Dependent(s) lost 'primary' Other Coverage previously selected in lieu of Plan coverage, as described in Section 2.03(A) and (B), herein; or

(3) within thirty-one (31) days (plus any extensions granted by the Plan Administrator) of the date on which the Eligible Employee acquired a new Eligible Dependent, or

(4) on or before such other date established by the Plan or Plan Administrator (plus any extensions of that date granted by the Plan Administrator) as being the deadline for submitting all materials relating to:

(a) an enrollment in the Plan for any reason not listed hereinabove in this Section 1.102; or,

(b) a mandatory re-enrollment required by the Plan Administrator.

(C) In the event the Plan Administrator receives an incomplete application (as determined in its sole discretion) during the thirty-one (31) day period described in Section 1.102(B)(1), (2) and (3) (plus any extensions granted by the Plan Administrator) or before the deadline date (plus any extensions granted by the Plan Administrator) described in Section 1.102(B)(4), the Eligible Employee or Employee-Participant (as applicable) submitting the application shall be contacted by the Plan Administrator (or its designee) and shall be informed of the corrections that must be made or the missing information that must be supplied in order for the application to be deemed complete along with a deadline date by which the properly completed application must be returned to the Plan Administrator who, upon receipt, will again review the application for completeness and approval.

(D) Failure of the Eligible Employee or Employee-Participant (as applicable) to return an application, completed to the sole satisfaction of the Plan Administrator, by the applicable date (plus any extensions) established by the Plan or the Plan Administrator, shall result in the Eligible Employee or Employee-Participant (as applicable) not being deemed to have made Timely Application.

1.103 **"Total Disability" or "Totally Disabled".** The physical state of a Participant or Eligible Dependent resulting from an Illness or Injury which wholly prevents

(A) the Participant, from engaging in any and every business or occupation and from performing any and all work for compensation or profit; and/or

(B) an Eligible Dependent, from performing the normal day-to-day living activities of a person of like age and sex in good health; provided, however, the Eligible Dependent is not institutionalized and resides with the Participant at the Participant's residence,

as determined by the Plan Administrator in its sole discretion based on Documentation satisfactory to the Plan Administrator. Subsequent to an initial determination of the Plan Administrator that a Participant or Eligible Dependent is Totally Disabled, the Plan Administrator shall have the right to reasonably request, at any time, updated Documentation relating to the Eligible Dependent's or Participant's condition for the purpose of determining whether the Participant or Eligible Dependent continues to be Totally Disabled. If, after reviewing the updated Documentation the Plan Administrator, in its sole opinion, determines that the Eligible Dependent or Participant is no longer Totally Disabled, the Eligible Dependent or Participant shall lose Total Disability status on the last day of the month following the date such determination made by the Plan Administrator.

This definition is separate and distinct from the definition of "Total Disability for Social Security Purposes" described under Section 6.01(G), hereinbelow.

1.104 **"Urgent Care Co-payment".** The Co-payment to be paid by the Participant for treatment in an urgent care facility before any other benefit provisions are applied. Urgent Care Co-payments do not apply towards Out-of-Pocket Maximums.

1.105 **"Vision Therapy".** Any treatment that utilizes eye exercises to correct defects of the eye including, but not limited to, strabismus and "lazy eye".

1.106 **"Well-Child Care".** Services rendered, by or at the discretion of a Physician, in keeping with current generally accepted medical standards, which are necessary to assess the health of a non-infant Child for the purpose of anticipating and averting physical incapacity due to ill health as stated in the "Schedule of Benefits" under Section 4.03, hereinbelow.

ARTICLE 2.0

ELIGIBILITY AND PARTICIPATION

2.01 **Participation Requirements for Eligible Employees**.

An Eligible Employee who has been Actively at Work more than twenty (20) hours per week over a period of four (4) consecutive weeks and who has made Timely Application, shall become an Employee-Participant at 12:01 a.m., local time on the thirty-first (31st) calendar day following that Eligible Employee's meeting the foregoing 'Actively at Work' requirement.

2.01.1 **Timely Application Not Made: Eligible Employee or Employee-Participant.**

In the event an Eligible Employee or (in the case of a mandatory re-enrollment required by the Plan Administrator) an Employee-Participant:

(A) meets the 'Actively at Work' requirement described in Section 2.01; and

(B) does not make Timely Application; or

(C) does not waive participation in the Plan,

the Plan Administrator shall, as soon as administratively possible, and in its sole discretion, enroll that Eligible Employee or Employee-Participant in, and the Eligible Employee or Employee-Participant shall become an Employee-Participant in the lowest-cost health insurance coverage sponsored by the Plan Sponsor.

Following such enrollment by the Plan Administrator, the Employee-Participant shall be permitted to elect a different coverage option during the Open-Enrollment Period coincident with or immediately following his enrollment by the Plan Administrator.

2.02 **Participation Requirements for Eligible Dependents.**

(A) An Eligible Dependent who is a Newborn shall become a Dependent-Participant at the moment of birth, following Timely Application by the Employee-Participant.

(B) An Eligible Dependent who is a newly-adopted Child shall become a Dependent-Participant from the moment the Child’s adoption is finalized by the court, following Timely Application by the Employee-Participant.

(C) An Eligible Dependent who is a Child for whom the Employee-Participant is the court-ordered guardian or court-ordered custodian shall become a Dependent-Participant at the time the guardianship or custody arrangement becomes effective, following Timely Application by the Employee-Participant.

(D) An Eligible Dependent who is an ‘alternate recipient’ under a Qualified Medical Child Support Order shall become a Dependent-Participant at the time specified in the order.

(E) An Eligible Dependent who is a Spouse shall become a Dependent-Participant entitled only to "secondary" coverage under the Plan following Timely Application by the Eligible Employee or Employee-Participant provided the Spouse:

(1) is enrolled in Other Coverage that provides 'primary' coverage; and

(2) is not Separated from the Eligible Employee or Employee-Participant.

2.02.1 **Waiver of Participation or Failure of Timely Application For Eligible Dependent or Dependent-Participant.**

(A) In the event the Employee-Participant does not make Timely Application for his Eligible Dependent upon initially meeting the Plan’s participation requirements, the Employee-Participant shall not be permitted to enroll such Eligible Dependent in the Plan until the immediately following Open-Enrollment Period.

(B) In the event of a mandatory re-enrollment required by the Plan Administrator the Employee-Participant fails to make Timely Application for the re-enrollment of his Dependent-Participant, the Dependent-Participant’s participation in the Plan shall be terminated as of the March 1 immediately following the mandatory re-enrollment period and the Employee-Participant shall be prohibited from re-enrolling the Dependent–Participant until the immediately following Open-Enrollment Period.

2.02.2 **Participation Requirements for Eligible Dependents Losing Coverage Under Other Coverage; Eligible Dependents Acquired After Initial or Open Enrollment.**

An Employee-Participant:

(A) whose Eligible Dependent (other than a Spouse) lost 'primary' Other Coverage or,

(B) who added a new Eligible Dependent through marriage, birth, adoption or placement for adoption,

shall cause the Eligible Dependent to become a Dependent-Participant as of the date of the Eligible Dependent's loss of such Other Coverage or the date the Eligible Dependent is added to the Employee-Participant's Family, after making Timely Application for that Eligible Dependent. Failure of the Employee-Participant to make Timely Application on behalf of the Eligible Dependent described in Section 2.02(A) or (B), above, will render that Eligible Dependent ineligible for Plan participation until the next Open-Enrollment Period.

2.02.3 **Special Rules Applicable to Spouses.**

(A) **Plan Coverage for Spouse-General Rule.**

(1) **No 'Primary' Coverage for Spouse On and After March 1, 2014.**

Effective March 1, 2014, 'primary' Plan coverage for a Spouse is eliminated. Subject to Section 8.03(H), herein, a Spouse will be eligible for 'secondary' coverage in accordance with the terms and conditions of this Plan.

(2) **No Contributions for 'Secondary' Coverage**

There is no premium or other contribution required for a Spouse who receives 'secondary' coverage under the Plan.

(B) **Failure to Properly Enroll Spouse; Dependent-Participant Spouse Separated; Recovery of Amounts Expended for Separated Spouse.**

(1) An Employee-Participant who fails or failed to properly enroll his Spouse in the Plan shall be responsible for any and all claims and costs incurred by and for that Spouse under the Plan. The Plan Administrator shall exercise

all rights of recovery for any and all amounts expended by the Plan during the time the Spouse was not properly enrolled in the Plan.

(2) A Spouse who incurred claims or costs under the Plan as a Dependent-Participant, but who was Separated from the Employee-Participant at the time such claims or costs were incurred, shall be responsible for any and all such claims and costs. The Plan Administrator shall exercise all rights of recovery for any and all amounts expended by the Plan during a period of time when such Spouse was Separated from the Employee-Participant.

2.03 **Waiver of Coverage and Subsequent Loss of Other Coverage.**

An Eligible Employee:

(A) who waived, in writing, Plan participation for himself and/or his Eligible Dependent(s) upon attaining initial eligibility for participation in the Plan; and

(B) whose written waiver stated Plan participation was declined because the Eligible Employee and/or Eligible Dependent had obtained Other Coverage on a 'primary' basis; and

(C) who subsequently loses the Other Coverage for himself and/or his Eligible Dependent(s);

shall, following Timely Application, become a Participant, along with his Eligible Dependent(s) at 12:01 a.m.(local time) on the day after the Other Coverage was lost, PROVIDED, however, that the Eligible Employee and/or any Eligible Dependent:

(D) was (were) under the Other Coverage's Consolidated Omnibus Budget Reconciliation Act continuation coverage and such continuation coverage was exhausted; or

(E) was (were) not under such Consolidated Omnibus Budget Reconciliation Act continuation coverage and the Other Coverage was terminated as a result of:

(1) loss of eligibility; or

(2) employer contributions toward such Other Coverage were terminated.

Notwithstanding anything in this Section 2.03 to the contrary, an Eligible Employee and/or Eligible Dependent who lost the Other Coverage due to nonpayment of premium(s) or for 'cause' (e.g., filing fraudulent claims) shall not be permitted to enroll in the Plan pursuant to this Section 2.03 and shall, instead, be required to satisfy the requirements of Section 2.01 and (if applicable) Section 2.02, hereof.

Solely for the purposes of this Section 2.03, and notwithstanding Section 1.33 hereof, the term "Eligible Dependent" shall exclude a "Spouse" as defined in Section 1.101, hereof.

2.04. **Maintenance of Participant Status; Loss of Plan Coverage.**

(A) **Maintenance of Participant Status.**

An Employee-Participant hired prior to March 1, 2001 shall maintain coverage under this Plan for himself and his Dependent-Participant(s) for any month or any portion of the month in which the Employee-Participant is in Active Pay Status or Active Work Status. Failure of the Employee-Participant to meet the immediately foregoing 'Active Pay Status' or 'Active Work Status' requirement shall result in the loss of Plan coverage, for the Employee-Participant and any Dependent-Participant, at the end of the last day of the month in which the requirement is not satisfied unless otherwise provided herein.

An Employee-Participant hired on or after March 1, 2001 shall maintain coverage under this Plan for himself and his Dependent-Participant(s) provided the Employee-Participant is in Active Pay Status or Active Work Status for a minimum of 80 hours during a calendar month. Failure of the Employee-Participant to meet the immediately foregoing 'Active Pay Status' or 'Active Work Status' requirement shall result in the loss of Plan coverage for the Employee-Participant and any Dependent-Participant and/or Spouse at the end of the last day of the month in which the requirement is not satisfied, unless otherwise provided herein.

(B) **Spouse's Loss of Coverage Due to Divorce, Annulment, Dissolution, Separation, Legal Separation, Termination of Domestic Partnership; Last Day of Plan Coverage; Employee-Participant Duty to Notify Plan Administrator.**

Notwithstanding anything in this Section 2.04 to the contrary, Plan coverage (except for COBRA coverage, as applicable) for a Spouse who is a Dependent-Participant shall cease on the day the Spouse's divorce, annulment of marriage, dissolution of marriage, Separation, Legal Separation from, or termination of domestic partnership with, the Eligible

Employee or Employee-Participant becomes ‘final’. For purposes of this Section 2.04, a:

(1) Separation is ‘final’ on the date the Plan Administrator, in its sole discretion, has determined that the Employee-Participant and his Spouse no longer Cohabitate.

(2) Divorce, annulment of marriage, dissolution of marriage or Legal Separation is ‘final’ on the date the court’s order or decree relating to the divorce, annulment of marriage, dissolution of marriage or Legal Separation is journalized by the court.

(3) Termination of a domestic partnership is ‘final’ on the date a ‘Notice of Termination of Domestic Partnership’ is filed with the City of Toledo, Ohio in accordance with Toledo Municipal Code Section 114.05 or the Plan Administrator receives written notice of the termination of the domestic partnership.

The Employee-Participant who is a party to the Spouse’s divorce, annulment of marriage, dissolution of marriage, Separation, Legal Separation or termination of domestic partnership is required to immediately notify the Plan Administrator of the occurrence of any of the events described in this paragraph (B).

(C) **Loss of Coverage Due to Employee-Participant's Termination of Employment, Retirement, Death, Military Service, Plan Termination and Last Day of Coverage.**

(1) Except as otherwise provided, an Employee-Participant shall lose Plan coverage for himself and any Dependent-Participant at midnight of the last day of the month in which the Employee-Participant’s employment with an Employer is terminated.

(2) Except as otherwise provided, an Employee-Participant who retires from an Employer shall lose Plan coverage for himself and any Dependent-Participant on the date that Employee-Participant becomes eligible for benefits under the Ohio Public Employees Retirement System.

(3) Except as otherwise provided, an Employee-Participant shall lose Plan coverage for himself on the date of his death. Plan coverage for Dependent-Participants of the deceased Employee-Participant shall continue through the last day of the month in which the Employee-Participant died.

(4) Except as otherwise provided under Section 2.11 hereinbelow, an Employee-Participant shall lose Plan coverage for himself and any Dependent-Participant on the date the Employee-Participant enters active United States military service.

(5) Coverage for all Employee-Participants and their Dependent-Participants shall cease on the date the Plan is terminated.

(D) **Loss of Coverage Due to Strike.**

Pursuant to Ohio Revised Code Section 4117.15(C), no Employee-Participant (along with any Dependent-Participant) shall be entitled to Lucas County-paid employee benefits (including Employer-paid coverage under this Plan) for the period during which the Employee-Participant is engaged in any strike against his Employer.

If eligible for COBRA coverage, a striking Employee-Participant will be offered COBRA coverage in accordance with Article 6.0, herein. In the event the striking Employee-Participant returns to Active Work Status after having paid a COBRA premium while on strike, that Employee-Participant will be reimbursed a pro-rata portion of the paid COBRA premium for the portion of the month the Employee-Participant was not on strike PROVIDED the Employee-Participant meets the requirements of Section 2.04(A).

(E) Special Rules Regarding Employees and Worker's Compensation

(1) **Special Rule for Employee-Participants Placed on Worker's Compensation before March 1, 2011.**

An Employee-Participant who is no longer Actively at Work because he has been placed on a worker's compensation leave of absence from an Employer commencing before March 1, 2011 shall retain Plan coverage for himself and any Dependent-Participant(s) for a period of up to two (2) years following the commencement of such leave of absence.

(2) **Special Rule for Employee-Participants Placed on Worker's Compensation On and After March 1, 2011**

An Employee-Participant who is no longer Actively at Work because he has been placed on a worker's compensation leave of absence from an Employer on or after March 1, 2011 shall retain Plan coverage for himself and any Dependent-Participants for a period of up to twelve (12) months following the commencement of such leave of absence.

(3) **Duration of Coverage for Employee-Participant on Worker's Compensation.**

The two (2) year period [twelve (12) month period on and after March 1, 2011] of Employer-paid Plan coverage described in Section 2.04(C)(1) and (2) is a "lifetime" limit that applies per Employee-Participant without regard to:

(a) the number of Employers he is or may have been employed by; or

(b) the number of times he may have been on a worker's compensation leave of absence from an Employer (subject to the limitations of paragraph (4), below).

That is, prior to March 1, 2011, a Participant is "credited" with two (2) years of Employer-paid Plan coverage that may be received during workers' compensation leaves of absence from an Employer [on and after March 1, 2011, the two (2) year period is reduced to become twelve (12) months of Employer-paid Plan coverage]. The two (2) year or twelve (12) month period (as applicable) is reduced by number of days during which Employer-paid Plan coverage was provided to the Employee-Participant during any and all workers' compensation leaves of absence from an Employer .

(4) **Workers' Compensation Leave of Absence and Employer-Paid Coverage Commencing Before March 1, 2011 and Ending After March 1, 2011; Employer-paid Coverage Offset.**

An Employee-Participant whose workers' compensation leave of absence from an Employer and Employer-paid Plan coverage begins prior to March 1, 2011 and continues beyond that date shall be eligible for Employer-paid Plan coverage during such leave of absence up to the two (2) year limit described under Section 2.04(C)(1), above, notwithstanding the reduction in the duration of the Employer-paid coverage period effective March 1, 2011.

An Employee-Participant:

(a) whose worker's compensation leave of absence from an Employer and Employer-paid Plan coverage commenced prior to March 1, 2011 and ended after March 1, 2011 ("original leave of absence"); and

(b) who, subsequent to the end of the "original leave of absence" described in the immediately preceding paragraph (a), is placed on a new worker's compensation leave of absence from an Employer,

shall be eligible for twelve (12) months of Employer-paid Plan coverage, as described under Section 2.04(C)(2); provided, however, that such twelve (12) month period of coverage shall be reduced by the number of days Employer-paid Plan coverage was provided to the Employee-Participant under the "original leave of absence" for the period of time on and after March 1, 2011.

(F) **Loss of Coverage by a Child**

(1) Plan coverage for a Dependent-Participant who is a Child defined under Section 1.13(A), (B) or (C) will terminate the end of the month in which that Dependent-Participant reaches age 26; however, such termination of coverage may be extended to the end of the month in which that Dependent-Participant reaches age 28 under certain circumstances, provided Timely Application is made to the Plan Administrator by the Employee and any Documentation required by the Plan Administrator is timely submitted.

(a) Notwithstanding anything in the immediately foregoing paragraph (1), a Dependent-Participant who is a Child defined under Section 1.13(A), (B) or (C) who has been determined to be Totally Disabled may have coverage extended beyond age 26 or age 28 (whichever is applicable) upon Timely Application and timely submission of any Documentation required by the Plan Administrator. Such an extension shall continue until the earlier of the date of the Dependent-Participant's death, the date the Dependent-Participant no longer resides at the Employee-Participant's residence or the last day of the month in which the Plan Administrator has determined that the Dependent-Participant is no longer Totally Disabled.

(2) Plan coverage for a Dependent-Participant who is a Child defined under Section 1.13(D), hereinabove, will terminate at the end of the month in which such Dependent-Participant reaches the State of Ohio's age of majority, unless otherwise provided elsewhere in this Plan document.

2.05 **Loss of Participant Status and Subsequent Eligibility.**

An Employee-Participant who:

(A) loses Employee-Participant status;

(B) has not elected COBRA coverage; and

(C) has had thirty (30) days or less elapse from the time Employee-Participant status was lost,

shall again become an Employee-Participant immediately upon resuming Active Work Status.

An Employee-Participant who has met the conditions of Section 2.05(A) and (B) hereinabove but who has had MORE THAN thirty (30) days elapse from the time Employee-Participant status was lost and who resumes Active Work Status shall be treated as a new Eligible Employee for Plan purposes and shall be required to meet the requirements of Section 2.01 hereinabove.

2.05.1 **Special Rule for Employees Receiving OPERS Disability Retirement Benefits**

In the event an Employee-Participant:

(A) becomes Disability Separated; and

(B) loses Employee-Participant status; and

(C) qualifies for disability retirement health benefits from the Ohio Public Employees' Retirement System ("OPERS"); and

(D) has his OPERS disability retirement health benefits terminated by OPERS on or before the fifth (5th) anniversary of the date his Disability Separation became effective, and

(E) resumes Actively at Work status,

then, upon resuming Actively at Work Status, that former Employee-Participant shall be treated as an Eligible Employee who shall again become an Employee-Participant on the day after his OPERS disability retirement health benefits ended upon making Timely Application provided:

(F) (in the case of an Eligible Employee whose initial date of hire was before March 1, 2001) the Eligible Employee was Actively at

Work for any portion of calendar month in which he resumed employment; or

(G) (in the case of an Eligible Employee whose initial date of hire was on or after March 1, 2001) the Eligible Employee was Actively at Work for an average of twenty (20) hours per week or eighty (80) hours total during the thirty-one (31) consecutive day period commencing with the day he resumes Actively at Work status.

2.06 Plan Contributions and Participation.

The Plan Administrator may require a contribution from or on behalf of a Participant in order to maintain participation in the Plan. An Eligible Employee will be advised of any contributions required for him and/or any Eligible Dependent at the time application for Plan participation is made. Participants in the Plan will be notified by the Plan Administrator prior to an increase in any required contribution amount.

Effective April 1, 2004 an Eligible Employee whose Timely Application includes 'primary' coverage for his Spouse shall be required to contribute a portion of the monthly premium for Family coverage in an amount determined solely by the Plan Administrator.

Effective March 1, 2014, 'primary' coverage for a Spouse is eliminated; monthly contributions to the Plan for a Spouse's 'primary' coverage will no longer be required, charged or accepted.

2.07 RESERVED

2.08 Coverage Options for Employee and Spouse Both Employed by an Employer.

(A) An Employee and his Spouse who are both employed by an Employer and who both meet the requirements for participation in the Plan shall be required to elect between the following Plan coverage options:

(1) "Single" (i.e. non-"family") coverage for each of them; or

(2) single (i.e., one) "family" coverage covering the both of them.

(B) In the event an Employee-Participant and his Spouse have been determined to be Separated during the Plan Year, the Plan coverage being

provided prior to such Separation shall continue uninterrupted notwithstanding such Separation (e.g. if "family" coverage was elected prior to the Separation, the "family" coverage shall continue during the Separation notwithstanding the fact that the parties no longer Cohabitate).

(C) In no event shall a Separated Employee-Participant and Spouse each be permitted to individually elect "family" coverage.

2.08.1 **Employee and Spouse Both Employed by an Employer.**

An Employee and his Spouse, both of whom are Eligible Employees, will be required to choose between the following Plan coverage options:

(A) separate ‘single’ coverage for each of them; or

(B) sole ‘Family’ coverage covering both of them.

In the case of

(C) an Employee and Spouse, BOTH of whom are employed by an Employer;

and

(D) EITHER of whom has their employment with their Employer terminated (whether voluntarily or involuntarily),

the following rules regarding coverage shall apply. Solely for purposes of this Section 2.08.1 ‘terminated individual’ shall mean the Employee or Spouse whose employment with their Employer was terminated and ‘employed individual’ shall mean the Employee or Spouse who continues employment with their Employer:

Status prior to termination:	**Action required from ‘employed individual’ to maintain Plan coverage for the ‘terminated individual’:**
Employee and Spouse each carry their own ‘single’ coverage.	‘Employed individual’ may request a change from ‘single’ coverage to ‘family’ coverage. The ‘terminated individual’ shall become, and shall be treated as, a Spouse seeking 'secondary' coverage under the Plan.

Employee and Spouse covered under ‘family’ coverage held by ‘terminated individual’.	‘Employed individual’ may request a change to ‘family’ coverage, effective as of the date the ‘terminated individual’ would otherwise have lost coverage. The ‘terminated individual’ shall become, and shall be treated as, a Spouse seeking 'secondary' coverage under the Plan.
Employee and Spouse covered under ‘family’ coverage held by the ‘employed individual’.	The ‘terminated individual’ shall become, and shall be treated as, a Spouse seeking 'secondary' coverage under the Plan.

In all of the foregoing instances described in this Section 2.08.1 and regardless of whether the termination of employment involves the Employee or the Spouse, the ‘employed individual’ is solely responsible for making Timely Application for coverage of the ‘terminated individual’ within 31 days of the termination of employment (plus any extensions that may have been granted by the Plan administrator).

2.09 Employer-Paid Coverage in the Event of Unpaid Medical Leave, Disability, Layoff.

(A) An Employee-Participant who:

(1) has exhausted his/her paid sick leave and is awarded an unpaid Authorized Medical Leave of Absence; or

(2) has been laid off and is not, or does not become, eligible for

(a) Medicare; or

(b) any other group health insurance coverage by reason of new employment, retirement, disability retirement or social security retirement;

or

(3) has become Disability Separated

is eligible for continued Employer-paid Plan coverage for himself and any Dependent-Participant for up to twelve (12) months following the otherwise-scheduled expiration of such coverage provided that

Employee-Participant has been in Active Pay Status for the twelve (12) consecutive calendar month period immediately preceding the effective date of the unpaid Authorized Medical Leave of Absence, layoff or Disability Separation.

2.09.1 **Twelve (12) Month Period of Coverage is Lifetime Limit.**

The twelve (12) month period of Employer-paid Plan coverage described in Section 2.09 is a "lifetime" limit that applies per Employee-Participant without regard to:

(A) the number of Employers he is or may have been employed by; or

(B) the number of times he may have been awarded an Authorized Medical Leave of Absence or Disability Separation, or was laid off.

That is, upon becoming a Participant, each Employee-Participant is "credited" with twelve (12) months of Employer-Paid Plan coverage that may be provided under Section 2.09. The twelve (12) month period is reduced:

(C) by each period of time Plan coverage was provided to the Employee-Participant pursuant to Section 2.09; and

(D) by the period of time any Plan coverage was provided to that Employee-Participant following such Employee-Participant's layoff, Disability Separation or taking of an Authorized Medical Leave of Absence, in his new status as a Spouse with 'primary' Plan coverage or other Dependent-Participant; and

Nothing in this Section 2.09.1 shall limit, or be interpreted as limiting, an Employee's right to continued benefits under the Family Medical Leave Act. Additional coverage beyond the twelve (12) month period of Employer-paid Plan coverage shall be provided if and as required under the Family Medical Leave Act.

2.09.1.1 **Maximum Amount of Employer-Paid Plan Coverage.**

(A) The twelve (12) month period of Employer-paid Plan coverage described in Section 2.09 shall be

reduced by periods of Employer-paid coverage (not to exceed a total of six (6) months) provided under the provision entitled "Extended Disability and Lay-Off" under the Lucas County Employee Health Benefit Plan (Revised March 1, 2007) as it existed prior to the Effective Date of this Plan (the "prior plan").

(B) In the event an Employee-Participant was receiving Employer-paid Plan coverage under the "Extended Disability and Lay-Off" provision of the "prior plan" and such coverage continued beyond the Effective Date, the Employee-Participant shall be entitled to a maximum of six (6) months of Employer-paid Plan coverage from the date such coverage began under the "prior plan" (i.e. the fact that the Employee-Participant's continuous period of disability or layoff began prior to the Effective Date of the Plan and continued after the Effective Date of the Plan would not entitle that Employee-Participant to a maximum additional six (6) months of Employer-paid Plan coverage). However, if:

(1) the Employee-Participant's Authorized Leave of Absence, Disability Separation or layoff began prior to March 1, 2011; and

(2) the Employee-Participant's Authorized Leave of Absence, Disability Separation or layoff ended on or after March 1, 2011; and

(3) the Employee-Participant was Actively at Work after the end of his Authorized Leave of Absence, Disability Separation or layoff; and

(4) the Employee-Participant subsequently incurred a new Authorized Leave of Absence, Disability, Separation, or layoff

that Employee-Participant shall be entitled to twelve (12) months of Employer-paid Plan coverage LESS the amount of time he received Employer-paid Plan coverage for Authorized Leave of Absences, Disability Separations or layoffs that began and

ended before March 1, 2011 and/or that began prior to March 1, 2011 and ended after March 1, 2011.

2.09.2 **COBRA Coverage After Exhaustion of Employer-Paid Coverage.**

An Employee-Participant who has exhausted the twelve (12) month period of Employer-paid coverage described in Section 2.09 shall be eligible for COBRA coverage as described under Article 6.0, herein.

2.09.3 **Plan Administrator's Disagreement With Award of Authorized Medical Leave of Absence and/or Disability Separation and Right to Require Independent Examination of Employee-Participant.**

The Plan Administrator shall have the right to challenge the award of an Authorized Medical Leave of Absence or Disability Separation for purposes of an Employee-Participant seeking the Employer-paid coverage described in Section 2.09. In challenging the award of an Authorized Medical Leave of Absence or Disability Separation, the Plan Administrator shall have the right to require that the Employee-Participant be examined by an independent medical examiner of the Plan Administrator's choosing, at the expense of the Plan Administrator, for the purpose of determining whether, for Plan purposes and in the Plan Administrator's sole opinion, the Authorized Medical Leave of Absence or Disability Separation is warranted by the Employee-Participant's medical condition(s). Failure of the Employee-Participant to submit to the independent medical examination required by the Plan Administrator shall result in a denial of the additional Employer-paid coverage to the Employee-Participant and his Dependent-Participant.

Each Employee-Participant is deemed, through his participation in the Plan, to authorize the Plan Administrator to review the results of the independent medical examination. If, in the Plan Administrator's sole opinion, the results of the examination do not support the award of the Authorized Medical Leave of Absence or Disability Separation, the Plan Administrator may, in its sole discretion, deny the twelve (12) month Employer-paid coverage. The Plan Administrator's decision shall be final and binding.

2.10 **Family and Medical Leave Act ('FMLA').**

All provisions relating to Plan coverage and participation are intended to be in compliance, and shall comply, with the Family and Medical Leave Act of 1993 (FMLA). To the extent the FMLA applies to an Employer, group health benefits may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted. Employee eligibility requirements, the obligations of the Employer and Employee concerning conditions of leave, and notification and reporting requirements are specified in the FMLA. Any Plan provision that conflicts with the FMLA is superseded by the FMLA to the extent such provision conflicts with the FMLA. A Participant with questions concerning any FMLA rights and/or obligations should contact his Employer.

2.11 **Military Leaves of Absence**.

Employee-Participants and/or Dependent-Participants on approved military leaves will have Plan benefits provided in accordance with the Uniformed Services Employment and Re-employment Rights Act ("USERRA") and any policy or provisions enacted by the Plan Sponsor.

ARTICLE 3.0

PRIOR AUTHORIZATION, UTILIZATION REVIEW PROGRAM AND NETWORK PROVIDERS

3.01 General Overview of Utilization Review.

All Inpatient Hospital admissions and other designated services, treatments, tests, care, medications and/or equipment must be Prior Authorized in accordance with the provisions of this Article 3.0. Participants are solely responsible for ensuring that the Prior Authorization requirement for any Inpatient Hospital admission and/or other applicable service, treatment, test, care, medication and/or equipment has been met prior to the Inpatient Hospital admission or other applicable service, treatment, test, or care being rendered to, or the medication or equipment received by, the Participant. Participants may confirm that Prior Authorization for a an Inpatient Hospital admission or other applicable service, treatment, test, care medication or equipment has been issued by contacting the Medical Management Company or the provider subject to the Prior Authorization requirement.

All benefits provided through the Plan are subject to, and contingent upon, the approval of the Medical Management Company retained by the Plan Administrator.

3.01.1 Failure to Obtain Prior Authorization.

If Prior Authorization is not obtained in accordance with the provisions of the Plan, benefits otherwise payable will be reduced by 20% or, at the sole discretion of the Plan Administrator, may not be covered at all. Furthermore, if a 20% reduction is imposed, the reduced amount will not accumulate toward the Out-of-Pocket Maximum.

3.02 Inpatient Hospital Admissions Must Be Certified as Medically Necessary.

A Hospital stay, to be covered under this Plan, must be Prior Authorized and Certified as Medically Necessary.

3.02.1 Non-Emergency (Elective) Hospital Admissions.

The Medical Management Company must receive a request for Prior Authorization of an impending non-Emergency Hospital admission at least seven (7) calendar days before the non-Emergency Hospital stay. If there are less than seven (7) calendar days before a scheduled non-Emergency Hospital admission, the Medical Management Company must receive the

request for Prior Authorization no less than forty-eight (48) hours prior to the admission in order to obtain Certification of Medical Necessity.

Following receipt of notification of the impending admission, the Medical Management Company will obtain the data needed to review the plan of treatment recommended by the Participant's attending Physician. Upon its review, the Medical Management Company will either:

(A) Agree with the Participant's attending Physician, in which case it will issue Certification of Medical Necessity for the Participant's Hospital admission and determine the length of Hospital confinement it deems Medically Necessary; or

(B) Disagree with the Participant's attending Physician and deny Certification of Medical Necessity in which case it will inform the Participant's attending Physician, the Participant, the Hospital and the Plan Administrator of the denial of the Certification, in writing. Upon receipt of the Certification denial, the Participant is entitled to appeal the Medical Management Company's decision through the appeals process described under Section 3.07, herein.

3.02.2 **Emergency Hospital Admissions.**

The Medical Management Company must be notified of a Participant's Hospital admission due to an Emergency within forty-eight (48) hours of the admission due to Emergency or by the next business day following such admission. Upon being notified of the admission due to Emergency, the Medical Management Company will obtain the data needed to review the plan of treatment recommended by the Participant's attending Physician. Following its review of the data, the Medical Management Company will either:

(A) Agree with the Participant's attending Physician, in which case it will issue Certification of Medical Necessity for the Hospital admission due to Emergency and will determine the length of Hospital confinement it deems Medically Necessary; or

(B) Disagree with the Participant's attending Physician and deny Certification of Medical Necessity in which case it will inform the Participant's attending Physician, the Participant, the Hospital and the Plan Administrator of the denial of the Certification. The denial will be supplied to the foregoing immediately by telephone and be followed by written confirmation. In addition, alternate methods of providing care may be recommended by the Medical Management Company.

Upon receipt of the Certification denial, the Participant is entitled to appeal the Medical Management Company's decisions through the appeals process described under Section 3.07, herein.

3.02.3 **Extension of Certification Following Hospital Admission.**

After a Participant's admission to a Hospital has been Certified as Medically Necessary, the Medical Management Company will monitor the Participant's stay for admission and discharge purposes. If the Participant's attending Physician subsequently prescribes more days than had been Certified for the Hospital stay, the Medical Management Company will confer with the Participant's attending Physician to review the decision to extend the Hospital stay. Upon its review, the Medical Management Company will either:

(A) Agree with the Participant's attending Physician, in which case it will provide Certification that the additional days are Medically Necessary for the Participant; or

(B) Disagree with the Participant's attending Physician and deny Certification of Medical Necessity for the additional days in which case it will so inform the Participant's attending Physician, the Participant, the Hospital and the Plan Administrator. The denial will be supplied to the foregoing immediately by telephone and be followed by written confirmation. In addition, alternate methods of providing care may be recommended by the Medical Management Company.

Upon receipt of the Certification denial, the Participant is entitled to appeal the Medical Management Company's decisions through the appeals process described under Section 3.07, herein.

3.03 **Other Designated Services Requiring Prior Authorization.**

In order for certain services to be covered under this Plan, the following services, treatments, tests, equipment, medications and/or care MUST be Prior Authorized by the Medical Management Company:

(A) All Inpatient hospitalizations;

(B) All biopsies;

(C) Skilled Nursing Facility stays;

(D) Outpatient surgeries not performed in a Physician's office and Outpatient surgeries not performed in the office in which the Physician routinely sees his patients, and for which a 'facility' or similar fee will be charged.

(E) All Speech Therapy;

(F) Chemotherapy/infusion therapy;

(G) Renal Dialysis;

(H) Radiation therapy;

(I) Human organ transplant evaluation and transplantation;

(J) Home Health Services;

(K) Hyperbaric oxygen treatment;

(L) Physical/Occupational/respiratory therapy after the first 15 visits;

(M) Prosthetic devices;

(N) Durable Medical Equipment ($1,500 purchase or rental);

(O) Hospice care,

(P) Blepheroplasty,

(Q) All medications costing more than five hundred dollars ($500.00) per dose;

(R) All Genetic Testing; and

(S) Any other service, procedure, treatment, test, equipment, medication and/or care deemed by the Plan Administrator, in its sole discretion, to require Prior Authorization.

The Medical Management Company must be notified in advance of the provision of the any of the foregoing services, treatments, tests, equipment, medications, procedures and/or care. Upon such notification, the Medical Management Company will obtain the data needed to review the plan of treatment recommended by the Participant’s attending Physician. Following its review, the Medical Management Company will either:

(T) Agree with the Participant's attending Physician, in which case it will issue Certification of the service or procedure as Medically Necessary for the Participant; or

(U) Disagree with the Participant's attending Physician and deny Certification of Medical Necessity for the service or procedure in which case it will so inform the Participant's attending Physician, the Participant, and the Plan Administrator. The denial will be supplied to the foregoing immediately by telephone and be followed by written confirmation. In addition, alternate methods of providing appropriate care may be recommended by the Medical Management Company.

Upon receipt of the Certification denial, the Participant is entitled to a case management review of the Medical Management Company's decision(s) through the process described under Section 3.07, herein.

3.04 **Newborns' and Mothers' Health Protection Act of 1996.**

The Plan does not restrict benefits for any Hospital length of stay in connection with childbirth for the Participant-mother or Newborn to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a caesarean section provided, however, the Newborns' and Mothers' Health Protection Act of 1996 generally does not prohibit the Participant-mother's or Newborn's attending Physician (after consulting with the Participant-mother) from discharging the Participant-mother or her Newborn earlier than forty-eight (48) hours (or ninety-six (96) hours, as applicable). In any case, the Plan may not, under Federal law, and shall not require that a provider obtain authorization from the Plan for prescribing a length of stay for the applicable forty-eight (48) or ninety-six (96) hour period.

3.05 **Women's Health and Cancer Rights of 1998.**

In accordance with the Women's Health and Cancer Rights Act of 1998 signed into law on October 21, 1998, the Plan provides the following coverage to a Participant who elects breast reconstruction in connection with a mastectomy:

(A) Reconstruction of the breast on which the mastectomy has been performed;

(B) Surgery and reconstruction of the non-reconstructed (or unaffected) breast to produce symmetrical appearance;

(C) Coverage for prostheses; and

(D) Coverage of all stages of mastectomy, including lymphedemas.

Such coverage shall be provided in a manner determined in consultation with the Participant's attending Physician and the Participant. Such coverage may also be subject to Coinsurance provisions, which are deemed appropriate and consistent with those established for other benefits under the Plan.

3.06 Incapacity of Participant.

In the event the Participant cannot obtain Certification of Medical Necessity due to incapacity (e.g. the Participant is unconscious) and no Close Relative, guardian of the Participant or other individual responsible for the care of the Participant is aware of the utilization review process, any denial of Plan coverage for services rendered or procedures performed will automatically be referred to the appeals process described in Section 3.07, herein, for disposition.

3.07 Case Management.

Case Management is a voluntary, collaborative process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet a Participant's health care needs through communications and available resources to promote quality cost effective outcomes. A case manager will consult with the Participant and his attending Physician to develop an alternative plan of treatment to provide the most appropriate health care in a timely, efficient and cost effective manner. An alternative plan of treatment and any extra-contractual services will be recommended to the Plan Administrator and must be approved by the Plan before they are implemented. Decisions regarding medical care remain the sole responsibility of the Participant and his attending Physician. Neither the Plan, nor its fiduciaries or agents, assumes responsibility for the medical treatment of any person.

When a Participant is diagnosed with a severe Injury or Illness (including, but not limited to: amputation, multiple fractures, spinal cord injury, cerebral vascular accident, head trauma, AIDS, multiple sclerosis, severe burns, severe psychiatric disorders, or high risk pregnancy/infants), an alternative plan of treatment may be determined based on any or all of the following:

(A) the Participant's current medical status;

(B) the current treatment plan;

(C) the potential of an alternative plan of treatment;

(D) the effectiveness of care; and/or

(E) the short-term and long-term implications.

The Plan retains the right to:

(F) review the Participant's medical status while the alternative plan of treatment is in effect; and

(G) discontinue the alternative plan of treatment with respect to medical services and supplies that are not Covered Expenses under the Plan if:

(1) the Participant's attending Physician does not provide medical records or information necessary to determine the effectiveness of the alternative plan of treatment; or

(2) the goal of the alternative treatment has been met; or

(3) the alternative plan of treatment is no longer beneficial to the Participant.

If payment of benefits ceases in accordance with paragraph (G)(1), (G)(2), or (G)(3) above, other benefits for Covered Expenses will remain in effect, subject to Plan maximums and limitations listed under Section 4.03, hereinbelow.

Covered Expenses for the alternative plan of treatment include the Reasonable and Customary charges, subject to Plan maximums and limitations, under Section 4.03, hereinbelow.

Case Management emphasizes the effective utilization of available health care benefits. Participants seeking alternatives through this voluntary program should contact the Medical Management Company. General health information is available 24 hours a day, seven days a week through the Medical Information Helpline, 1-800-877-5762.

ARTICLE 4.0

SCHEDULE OF BENEFITS

4.01 **Coverage Under This Plan.**

Coverage provided under this Plan for Participants shall be in accordance with the provisions as stated in this Plan Document, including any coverage classification stated in the Schedule of Benefits under Section 4.03, hereinbelow.

If coverage classifications are designated on the Schedule of Benefits, any change in the amount of coverage available to a Participant occasioned by a change in the Participant's classification shall become effective automatically on the classification change date provided by the Employer.

4.02 **Schedule of Benefits and Network, Non-Network Providers.**

(A) Network Providers

The Plan Sponsor has contracted with selected providers to serve as preferred Network Providers. As described in the Schedule of Benefits under Section 4.03, hereinbelow, the amount of benefits payable is higher when a Participant obtains services from a Network Provider rather than a Non-Network Provider.

The Network Provider for the Plan can be found at www.frontpathcoalition.com. Participants are referred to that website's provider directory for a full listing of Network Providers.

Providers designated as Network Providers are subject to change from time to time, at the sole discretion of the Plan Sponsor.

(B) Exceptions Where There Is No Access to Network Providers

(1) In cases where medical services are required and there is no access to Network Providers, the Plan will allow the following Covered Expenses based on the Network Provider schedule of benefits:

(a) medical care for a Child who is a Dependent-Participant living away from the Employee-Participant's residence while enrolled at an educational institution that is located outside the service area of the Network Providers;

(b) required medical care while traveling on business or vacation outside the service area of Network Providers (Prior Authorization requirements are applicable); PROVIDED, however, that with respect to providers located outside the United States of America, the Participant (at his expense) is solely responsible for obtaining an English language translation of any foreign country provider claims, invoices, bills, etc. and all medical records pertaining to the services rendered and/or procedures performed as well as documented proof of the rate of currency exchange;

(c) trauma victims transported by a Non-Network Provider to a Non-Network Provider facility by emergency medical services (such as ground or air transportation) when the Participant is not able to choose a medical facility, or is outside of the network area [see also Section 4.02(B)(2), hereinbelow];

(d) when specialty services are required and cannot be rendered by a Network Provider (however, Prior Authorization is required); and/or

(e) services with no Network Provider representation.

(2) If an Emergency exists and a Network Provider cannot reasonably be used to provide the necessary Emergency care, then Covered Expenses incurred from a Non-Network Provider in the course of treatment of the Emergency will be reimbursed according to the schedule for a Network Provider.

(3) If a Medically Necessary service is not available from any Network Provider, then Covered Expenses incurred from a Non-Network Provider in the course of treatment for such service will be reimbursed according to the schedule for a Network Provider, provided the Participant obtains Prior Authorization.

(4) Participants who:

(a) have dependents that reside beyond the service area of Network Providers; and
(b) are required by court order to provide medical insurance for those dependents,

may obtain coverage through the Plan with benefits consistent with Network Provider benefits provided the Participant receives Prior Authorization for any services or procedures to be performed.

4.03 **Schedule of Benefits.**

Service, treatment, test, equipment, medication and/or care:	Benefit paid by Lucas County Plan thru Frontpath Network; Participant Coinsurance: Except as otherwise stated, 30% Coinsurance applies to certain clinical, diagnostic and therapeutic procedures delivered by Network Providers. 50% Coinsurance applies to non-Emergency, Non-Network Provider services. All Covered Expenses are subject to Reasonable and Customary guidelines.
Pre-Existing Condition	Not applicable
Out-Of-Pocket Maximum	$2000 Single/$4000 Family Out-of-Pocket Maximum per Plan Year. Co-payments will NOT count toward satisfying the Plan Year Out-of-Pocket Maximums. There is NO Out-of-Pocket maximum for non-Emergency, Non-Network Provider services.
Certain Network Provider "preventive care" will be covered at 100% with no Co-payment. "Preventive care" includes screenings, checkups, patient counseling to prevent illnesses, diseases or other health problems, including, but not limited to the following:	
Well Child Care	100% with no Co-payment.
Well baby care	100% with no Co-payment.

Routine pap test	100% with no Co-payment.
Mammograms	100% with no Co-payment.
Prostate exams	100% with no Co-payment.
Immunizations	100% with no Co-payment.
Routine preventive services & screenings	100% with no Co-payment.
Diagnostic testing	100% with no Co-payment.
Certain health education	100% with no Co-payment.
Certain genetic testing	100% with no Co-payment; Prior Authorization required.
Hearing examination	100% with no Co-payment. Limited to one examination per Plan Year.
Vision Examination (Children under age 5 only); Hardware	100% with no Co-payment. Limited to one examination per Plan Year. Hardware- $100 reimbursement every 24 months for frames, lenses or contact lenses, or additional exam with a paid receipt.
The following benefits are subject to Co-payments and/or Coinsurance.	
Office visits for (non-preventive) medical problems	$10 Office Visit Co-Payment for general practitioner. Remainder paid at 70% Plan, 30% Participant Coinsurance.

Specialist visit	$15 Office Visit Co-payment. Remainder paid at 70% Plan, 30% Participant Coinsurance.
OB/GYN (other than for routine preventive services) Contraceptive services, (e.g. injection, devices and implants):	$10 Office Visit Co-payment. Remainder paid at 70% Plan, 30% Participant Coinsurance. $10 Office Visit Co-payment. Remainder paid at 70% Plan, 30% Participant Coinsurance.
Maternity Care	$10 Office Visit Co-payment. Remainder paid at 70% Plan, 30% Participant Coinsurance.
Allergy Treatment	Testing: Plan pays 70% up to $1000 max., Participant pays 30% Coinsurance. Injection: Plan pays 70%, Participant pays 30% Coinsurance.
Infertility Diagnosis & Testing	Plan pays 70%, Participant pays 30% Coinsurance. Excludes all reproductive technologies.
Sterilization services, vasectomy, tubal ligation	Plan pays 70%, Participant pays 30% Coinsurance.
Vision examinations (other than for a Child under age 5); Hardware	Vision- $15 Office Visit Co-payment for one routine vision exam every 365 days. Plan pays up to Reasonable and Customary amount. No referral required. Hardware- $100 reimbursement every 24 months for frames, lenses or contact lenses, or additional exam with a paid receipt.

Renal dialysis	Plan pays 70%, Participant pays 30%. Requires Prior Authorization. Participant must enroll in Medicare Part A & B if eligible. Plan will reimburse Participant for the cost of Medicare Part B enrollment regardless of Participant's 'primary' or 'secondary' coverage status under the Plan. In no event shall Plan reimbursement exceed the negotiated Reasonable and Customary amount.
Cardiac rehabilitation	Plan pays 70%, Participant pays 30% Coinsurance (however, rehabilitation may be eligible for payment at 100% through the Lucas County Wellness Program).
Chemotherapy & radiotherapy	Plan pays 70%, Participant pays 30% Coinsurance. Requires Prior Authorization.
Outpatient surgery	Plan pays 70%, Participant pays 30% Coinsurance. Requires Prior Authorization.
Ambulance	Air/Ground Emergency Transportation– Plan pays 70%, Participant pays 30% Coinsurance.
Emergency accident care, urgent care centers	$100 Emergency Room Co-payment (waived if Participant admitted to Hospital within 48 hours).

	If admitted, then Plan pays 70%, Participant pays 30% Coinsurance. $15 Urgent Care Co-payment per visit. If so admitted to Hospital, then Plan pays 70%, Participant pays 30% Coinsurance.
Mental health (Outpatient)	$15 Office Visit Co-payment. Plan pays 70%, Participant pays 30% Coinsurance.
Mental health (Inpatient)	Plan pays 70%, Participant pays 30% Coinsurance. Requires Prior Authorization.
Outpatient chemical dependency, substance abuse at a facility approved by any of the following: Medicare, Medicaid, NCQA or CARF International	$15 Co-payment per visit.
Home Health Services	Plan pays 70%, Participant pays 30% Coinsurance. Requires Prior Authorization.
Hospice care	Plan pays 70%, Participant pays 30% Coinsurance. Requires Prior Authorization. Bereavement counseling limited to 2 visits.
Chiropractic services and neuro-muscular manipulations	Plan pays 70%, Participant pays 30% Coinsurance.
Room & Board; ancillary services in Semiprivate, Intensive Care Unit or	Plan pays 70%, Participant pays 30% Coinsurance. Requires Prior Authorization.

coronary unit	
Inpatient chemical dependency/substance abuse at a facility approved by any of the following: Medicare, Medicaid, NCQA or CARF International	Plan pays 70%, Participant pays 30% Coinsurance. Requires Prior Authorization.
Physical and Occupational Therapy (provided in an Outpatient setting or specialist's office)	Plan pays 70 %, Participant pays 30% Coinsurance. Limited to 15 visits per Plan Year. Additional visits with Prior Authorization.
Speech Therapy (provided in an Outpatient setting or specialist's office)	Plan pays 70%, Participant pays 30% Coinsurance. Requires Prior Authorization
In-Hospital Physician services (includes surgery & anesthesia)	Plan pays 70%, Participant pays 30% Coinsurance (unless otherwise specified elsewhere in the Plan document). Plan pays 20% surgical allowance for assistant surgeon.
Skilled nursing facility (up to a maximum of 100 days per Participant)	Plan pays 70%, Participant pays 30% Coinsurance. Requires Prior Authorization.
Durable Medical Equipment	Plan pays 70%, Participant pays 30% Coinsurance. Requires Prior Authorization for items over $1,500.
All other Medically Necessary Covered Services not described hereof.	Services provided by Network Provider: Plan Pays 70%, Participant pays 30%

	Coinsurance; Out-of-Pocket Maximum applies. Services provided by Non-Network Provider: Plan pays 50%, Participant pays 50% Coinsurance; Out-of-Pocket maximum does not apply.

Other designated services requiring Prior Authorization: All Inpatient hospitalizations, all biopsies, Convalescent/Skilled Nursing Facility stays, Outpatient surgeries (not performed at Physician's office), chemotherapy/infusion therapy, renal dialysis, radiation therapy, human organ transplant evaluation and transplantation, Home Health Services, hyperbaric oxygen treatment, Speech Therapy/respiratory therapy prior to first visit, Physical/Occupational Therapy after the first 15 visits, Durable Medical Equipment ($1,500 purchase or rental), Hospice care, blepheroplasty, breast reduction (except as otherwise provided in the Plan), all Genetic Testing and all medications/Prescription Drugs costing $500 or more per dose.

4.03.1 **Deductible for Center of Excellence".** Notwithstanding anything in this Plan document herein to the contrary, a $500 per Participant annual Plan Year deductible shall apply for use of any Inpatient or Outpatient services at a Center of Excellence. This $500 per Participant deductible shall apply towards the Participant's Out-of-Pocket Maximum.

The $500 per Participant deductible shall **NOT** apply to:

(A) a Participant whose treatment at a Center of Excellence began before March 1, 2013 and whose treatment was continuous on and after that date until that treatment is concluded (as determined by the Medical Management Company); and

(B) a Participant seeking only a Physician's opinion at an initial visit at a Center of Excellence.

4.03.2 **Deductible for Failure to Complete Annual Health Risk Assessment.** Commencing March 1, 2013, and for each Plan Year thereafter, each Employee-Participant shall be required to complete an **annual** health risk assessment in accordance with rules and procedures established by the Plan Administrator or its designate. Failure of the Employee-Participant to complete the assessment before the first day of the immediately following Plan Year in good faith and to the best of their knowledge shall result in the application of a $100 deductible for that Employee-Participant in the Plan Year immediately following the Plan Year in which the health risk assessment was required to be completed.

For example, an Employee-Participant who does **NOT** complete the health risk assessment before March 1, 2014 shall be required to pay a $100 deductible in the Plan Year commencing March 1, 2014. By extension, if that same Employee-Participant subsequently **COMPLETES** the health risk assessment in accordance with the immediately preceding paragraph, during the Plan Year commencing March 1, 201**4**, a $100 deductible will be charged for the 2014 Plan Year but NO deductible shall be charged in the Plan Year commencing March 1, 201**5**.

ARTICLE 5.0

MEDICAL EXPENSE BENEFITS

5.01 **Benefit Percentage.**

For a Covered Expense incurred by a Participant, the Plan will pay the benefit percentage stated in Section 4.03 hereinabove, however, the Participant, not the Plan, must pay any and all amounts needed to satisfy the Out-of-Pocket Maximums listed under Section 4.03, hereinabove.

5.02 **Applicability of Certain Co-payments Toward Out-of-Pocket Maximum.**

Office Visit Co-payments, Urgent Care Co-Payments, Emergency Room Co-Payments and Co-payments for ambulance services and Prescription Drugs apply each time the facility or service is used or Prescription Drug purchased regardless of whether the Out-of-Pocket Maximum has been met.

5.03 **Allocation and Apportionment of Benefits.**

The Plan Administrator may allocate a Co-payment amount to any Covered Expense and apportion the benefits to the Participant and any assignees. Such allocation and apportionment shall be conclusive and binding upon the Participant and all assignees.

5.04 **Plan Benefit Maximum.**

The total Covered Expense benefits payable for a Participant shall not exceed the Participant's Plan benefit maximum as specified in the Section 4.03, hereinabove, even though the Participant may not have been continuously covered under the Plan.

5.05 **Covered Expenses Must Result From Medically Necessary Treatment by a Physician.**

To be eligible for payment under this Plan, a Covered Expense incurred by a Participant must result from treatment by a Physician and must be Medically Necessary for the diagnosis and treatment of an Illness or Injury, unless otherwise specifically covered herein.

Covered Expenses include the Reasonable and Customary charges for the following, subject to any exclusion or limitation under the Plan:

(A) Charges made by a Hospital for:

(1) Inpatient treatment:

(a) Semi-private Room and Board or confinement in an Intensive Care Unit or cardiac care unit, not to exceed the Reasonable and Customary charge;

(b) Meals, including special diets:

(c) General nursing services; and

(d) Medically Necessary Inpatient services and supplies furnished by the Hospital, other than Room and Board.

(2) Outpatient Treatment:

(a) Emergency room use;

(b) Treatment for chronic conditions;

(c) Physical Therapy treatments;

(d) Hemodialysis

(e) X-ray and linear therapy;

(f) Use of facilities and supplies when surgery is performed in the outpatient department of a Hospital, or at a freestanding or emergency care facility; and Medically Necessary pre-admission x-ray and laboratory tests are performed prior to a Hospital confinement, provided such tests are accepted by the Hospital in lieu of similar Inpatient testing and:

(i) are made within seven (7) calendar days prior to the Hospital confinement;

(ii) are normally required during a Hospital confinement; and

(iii) would be covered during a Hospital confinement.

(B) Charges for the most complex surgical procedure when Multiple Surgical Procedures are performed through the same body opening during one surgical operation, unless more than one body system is involved or the procedures are needed for handling multiple trauma. Benefits otherwise payable for the less complex surgical procedure(s) will be reduced by 50%.

(C) Surgical assistance services rendered by a Physician (who is other than a Hospital intern, Hospital resident Physician, Hospital employee or medical student) when performed at the request of the operating Physician in connection with covered major surgery in a Hospital.

(D) Charges made by Hospice during a Hospice Benefit Period for services which are provided to a terminally ill patient with a life expectancy of six (6) months or less. Hospice services must be provided according to a Physician-prescribed plan of care and be Prior Authorized by the Plan. Covered Hospice services include:

(1) Nursing care by a Registered Nurse, a Licensed Practical Nurse, a vocational nurse, a public health nurse, or a certified home health aide, all of whom are under the direct supervision of a Registered Nurse;

(2) Physical, Occupational and Speech Therapy when rendered by a licensed therapist;

(3) Medical supplies including drugs and the use of medical appliances;

(4) Physician's services;

(5) Services, supplies, and treatments deemed Medically Necessary and ordered by a Physician, including medical social services, inhalation therapy, dietary counseling and laboratory services; and

(6) Bereavement counseling [limited to two (2) visits].

(E) Charges made by a Home Health Care Agency, when provided according to a Physician-prescribed plan of care and Prior Authorized by the Plan, for:

(1) Registered Nurses or Licensed Practical Nurses;

(2) Certified home health aides under the direct supervision of a Registered Nurse;

(3) Registered therapists performing Physical Therapy, Occupational Therapy, or Speech Therapy;

(4) Physician calls in an office, home, clinic or Outpatient department;

(5) Services, drugs and medical supplies Medically Necessary for the treatment of the Participant that would have been provided in the Hospital, but not including Custodial Care.

(F) Rental or (if economically justified in the sole opinion of the Plan Administrator) the purchase of Durable Medical Equipment, whichever is less. The services of a Physician for medical care including office visits, home visits, Hospital Inpatient care visits (limited to one per day of Hospital confinement), Hospital Outpatient visits and exams, clinic care, and medical/surgical opinion consultations (limited to one per diagnosis per Hospital admission).

(G) Fees of Registered Nurses or Licensed Practical Nurses for private duty nursing, (exclusive of Custodial Care) provided the Registered or Licensed Practical Nurse is a not member of the Participant's immediate family or is residing in the Participant's home.

(H) Treatment or services rendered by a licensed physical or occupational therapist in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury.

(I) Fees of a duly qualified Physician or qualified speech therapist for restorative or rehabilitative Speech Therapy for speech loss or impairment due to an Illness or Injury, other than a functional nervous disorder, or due to surgery performed as the result of an Illness or Injury. If the speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the Speech Therapy. Expenses are not covered for services to correct non-organic articulatory disorders and services that are otherwise provided by the public schools or other agencies such as, but not limited to, the "Crippled Children's Programs".

(J) Charges for professional ambulance service to the nearest facility where emergency care or treatment is rendered to the Participant.

(K) Charges for the processing and administration of blood or blood components, including the actual blood or blood components, if not replaced.

(L) Charges for oxygen and other gases and their administration.

(M) Charges for the cost and administration of an anesthetic.

(N) Charges for x-rays, microscopic tests, laboratory tests and other diagnostic tests and procedures.

(O) Charges for radiation therapy, chemotherapy, and kidney dialysis.

(P) Charges for dressings, casts, splints, trusses, braces and/or other Medically Necessary medical supplies, with the exception of dental braces, corrective shoes, syringes and needles (except for insulin) or supplies usually stocked in the home for general use (such as, but not limited to, adhesive bandages, thermometers and petroleum jelly).

(Q) Charges for rental or (if economically justified in the sole opinion of the Plan Administrator) the purchase of a wheelchair, hospital bed, or other Durable Medical Equipment required for temporary therapeutic use, or the purchase of this equipment if economically justified, whichever is less.

(R) Charges for Orthotic Appliances, artificial limbs, eyes, or larynx; including their replacement, repair, or adjustment when Medically Necessary.

(S) Charges covered by the Convalescent/ Skilled Nursing Facility care benefits that are for Medically Necessary services, medicines, and supplies. Convalescent/Skilled Nursing Facility care must be provided according to a Physician-prescribed plan of care and be Prior Authorized.

(T) Physician charges for obstetrical services are paid on the same basis as for an Illness, including the mother's prenatal care.

(U) Charges incurred for:

(1) An alveolectomy, for gingivectomy or for the removal of full or partial bone impacted teeth (no allowance for other extractions) on an Outpatient basis, or, if deemed to be Medically Necessary by the Participant's attending Physician, on an Inpatient basis; and

(2) Treatment required because of an accidental bodily Injury to the Participant's face, jaws or sound natural teeth (excluding dentures), provided:

(a) treatment begins within thirty-one (31) calendar days of such Injury; and

(b) the Participant maintains his status as a Participant during the entire course of treatment for such Injury; and

(c) treatment is completed no later than six (6) months from the date of such Injury.

(3) The Participant's dental insurance plan (if any) will be responsible for 'primary' for the services listed in the immediately preceding paragraphs (U)(1) and (U)(2).

(V) Charges for mental illness or disorder and chemical dependency/ substance abuse treatment rendered by a Physician, or certified and licensed social worker under the direct supervision of a Physician, subject to the percentages and amounts listed in Section 4.03, hereinabove.

(W) Hospital and Physician charges for a healthy Newborn Dependent-Participant, including circumcision. These charges are subject to the Newborn-Dependent-Participant's separate Coinsurance amounts.

(X) Charges for human organ transplant of the following:

(1) bone marrow;

(2) heart;

(3) heart/lung;

(4) liver;

(5) lung;

(6) pancreas;

(7) kidney.

Covered Expenses for any of the foregoing organ transplants include acquisition costs, transportation costs, Inpatient Hospital expenses, surgical expenses, nursing charges and charges for related services and supplies all subject to percentages and amounts listed under Section 4.03, hereinabove.

(Y) Charges for sterilization.

(Z) Charges for neuromuscular manipulation and other modalities, subject to percentages and amounts listed under Section 4.03, hereinabove.

(AA) Charges for allergy testing and allergy serum, subject to percentages and amounts listed under Section 4.03, hereinabove.

(BB) Preventive care services (e.g. routine physical examination, routine well infant check-ups, routine Well Child Care, mammography, pap smear, and prostate examinations/tests), subject to the percentages and amounts listed under Section 4.03, hereinabove.

(CC) Charges for an "observation stay". "Observation stay" means active, short-term medical and/or nursing services rendered at a facility other than a clinic, Physician's office, urgent care center or mental health/substance abuse treatment facility for the purpose of monitoring a patient's condition for a period of time not exceeding seventy-two (72) hours in order to determine whether Inpatient care is appropriate. An "observation stay" cannot be used for a planned or elective admission and is reimbursed as an Outpatient service. An "observation stay" of less than twenty-four (24) hours shall not require Prior Authorization. An "observation stay" of twenty-four (24) hours or more shall require Prior Authorization.

ARTICLE 6.0

CONTINUATION COVERAGE UNDER COBRA

6.01 **COBRA Definitions.**

For purposes of this Article 6.0 and with respect to any reference to COBRA benefits throughout the Plan document, the following definitions shall apply in addition to those described in Article 1.0, "Definitions".

(A) **"Code".** The Internal Revenue Code of 1986, as amended.

(B) **"Continuation Coverage".** The Plan coverage elected by a Qualified Beneficiary following a Qualifying Event.

(C) **"Covered Employee"**. An individual defined under 42 USC §300bb-8(2).

(D) **"Group Health Plan".** Has the same meaning as that term is defined in COBRA and the regulations thereunder.

(E) **"Qualified Beneficiary".**

(1) An Employee-Participant whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering him/her ineligible for coverage under the Plan;

(2) A Dependent-Participant who becomes eligible for coverage under the Plan due to a Qualifying Event; and/or

(3) A Newborn or newly adopted Child of a Participant who is continuing coverage under COBRA.

(F) **"Qualifying Event".** Any of the following events that may permit a Qualified Beneficiary to elect Continuation Coverage:

(1) termination of the Qualified Beneficiary's employment with his Employer (other than for gross misconduct) or reduction in the Qualified Beneficiary's hours of employment;

(2) the death of a Qualified Beneficiary who was employed by an Employer;

(3) the divorce or Legal Separation of the Qualified Beneficiary;

(4) the Qualified Beneficiary who is an Employee-Participant becoming entitled to Medicare coverage; or

(5) a Child ceasing to be Dependent-Participant.

(G) **"Totally Disabled for Social Security Purposes" or "Total Disability for Social Security Purposes".** A determination made by the Social Security Administration that the Participant is totally and permanently disabled under Title II or Title XVI of the Social Security Act.

6.02 **Right to Elect Continuation Coverage.**

If a Qualified Beneficiary loses coverage under the Plan due to a Qualifying Event, he may elect to continue coverage under the Plan in accordance with COBRA upon payment of the monthly premium specified from time to time by the Plan Administrator. A Qualified Beneficiary must elect the coverage by no later than the sixtieth (60th) day following the later of:

(A) the date of the Qualifying Event triggering the right to elect Continuation Coverage; or

(B) the date the Qualified Beneficiary was notified of his right to elect Continuation Coverage.

6.03 **Notification of Qualifying Event.**

In the event of a Qualifying Event resulting from divorce, Legal Separation or a Dependent Child's ineligibility under the Plan, the Qualified Beneficiary must notify the Employer of the Qualifying Event within sixty (60) days of the Qualifying Event in order for coverage to continue. In addition, a Qualified Beneficiary who is Totally Disabled for Social Security Purposes must notify the Employer in accordance with Section 6.07, below, in order for Plan coverage to continue.

6.04 **Duration of Continuation Coverage.**

(A) The maximum period of time a Qualified Beneficiary may maintain Continuation Coverage for himself (and, if applicable, any Dependent-

Participants) as a result of the Qualified Beneficiary's loss of Plan coverage due to a reduction in hours of employment or termination of employment (other than for gross misconduct) is:

(1) eighteen (18) months from the date of the Qualifying Event; or

(2) (regardless of the date of the Qualifying Event), twenty-nine (29) months from the date of the Qualifying Event if the Qualified Beneficiary is determined to be Totally Disabled for Social Security Purposes within sixty (60) days of the Qualifying Event, PROVIDED the Qualified Beneficiary notifies the Plan Administrator of the Social Security Administration's determination of his Total Disability for Social Security Purposes before the end of the original eighteen (18) month period of Continuation Coverage and no later than sixty (60) days following the date of such determination.

(B) A Qualified Beneficiary (other than an Employee-Participant) who loses coverage due to the Employee-Participant's death, divorce or entitlement to Medicare, and Dependent-Participant who is a Child who has become ineligible for Plan coverage, is eligible for Continuation Coverage for up to thirty-six (36) months from the date of the Qualifying Event or for such period as prescribed by the Internal Revenue Code, ERISA, and the regulations and administrative pronouncements promulgated thereunder.

6.05 **Termination of Continuation Coverage.**

Continuation Coverage will automatically end earlier than the applicable eighteen (18), twenty-nine (29) or thirty-six (36) month period for a Qualified Beneficiary provided:

(A) the required monthly premium is not received by the Plan Administrator within thirty (30) days following the date it is due;

(B) the Qualified Beneficiary becomes covered under any other group medical insurance plan as an employee or otherwise. If the other group medical insurance plan contains an exclusion or limitation relating to a pre-existing condition, and such exclusion or limitation applies to the Qualified Beneficiary, then the Qualified Beneficiary shall be eligible for the remaining balance of the Continuation Coverage period specified above under this Plan as long as the exclusion or limitation relating to the pre-existing condition limitation or exclusion applies to the Qualified Beneficiary;

(C) (for a Qualified Beneficiary who is Totally Disabled for Social Security Purposes and continuing coverage for up to twenty nine (29) months) the last day of the month coinciding with or immediately following the thirtieth (30th) day following the date of a final determination by the Social Security Administration that such Qualified Beneficiary is no longer Totally Disabled for Social Security Purposes;

(D) the Qualified Beneficiary becomes entitled to Medicare benefits; or

(E) the Employer ceases to offer any group medical insurance plan.

6.06 **Multiple Qualifying Events.**

If a Qualified Beneficiary maintains Continuation Coverage due to a Qualifying Event for which the maximum Continuation Coverage is eighteen (18) or twenty-nine (29) months, and a second Qualifying Event occurs during the eighteen (18) or twenty-nine (29) month period, that Qualified Beneficiary may elect, in accordance with Section 6.02 hereinabove, to maintain Continuation Coverage for up to thirty-six (36) months from the date of the first Qualifying Event. In addition, if a Qualified Beneficiary who was an Employee-Participant becomes entitled to benefits under Medicare (whether or not this triggers a Qualifying Event), a Qualified Beneficiary (other than the Employee-Participant) may elect Continuation Coverage for a maximum of thirty-six (36) months from the date of the initial Qualifying Event, to the extent another period of Continuation Coverage is not required by law under COBRA.

6.07 **Total Disability for Social Security Purposes.**

(A) In a case of a Qualified Beneficiary who is determined to be Totally Disabled for Social Security Purposes within sixty (60) days of a Qualifying Event (if the Qualifying Event is termination of employment or reduction in hours), that Qualified Beneficiary may continue coverage (including coverage for Dependent-Participants who were covered under the Continuation Coverage) for a total of twenty-nine (29) months PROVIDED the Qualified Beneficiary notifies the Plan Administrator:

(1) prior to the end of eighteen (18) months of Continuation Coverage that he was disabled as of the date of the Qualifying Event; and

(2) within sixty (60) days of the determination of Total Disability for Social Security Purposes.

(B) The Plan Administrator will charge the Qualified Beneficiary an increased premium for Continuation Coverage extended beyond eighteen (18) months pursuant to the Section.

(C) If during the period of extended coverage for Total Disability for Social Security Purposes (i.e. Continuation Coverage in excess of eighteen (18) months and less than or equal to twenty-nine (29) months) a Qualified Beneficiary is determined to be no longer Totally Disabled for Social Security Purposes:

(1) The Qualified Beneficiary shall notify the Plan Administrator of this determination within thirty (30) days of the Qualified Beneficiary receiving notice of the determination; and

(2) Continuation Coverage shall terminate the last day of the calendar month that is at least thirty (30) days after the date of the final determination under the Act that the Qualified Beneficiary is no longer Totally Disabled for Social Security Purposes.

6.08 **Continuation Coverage.**

The Continuation Coverage elected by a Qualified Beneficiary is subject to all of the terms, conditions, limitations and exclusions which are applicable to the Group Health Plan offered to similarly situated Employee-Participants and Dependent-Participants. The Continuation Coverage is also subject to the rules and regulations under COBRA. If COBRA permits Qualified Beneficiaries to add dependents for Continuation Coverage, such dependents must meet the definition of Eligible Dependent under the Plan.

6.09 **Carryover of Plan Maximums.**

If Continuation Coverage elected by a Qualified Beneficiary, expenses already credited to the Plan's applicable Co-payment features for the Plan Year will be carried forward into the Continuation Coverage.

Similarly, amounts applied toward any maximum payments under the Plan will also be carried forward into the Continuation Coverage. Coverage will not be continued for any benefits for which Plan maximums have been reached.

6.10 **Payment of Premium.**

(A) The Plan Administrator will determine the amount of premium to be charged for Continuation Coverage for any period. Such premium will be

a reasonable estimate of the cost for providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.

(1) The Plan may require a Qualified Beneficiary to pay a premium for coverage that does not exceed 102 percent of the applicable contribution for that period.

(2) For Qualified Beneficiaries whose coverage is continued pursuant to Section 6.07 hereinabove, the Plan may require the Qualified Beneficiary to pay a premium for coverage that does not exceed 150 percent of the applicable premium for Continuation Coverage in excess of eighteen (18) months but less that or equal to twenty-nine (29) months.

(3) Premiums for coverage may, at the election of the payor, be paid in monthly installments.

(B) If Continuation Coverage is elected, the first monthly premium for coverage must be made within forty-five (45) days of the date of election.

(C) Without further notice from the Plan Administrator, the Qualified Beneficiary must pay the monthly premium for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Employer within thirty (30) days of the payment's due date, Continuation Coverage will terminate in accordance with the Section 6.05(A) hereinabove.

(D) No claim will be payable under this provision for any period for which the premium for coverage is not timely received from or on behalf of the Qualified Beneficiary.

6.11 **Bankruptcy Under Title XI.**

(A) For purposes of this Section 6.11 only:

(1) "Qualified Beneficiary" means:

(a) An Employee-Participant who retired on or before the date of the Qualifying Event and who was covered as a retiree under the Plan;

(b) An individual who was covered under the Plan as a surviving Spouse of a deceased retiree on the day before the date of the Qualifying Event; and

(c) A Dependent of (a) or (b) above who was covered under the Plan on the day before the date of the Qualifying Event.

(2) "Qualifying Event" means the substantial elimination of coverage under the Plan within one year before or after the Employer files a petition in bankruptcy under Title XI of the United States Code.

(B) If a Qualified Beneficiary experiences a Qualifying Event , he may elect to continue coverage under the Plan if he pays the monthly premium specified from time to time by the Plan Administrator, and makes his election in accordance with Section 6.02, hereinabove.

(C) Continuation Coverage elected under this Section 6.11 will automatically end earlier than the periods specified above if the required contribution for coverage is not paid on a timely basis or if the Employer ceases to offer any group health plans.

SECTION 7.0

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

7.01 Exclusions from, and Limitations On, Incurred Expenses.

The following charges and expenses shall not qualify as a Covered Expense:

(A) Charges incurred prior to an Eligible Employee or Eligible Dependent becoming a Participant in the Plan, or after a Participant's coverage is terminated.

(B) Charges incurred by a Participant as a result of war or any act of war, whether declared or undeclared, caused during the Participant's service in the armed forces of any country, involvement in insurrection or civil disobedience, or caused by nuclear explosion or nuclear accident.

(C) Charges arising out of or in the course of any employment or occupation for wage or profit, or for which the Participant is entitled to benefits under any worker's compensation or occupational disease law, or any such similar law.

(D) Charges incurred for which the Participant is not legally obligated to pay, or for which a charge would not ordinarily be made in absence of Plan coverage, including but not limited to: Charges incurred to the extent that the Participant is reimbursed, entitled to reimbursement, or in any way indemnified for the expenses by or through any public program.

(E) Charges resulting from an Illness or Injury arising out of or occurring during the commission of an illegal act by the Participant, including, without limitation, the engaging in an illegal occupation.

(F) Charges incurred for routine medical examinations or routine health checkups, nutritional supplements, or immunizations not Medically Necessary for the treatment of an Injury or Illness, unless specifically shown as a Covered Expense elsewhere in this Plan.

(G) Charges incurred for services or supplies which constitute personal comfort or cosmetic items.

(H) Charges for telephone, television, radio, guest trays, personal convenience items, take-home drugs following discharge from a Hospital, or any sales tax or other tax that may be imposed.

(I) Charges incurred for travel, whether or not recommended by a Physician, unless specifically shown as a Covered Expense elsewhere in the Plan.

(J) Charges incurred in connection with Custodial Care and/or Respite Care.

(K) Charges incurred for Cosmetic Procedures, except for the correction of defects from traumatic Injuries, and services rendered to, or procedures performed on, a Newborn which are necessary for treatment or correction of a congenital defect. Specifically excluded charges for the following Cosmetic Procedures include but are not limited to:

(1) surgery to the upper and lower eyelid;

(2) penile implants;

(3) augmentation mammoplasty or reduction mammoplasty (except as may otherwise be required under the Plan);

(4) full or partial face-lift;

(5) derma- or chemo-abrasion and/or electrolysis for hair removal;

(6) scar revision;

(7) otoplasty;

(8) lift, stretch, or reduction of abdomen, buttocks, thighs or upper arm;

(9) silicone injections to any part of the body;

(10) rhinoplasty; and

(11) Botox injections (unless deemed Medically Necessary and are Prior Authorized).

(L) Charges incurred in connection with services and supplies which are:

(1) not Medically Necessary for the treatment of an Injury or Illness or for preventative care as specifically provided by this Plan; or

(2) in excess of Reasonable and Customary charges; or

(3) not recommended and approved by a Physician unless specifically shown as a Covered Expense elsewhere in the Plan.

(M) Charges for services, supplies or treatment not recognized by the American Medical Association as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury or for preventative care as specifically provided by this plan; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value.

(N) Charges for services rendered by a Physician, nurse, licensed therapist, or Home Health Care Agency employee if such individual is a Close Relative of the Participant, or resides in the same household as the Participant.

(O) Charges incurred outside the United States if the Participant traveled to such a location for the purpose of obtaining medical services, drugs, or supplies.

(P) Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent care, Respite Care or rest care, or any routine physical examinations or tests not connected with the actual Illness or Injury.

(Q) Charges for Physicians' fees for any treatment not rendered by or in the physical presence of a Physician.

(R) Charges incurred in connection with Vision Therapy, eye refractions, the purchase or fitting of eyeglasses, contact lenses, hearing aids, or such similar aid devices, unless specifically shown as a Covered Expense elsewhere in this Plan. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery.

(S) Charges for foot care, which is provided solely to improve comfort or appearance, including, but not limited to, care for flat feet, subluxation, corns, bunions (except capsular or bone surgery), calluses, toenails and the like.

(T) Charges for acupuncture or for the detection or correction of structural imbalance, distortion, or subluxation in the human body, by manual or mechanical means, for the purpose of removing nerve interference or the effects thereof, where such interference is the result of or related to the imbalance, distortion, or subluxation of or in the vertebral column unless specifically shown as a Covered Expense elsewhere in the Plan.

(U) Charges related to or in connection with artificial insemination, in-vitro fertilization or reversal of sterilization.

(V) Charges for outpatient prescription drugs are not covered under the medical benefits.

(W) Charges related to transsexual surgery or to sexual dysfunctions or inadequacies.

(X) Charges for radial keratotomy or other procedures performed to correct refraction.

(Y) All charges for treatment of obesity and/or weight loss procedures including, but not limited to: gastric reservoir reduction, gastric stapling or diversion for weight loss, corrective or remedial surgery for previously-performed gastric bypasses or other gastric procedures performed for the purposes of treatment of obesity or weight-loss.

(Z) Charges for marital counseling or hospitalization for environmental change.

(AA) Charges for professional nursing services if rendered by other than a Registered Nurse or Licensed Practical Nurse, unless such care was vital as a safeguard of the Covered Person's life and unless such care is specifically listed as a Covered Expense elsewhere in the Plan.

(BB) Charges for Experimental/Investigational procedures, drugs, or research studies, or for any services or supplies that are not considered legal in the United States whose use is limited to experimental or investigational purposes by laws or regulations under state or federal law.

(CC) Charges incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or a molar process and any other dental, orthodontic or oral surgical charges except as stated elsewhere in this document.

(DD) Charges for hypnotism or biofeedback.

(EE) Charges for completion of claim forms or for preparation of medical reports, referral forms or Prior Authorization forms.

(FF) Charges for telephone consultations.

(GG) Charges for missed appointments.

(HH) Charges for advance payment of services. Covered Expenses will only be paid after the services have been rendered.

(II) Charges for educational or vocational training except for pre-approved disease management education/training such as diabetic education classes.

(JJ) Charges for Hospital services not consistent with, and not required in, the management and treatment of an Illness or Injury, or other condition for which a person is admitted.

(KK) Charges for Room and Board incurred in connection with a Hospital admission on a Friday or Saturday unless the admission is Prior Authorized by the Plan or is for an acute medical Emergency, an accident, or if surgery is performed within twenty-four (24) hours of the admission.

(LL) Charges for human organ or tissue not specifically shown as a Covered Expense elsewhere in the Plan.

(MM) Charges for growth hormone treatment or therapy.

(NN) Third party coverage, such as other primary insurance, workers' compensation, and Medicare will not be duplicated.

(OO) External nutritional therapy (except for a pump for feeding a patient through an intestinal feeding tube and as otherwise required by applicable law).

(PP) Health club membership, exercise equipment, or weight loss clinics and massage (except when part of a prescribed physical or occupational therapy program).

(QQ) Intelligence Quotient (I.Q.) or other testing for educational purposes.

(RR) 'MENS' (Microcurrent Electrical Neuromuscular Stimulation) unit.

(SS) Nonmedical supportive counseling services, such as alcoholics anonymous ("AA"), narcotics anonymous ("NA"), aftercare and other community-sponsored group alcohol and substance abuse.

(TT) Physiotherapy (such as therapeutic muscle exercises, galvanic or transcutaneous nerve stimulation, vapocoolant sprays, ultrasound or diathermy) which is not part of a Physical Therapy program.

(UU) Peak flow meters, unless use of a peak flow meter is part of an approved asthma management program.

(VV) Screening or treatment associated with learning disabilities, mental retardation and autism.

(WW) Surgical removal of impacted teeth (except bony or partially bony impacted).

(XX) Vaccination for cholera, plague and yellow fever.

(YY) Charges for any service not specified in this Plan as a covered service.

(ZZ) Treatment of temporomandibular joint (“TMJ”) dysfunction.

(AAA) All charges incurred as a result of a non-covered procedure.

(BBB) Charges for breast augmentation or reduction except as may be required under Section 3.05, hereinabove.

(CCC) Charges for medical equipment and supplies not covered by Medicare Part B.

(DDD) Charges for sclerotherapy for spider angiomas (veins), unless medically necessary.

(EEE) Charges for revisions to, corrections of and/or treatment for complications arising directly from, any procedure, service or treatment listed as a specific exclusion under this Plan.

(FFF) RESERVED

(GGG) Any non-covered procedures including, but not limited to, surgeries, services, tests or treatments.

(HHH) Inpatient and outpatient services provided at a facility not approved by Medicare, Medicaid, NCQA or CARF International.

ARTICLE 8.0

COORDINATION OF BENEFITS

8.01 **Coordination of Benefits.**

This Article 8.0 is intended to prevent the duplication of benefits. It applies when a Participant is also covered by any other medical insurance plan(s). When coverage under more than one plan exists, one plan normally pays its benefits in full and the 'other plan(s)' pay a reduced benefit. The Plan will always pay its portion of Allowable Expenses that, when added to benefits payable by the 'other plan', will not exceed 100% of billed charges or this Plan's Allowable Expenses, whichever is less. Only the amount paid by this Plan will be charged against the Plan benefit maximums.

When this Plan is considered as providing 'secondary' coverage, the benefit payment for each claim submitted by a Participant is calculated by first deducting the amount paid by the 'other plan' (which is providing 'primary' coverage) from expenses determined to be Allowable Expenses under this Plan. The balance is then subject to Co-payments, Benefit Percentage amounts and other provisions as described in Section 4.03, hereinabove.

This Coordination of Benefits provision applies whether or not a claim is filed under the 'other plan'. If the 'other plan' provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

The Plan Administrator and Claims Administrator may release to and obtain from any other insurer, plan or party, any information that it deems necessary for purposes of this Article 8.0. The Participant shall cooperate in obtaining such information and shall furnish all information necessary to implement the provisions of this Article 8.0.

8.01.1 **'Other Plan'.**

For purposes of this Article 8.0 only, the term 'other plan' shall mean any plan, policy or coverage (other than the Plan) providing benefits or services for or by the reason of health, medical or dental care or treatment. Such plans may include, without limitation:

(A) Group insurance or any other arrangement for coverage for Participants in a group, whether on an insured or uninsured basis, including but not limited to:

(1) Hospital indemnity benefits; and

(2) Hospital reimbursement-type plans;

(B) Hospital or medical service organizations on a group basis, group practice and other group prepayment plans;

(C) Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;

(D) A licensed health maintenance organization ("HMO");

(E) Any coverage for students which is sponsored by, or provided through, a school or other educational institution;

(F) Any coverage under a government program, and any coverage required or provided by statute;

(G) Group automobile insurance;

(H) Individual automobile insurance coverage on an automobile leased or owned by the Employer;

(I) Individual automobile insurance coverage based upon the principles of "no fault" coverage;

(J) Any plans or policies funded in whole or part by an employer or deductions made by an employer from an employee's compensation or retirement benefits; or

(K) Labor/management trustee, union welfare, employer organization or employee benefit organization plans.

8.02 **Order of Payment of Claims by Plans.**

With respect to claims submitted that involve the coordination of benefits, the Plan and any 'other plan' shall make claim payments according to the following rules of order, provided Medicare is not involved:

(A) If the 'other plan' contains no provision for the coordination of benefits or states that its coverage is primary, the 'other plan' shall pay a submitted claim before any other plan makes any payment.

(B) If the 'other plan' covers a claimant as an employee (or named insured) that 'other plan' will pay a submitted claim before a plan which covers the claimant as a dependent or as a recipient of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985.

(C) If the ‘other plan’ covers a claimant as an employee’s dependent, that ‘other plan’ will pay a submitted claim before a plan which covers the claimant as a dependent of a “qualified beneficiary”, as that term is defined under the Consolidated Omnibus Budget Reconciliation Act.

(D) Pursuant to rules established by the Ohio Department of Insurance, if the claimant is a dependent child, the plan of the parent whose birthday falls first (omitting year of birth) during the calendar year shall be deemed to provide ‘primary’ coverage and shall pay on any claims in that capacity. The plan of the other parent shall be deemed to provide ‘secondary’ coverage and shall pay any claims in that capacity.

Notwithstanding the immediately preceding paragraph, if the child’s parents are separated or divorced, then, the plan deemed to provide ‘primary’ coverage will be determined by the first of the following events to occur:

(1) If a court decree or order makes one parent responsible for the child’s health care expenses, that parent’s plan is responsible for ‘primary’ coverage and the other parent’s plan is responsible for secondary coverage;

(2) If a court decree or order grants joint custody or ‘shared parenting of the child and does not mention health care, then the ‘birthday rule’ described in the initial paragraph of this Section 8.02(D) applies; or

(3) If neither Section 8.02(D)(1) or (D)(2) above applies, then the order for payment of claims is as follows:

(a) The plan of the parent with custody of the child.

(b) The plan of the spouse of the parent with custody of the child.

(c) The plan of the parent not having custody of the child.

(d) The plan of the spouse of the parent not having custody of the child.

(E) If an ‘other plan’ does incorporate the rule described in Section 8.02(D), above, but, instead, has a rule based upon the gender of the parent, and if, as a result, the Plan and the ‘other plan’ do not agree on the order of the benefit payment, the Claims Administrator will determine the order of benefit payments.

(F) A "no fault" automobile policy not described in Section 8.02(A), above, will pay last;

(G) If the order set out in Section 8.02(A), (B), (C), (D), (E), or (F) above does not apply in a particular case, then the plan that has covered the claimant for the longest period of time will pay first.

The Plan Administrator reserves the right to:

(H) obtain information from, or share information with, the 'other plan(s)' regarding Coordination of Benefits without the claimant's consent.

(I) require that the claimant provide information to the Plan Administrator about 'other plans' so that this Article 8.0 may be implemented; and

(J) pay the amount due under the Plan to the 'other plan' if necessary in the Plan Administrator's opinion, in order to satisfy the terms of this Article 8.0.

8.03 **Coordination With Medicare.**

With respect to

(A) Eligible Employees who have Plan coverage by virtue of their current employment status as defined by Medicare; or

(B) Spouses who have Plan coverage by virtue of the Eligible Employee's employment status as defined by Medicare,

who are age sixty-five (65) or older and who are entitled to benefits under Medicare, this Plan will pay 'primary' benefits, unless the Eligible Employee or Spouse refuses coverage under this Plan. If such Eligible Employee or Spouse refuses coverage under this Plan, Medicare will be the sole source of benefits. Eligible Employees or Spouses who have enrolled in this Plan are deemed to have accepted coverage under this Plan until the Plan Administrator receives written notification from the Eligible Employee or Spouse stating that the Eligible Employee or Spouse refuses coverage under this Plan. Any charges which are not paid under this Plan shall be submitted to Medicare as a 'secondary' payor.

With respect to

(C) Eligible Employees who have Plan coverage by virtue of their current employment status as defined in Medicare; or

(D) Eligible Dependents who have Plan coverage by virtue of a family member’s current employment status as defined in Medicare

who are entitled to benefits under Medicare by reason of receiving Social Security Disability benefits (and who are not or would not be entitled to benefits under Medicare on the basis of ‘end stage renal disease’), this Plan will pay ‘primary’ benefits, unless the Eligible Employee or Eligible Dependent refuses coverage under this Plan. If such Eligible Employee or Eligible Dependent refuses coverage under this Plan, Medicare will be the sole source of benefits. Eligible Employees and/or Eligible Dependents who become Participants in this Plan are deemed to have accepted coverage under this Plan until the Plan Administrator receives written notification from the Eligible Employee or Eligible Dependent stating that the Eligible Employee or Eligible Dependent refuses or waives coverage under this Plan. Any charges, which are not paid under this Plan, should be submitted to Medicare as a ‘secondary’ payor.

For those Eligible Employees or Eligible Dependents who are entitled to benefits under Medicare Part A solely on the basis of ‘end stage renal disease’ the following will apply:

(E) For items and services furnished on or after August 5, 1997, with respect to Eligible Employees or Eligible Dependents who become entitled to benefits under Part A of Medicare on or after February 5, 1996, the Plan will pay ‘primary’ benefits during the thirty (30) month period beginning on the earlier of:

(1) The first month in which the Eligible Employee or Eligible Dependent becomes entitled to benefits under Part A of Medicare; or

(2) The first month in which the Eligible Employee or Eligible Dependent would have been entitled to benefits under Part A of Medicare if such person had filed an application for such benefits. After the expiration of such thirty (30) month period, Medicare benefits will be ‘primary’ and this Plan will pay ‘secondary’ benefits.

Solely for the purposes of this Section 8.03(E), and notwithstanding Section 1.33 hereof, the term "Eligible Dependent" shall exclude a "Spouse" as defined in Section 1.101, hereof.

(F) Otherwise, the Plan will pay ‘primary’ benefits during the eighteen (18) month period beginning on the earlier of:

(1) The first month in which the Eligible Employee or Eligible Dependent becomes entitled to benefits under Part A of Medicare; or

(2) The first month in which the Eligible Employee or Eligible Dependent would have been entitled to benefits under Part A of Medicare if such person had filed an application for such benefits. After the expiration of such eighteen (18) month period, Medicare benefits will be ‘primary’ and this Plan will pay ‘secondary’ benefits.

For those Eligible Employees or Eligible Dependents who are entitled to benefits under Medicare solely on the basis of ‘end stage renal disease’ and who subsequently become entitled to benefits under Medicare for the reason of attaining age sixty five (65) or for a disability other than ‘end stage renal disease’, this Plan will pay in accordance with the ‘end stage renal disease’ provisions stated above.

For those Eligible Employees or Eligible Dependents who are entitled to benefits under Medicare on the basis of attaining age sixty five (65) or because of disability (other than ‘end stage renal disease’), and who subsequently become entitled to benefits under Medicare on the basis of ‘end stage renal disease’, then the ‘end stage renal disease’ provisions stated above will apply but only if, prior to such entitlement to benefits under Medicare, Medicare was to pay ‘secondary’ benefits under other provisions of the Plan.

For those Eligible Employees or Eligible Dependents who are not entitled to benefits under Medicare on the basis of attaining sixty five (65) or because of disability (other than ‘end stage renal disease’) and, simultaneously, ‘end stage renal disease’, the ‘end stage renal disease’ provisions stated above will apply. When this Plan’s benefits are ‘secondary’, benefits will be paid as ‘secondary’ as described under this Article 8.0.

For purposes of this Section 8.03:

(G) Effective March 1, 2014 a Spouse shall no longer be entitled to, or receive, 'primary' benefits under the Plan. A Spouse will, however, be eligible to receive 'secondary' benefits upon satisfying the Plan's eligibility and enrollment requirements described herein subject, however, to the provisions of Section 8.03(H) herein,

(H) Any Eligible Employee or Eligible Dependent who receives 'primary' coverage benefits under any health insurance plan, program or scheme sponsored by the federal government including, but not limited to, Medicare, Medicaid or Tri-Care, shall not be eligible for, and shall not receive, 'secondary' coverage under this Plan.

8.04 **Right of Recovery.**

Solely for purposes of this Section 8.04, the term “Participant” will include anyone acting for, or on behalf of, a Participant.

In the event the Plan has a subrogated interest or right of recovery, no Participant shall release any party, person, corporation, entity, insurance policies or funds that may be liable or obligated to that Participant for the acts or omissions of any person or entity, without the written approval of the Plan.

In the event a Participant pursues a claim against a third party or Other Coverage, the Participant agrees to include the Plan’s subrogated interest and rights of recovery in that claim, and if there is a failure to do so, the Plan shall be legally presumed to be included in such claim. In the event the Participant does not pursue a claim against a third party or Other Coverage, the Plan shall have the right to pursue, sue, compromise or settle any such claims in the Participant’s name and to execute any and all documents necessary to pursue said claims in the Participant’s name.

Each Participant hereby agrees to reimburse the Plan, for any past, present and future benefits paid by the Plan, out of any monies recovered from any person, entity, or Other Coverage as a result of judgment, settlement or otherwise, regardless of how those monies are classified. In the event a Participant settles, recovers, or is reimbursed by any third party or Other Coverage, the Participant shall hold any such monies in trust for the benefits of the Plan and shall reimburse the Plan for any benefits so paid hereunder on a first priority basis, regardless of whether or not the Participant has been made whole. If a Participant fails to reimburse the Plan in accordance with this provision the Participant shall be liable to the Plan for any and all expenses (whether in the form of fees or costs) associated with the Plan’s attempt to recover such monies from the Participant. Each Participant also agrees to execute and deliver all necessary instruments to furnish such information and assistance, and to take any action the Plan Administrator may require to facilitate enforcement of its rights. The Plan will not pay or be responsible for, without the written consent of the Plan Administrator, any fees or costs associated with a Participant pursuing a claim against a third party or any other coverage.

ARTICLE 9.0

CLAIM PROCEDURES

9.01 Notice and Proof of Claim.

Written notice of a Covered Expense must be given by the Participant or provider to the Claims Administrator, or its designee, on or in a form designated by the Claims Administrator as soon as is administratively feasible, but in no event no later than one (1) year after the date on which the Covered Expense was incurred.

The Claims Administrator or its designee shall approve, partially approve or deny a claim within the time mandated by the Ohio Revised Code. If special circumstances require more time, the Claims Administrator or its designee shall have additional time to complete its review upon notice to the Participant or provider. If a claim is denied (in whole or in part) the Claims Administrator shall provide the Participant or provider with a written notice which will specify the reason(s) for the denial or, if more information about the claim is needed, describe any additional information that may be required to make its decision. This written notice may take the form of an 'explanation of benefits' worksheet or a letter.

9.02 Appealing a Denial of a Claim or Certification of Medical Necessity

The Participant or his Authorized Representative shall have the right to appeal any Adverse Benefit Determination through an Internal Appeal Review, an External Review, or both, depending upon the circumstances.

(A) **Requesting an Internal Appeal Review.** The request for an Internal Appeal Review must be made in writing on an Appeal Request Form requested from and provided by the Claims Administrator. The Appeal Request Form must be submitted by the Participant or his Authorized Representative to the Appeals Committee in writing, within 180 days after receiving notice of an Adverse Benefit Determination. The Participant or Authorized Representative may request and obtain an Appeal Request Form by contacting the Claims Administrator by phone, facsimile, regular U.S. Mail or e-mail at info@NFPBA.org .

(B) **Internal Appeal Review decision process.** Once an Internal Appeal Review is timely requested and a complete Appeal Request Form is received by the Appeals Committee, the Appeals Committee shall review the documentation and evidence relating to the appeal. A written decision

containing the Appeals Committee's findings will be provided to the Participant or his Authorized Representative initiating the appeal within:

(1) thirty (30) days of the Appeals Committee's receipt of a complete request for an Internal Appeal Review of an Adverse Benefit Determination involving a non-Urgent medical condition for which services have not yet been rendered; or

(2) sixty (60) days of the Appeals Committee's receipt of a complete request for an Internal Appeal Review of an Adverse Benefit Determination involving services already received by the Participant.

If the appeal is denied or a decision is not rendered in the thirty (30) or sixty (60) period described hereof, the Participant or his Authorized Representative may request an External Review.

(3) **"Expedited" Internal Appeal Review.** The Participant or his Authorized Representative may request an "expedited" Internal Appeal Review upon the Participant's treating Physician certifying to the Appeals Committee in writing on the Appeal Request Form that the Participant has an Urgent medical condition.

The Participant or his Authorized Representative may also submit a request for an "expedited" Internal Appeal Review by facsimile or e-mail at info@NFPBA.org) by completing an Appeal Request Form, checking the appropriate box(es) on the Form and providing any necessary certifications.

Requests for "expedited" Internal Appeal Reviews may also be made orally by a Participant or his Authorized Representative by calling the Appeals Committee's 'Appeals Team' at (419) 244-0135 and asking for a member of the 'Appeals Team' because of a Participant's Urgent condition. Written confirmation of the oral request, Urgent condition and any required certifications must be submitted by the individual making the request to the Appeals Committee no later than five (5) days after the request for an "expedited" Internal Appeal Review is made.

Upon receiving a complete request for an "expedited" Internal Appeal Review, the Appeals Committee shall review the evidence and documentation relating to the Adverse Benefit Determination being appealed and shall issue its decision, in writing, to the Participant or his Authorized Representative requesting the appeal within seventy-two (72) hours of receiving the complete "expedited" Internal Appeal request.

If the appeal is denied or a decision is not rendered in the seventy-two (72) hour period described hereof, the Participant or Authorized Representative may request an External Review.

(C) **External Review.** A Participant is entitled to an External Review conducted by either the Ohio Department of Insurance or an Independent Review Organization.

The Ohio Department of Insurance will conduct the External Review in cases where the Adverse Benefit Determination:

(1) is based on a contractual issue that does not involve a medical judgment or any medical information; or

(2) indicates that emergency medical services did not meet the definition of Emergency AND the Adverse Benefit Determination has already been upheld through an External Review by an IRO.

An Independent Review Organization will conduct the External Review only in cases where the Adverse Benefit Determination:

(3) involves a medical judgment or is based on any medical information; or

(4) indicates the requested service is experimental or investigational and the treating Physician certifies that:

(a) standard health care services have not been effective in improving the condition of the Participant; or

(b) standard health care services are not medically appropriate for the Participant; or

(c) no available standard health care service covered by the Plan is more beneficial than the requested health care service.

An External Review may be of the "standard" or "expedited" type.

(5) **"Standard" External Review Procedure.**

A "standard" External Review must be requested by the Participant or his Authorized Representative, in writing on an Appeal Request Form requested from, and provided by, the Claims

Administrator and filed with the Appeals Committee within 180 days of the date an Adverse Benefit Determination is issued.

(a) **Procedure if "standard" External Review request is complete.** If an External Review request is complete and eligible for review, the Appeals Committee will initiate the External Review and shall so notify the Participant or his Authorized Representative making the request, in writing The notification shall also:

(i) include the name and contact information for the assigned IRO or the Ohio Department of Insurance (whichever is applicable) for the purpose of submitting additional information; and

(ii) inform the Participant or Authorized Representative making the request that, within ten (10) business days after receipt of the notice, additional information in writing may be submitted to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review.

The Appeals Committee will forward all documents and information used to make its Adverse Benefit Determination to the IRO or the Ohio Department of Insurance (as applicable).

If the External Review is being conducted by an IRO:

(iii) Upon receipt, the IRO must forward any additional information it receives from the Participant or his Authorized Representative to the Appeals Committee. The Appeals Committee may, at any time, reconsider and reverse the Adverse Benefit Determination; however, reconsideration will NOT delay or terminate the External Review. If the Adverse Benefit Determination is reversed, the Appeals Committee shall notify the Participant or his Authorized Representative, the assigned IRO and the Ohio Department of Insurance within one business (1) day of making the decision. Upon receiving notice of the reversal from the Appeals Committee, the IRO will terminate the Review.

(iv) In addition to all documents and information considered and/or used in making the Adverse

Benefit Determination, the IRO shall take into consideration factors such as: the Participant's medical records, the treating Physician's recommendation, consulting reports from appropriate health care professionals, the Plan's terms and conditions and the most appropriate practice guidelines.

Written decisions in "standard" External Reviews are normally provided to the Participant or his Authorized Representative within thirty (30) days of the Appeal Committee's receipt of a complete request for a "standard" External Review; however, a "standard" External Review decision made by an IRO shall be sent to the Appeals Committee and the Ohio Department of Insurance and shall include the following information:

(v) a general description of the reason for the request of the "standard" External Review;

(vi) the date the IRO was assigned to conduct the "standard" External Review;

(vii) the dates over which the "standard" External Review was conducted;

(viii) the date on which the IRO's decision was made;

(ix) the rationale for the IRO's decision; and

(x) references to the evidence or documentation (including any evidence-based standards) that the IRO used or considered in reaching its decision.

(b) **Procedure if the "standard" External Review request is NOT complete.** The Appeals Committee will inform the Participant or his Authorized Representative that a "standard" External Review request is not complete, in writing, and shall specify what information is needed to complete the request.

(6) **"Expedited" External Review.** An "expedited" External Review due to an Urgent medical condition may be requested on an Appeal Request Form requested from the Claims Administrator and submitted to the Appeals Committee within 180 days of an

Adverse Benefit Determination being issued, if any of the following apply**:**

(a) the Participant's treating Physician certifies to the Appeals Committee on the Appeal Request Form that the Adverse Benefit Determination involves the Participant's Urgent medical condition;

(b) the Adverse Benefit Determination involves an admission, availability of care, continued stay or health care service for which the Participant received treatment for an Emergency, but has not yet been discharged from a facility;

(c) an "expedited" Internal Appeal Review is in process for an Adverse Benefit Determination of an Experimental / Investigational treatment and the Participant's treating Physician certifies to the Appeals Committee in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

The Participant or his Authorized Representative may also submit a request for an "expedited" External Review by facsimile or e-mail at info@NFPBA.org, by completing an Appeal Request Form, ensuring the appropriate box(es) relating to the "expedited" External Review request are checked and providing the Appeals Committee with any necessary certifications relating to the Participant's Urgent condition.

Requests for "expedited" External Reviews may also be made orally by a Participant or his Authorized Representative by calling the Appeals Committee and asking to speak to a member of the 'Appeals Team' due to an Urgent situation. Written confirmation of the oral request, the Participant's Urgent condition and any other certifications relating to the "expedited" External Review request must be submitted to the Appeals Committee no later than five (5) days after the oral request is made.

The Appeals Committee will initiate the External Review and notify the Participant, Authorized Representative or treating Physician making the request, in writing, if the 'expedited' External Review request is complete and eligible for review. The notification shall also:

(i) include the name and contact information for the assigned IRO or the Ohio Department of Insurance

(whichever is applicable) for the purpose of submitting additional information; and

(ii) inform the Participant or his Authorized Representative that, within ten (10) business days after receipt of the notice, additional information in writing may be submitted to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review.

The Appeals Committee will forward all documents and information used in making the Adverse Benefit Determination to the IRO or the Ohio Department of Insurance (as applicable).

If the 'expedited' External Review is being conducted by an IRO:

(iii) Upon receipt, the IRO must forward and additional information it receives from the Participant or his Authorized Representative to the Appeals Committee. The Appeals Committee may, at any time, reconsider and reverse the Adverse Benefit Determination; however, reconsideration will NOT delay or terminate the External Review. If the Adverse Benefit Determination is reversed, the Appeals Committee shall notify the Participant or his Authorized Representative, the assigned IRO and the Ohio Department of Insurance within one (1) business day of making the decision. Upon receiving notice of the reversal from the Appeals Committee, the IRO will terminate the Review.

(iv) In addition to all documents and information considered and/or used in making the Adverse Benefit Determination, the IRO shall take into consideration factors such as: the Participant's medical records, the treating Physician's recommendation, consulting reports from appropriate health care professionals, the Plan's terms and conditions and the most appropriate practice guidelines.

Written decisions in "expedited" External Reviews are normally provided to the Participant, Authorized Representative or treating Physician making the request

within seventy-two (72) hours of the Appeals Committee's receipt of a complete request for the "expedited" External Review. The decision made by an IRO shall be sent to the Appeals Committee and the Ohio Department of Insurance and shall include the following information:

(v) a general description of the reason for the request of the "expedited" External Review;

(vi) the date the IRO was assigned to conduct the "expedited" External Review;

(vii) the dates over which the "expedited" External Review was conducted;

(viii) the date on which the IRO's decision was made;

(ix) the rationale for the IRO's decision; and

(x) references to the evidence or documentation (including any evidence-based standards) that the IRO used or considered in reaching its decision.

(D) **Adverse Benefit Determination not eligible for External Review by IRO.** If the Appeals Committee determines that the Adverse Benefit Determination is not eligible for External Review by an IRO, it shall so notify the Participant or his Authorized Representative, in writing. The notification shall provide the reason for the denial along with a statement that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may, in accordance with the terms of the Plan document and all applicable provisions of the law, determine that the Adverse Benefit Determination is eligible for External Review regardless of the Appeals Committee's decision and can require that the External Review take place.

(E) **Concurrent "expedited" Internal Appeal and "expedited" External Review.** A Participant or his Authorized Representative may request an "expedited" Internal Appeal Review and an "expedited" External Review be conducted concurrently in cases where:

(1) the Participant has an Urgent medical condition; or

(2) in the judgment and expertise of the Participant's treating Physician a proposed Experimental/Investigational treatment must begin promptly.

The Participant or his Authorized Representative may submit the request for the concurrent Reviews by requesting and completing a Appeal Request Form, **making sure the section relating to a concurrent "expedited" Internal Appeal Review and "expedited" External Review" are properly completed and the Participant's treating Physician has completed the "Treating Physician Certification Form for Internal Appeal and/or External Review".**

The request for the concurrent Reviews may be made in person, by mail or by facsimile or e-mail at info@NFPBA.org. The request may also be made orally by calling the Appeals Committee and asking to be transferred to a member of the 'Appeals Team' due to an Urgent situation. Written confirmation of the oral request and Urgent condition and any certifications must be submitted to the Appeals Committee no later than five (5) days after such a request is made.

Upon receiving a complete request for a concurrent "expedited" Reviews the Appeals Committee and the IRO will issue their decisions in accordance with the procedures described under Sections 9.02(B)(3) and (C)(6) within seventy-two (72) hours of the Appeals Committee receiving the complete request for the concurrent "expedited" Reviews.

(F) **Submitting additional information about a Participant's claim.** A Participant may supply additional information regarding his claim for consideration during the appeal review. Any such information along with a copy of the 'explanation of benefits' must be sent to the Appeals Committee by regular mail, courier service (e.g. FedEx) or by facsimile.

(G) **Requesting copies of information relevant to the Participant's claim.** The Participant or his Authorized Representative may request copies of information relevant to the Participant's claim free of charge. If a coding error is suspected of having caused the claim to be denied, the Participant or his Authorized Representative has the right to have billing and diagnosis codes provided to them. Copies of such information can be requested and obtained by contacting the Appeals Committee by mail, phone, facsimile or e-mail.

(H) **Binding nature of External Review decision.** Any External Review decision, whether "standard", "expedited" or "concurrent", is binding on the Plan except to the extent the Plan has other remedies available under Ohio law. The decision is also binding on the Participant except to the extent the Participant has other remedies available under applicable Ohio or federal law.

A Participant may not file a subsequent request for any kind of External Review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to the Appeals Committee.

(I) **Further information about appeal rights.** Further information regarding appeal rights and/or additional assistance regarding Plan appeals may be obtained from:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp

Consumer complaints may be filed at:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

9.02.1 **Definitions for Section 9.02.** The following definitions shall apply solely to Section 9.02:

(A) **"Adverse Benefit Determination".** A decision made by the Claims Administrator:

(1) declining to provide or pay for any item or service (in whole or in part);

(2) not to issue Plan coverage to the Participant; or

(3) to rescind a Participant's Plan coverage.

(B) **"Appeal Request Form".** The form provided by the Claims Administrator that must be completed by the Participant or his Authorized Representative in order to commence any appeal of an Adverse Benefit Determination under the Plan's appeal process.

(C) **"Authorized Representative".** An individual authorized by law or designated by the Participant (including, but not limited to, the Participant's treating Physician) to act on, or appeal, an Adverse Benefit Determination on the Participant's behalf. To be valid, the Participant's Authorized Representative must be identified in writing on the Appeal Request Form.

(D) **"External Review".** The process that allows the Participant or his Authorized Representative to request a review of an Adverse Benefit Determination (circumstances permitting) by the Ohio Department of Insurance or an IRO.

(E) **"Independent Review Organization" or "IRO".** An accredited and qualified entity selected at random, to conduct an External Review (based on the type of health care service involved with an Adverse Benefit Determination) by the Ohio Department of Insurance from its secure web-based system

(F) **"Urgent".** A situation or condition in which the:

(1) Participant's health or life may be in serious jeopardy; or

(2) Participant may not be able to regain maximum function if treatment is delayed; or,

(3) Participant may experience pain that cannot be adequately controlled while he waits for a decision on his appeal.

9.03 Independent Medical Examination.

The Plan Administrator or its designee shall have the right and opportunity to have the Participant, whose Injury or Illness is the basis of a claim hereunder, examined by an independent medical examiner of the Plan Administrator’s choosing when and as often as it may reasonably require during pendency of a claim. Any such examination and related expenses shall be paid for by the Plan. Each Participant is deemed, through his participation in the Plan, to authorize the Plan Administrator to review the results of the independent medical examination. The Plan Administrator or its designee shall also have the right and opportunity to have an autopsy performed in case of death where it is not forbidden by law.

9.04 Legal Proceedings.

Unless the Participant claiming benefits shall have first exhausted his/her administrative remedies by filing proof of loss and pursuing an appeal under the terms provided in the Plan:

(A) No action at law or in equity shall be brought to recover benefits under the Plan prior to the expiration of a sixty (60) day period (as may be extended by the Plan Administrator) following the filing of proof of loss in accordance with the claim procedures described in this Article 9.0; and

(B) Any action at law or in equity brought to recover benefits under the Plan must be brought within one (1) year from the expiration of the time within which proof of loss is required by the Plan.

9.05 Payment of Claims.

When the Claims Administrator receives proof of loss, the Claims Administrator will pay any benefits due. Benefits that provide for periodic payment will be paid for each period, as the Plan becomes liable. The Claims Administrator or its designee will pay benefits to the Participant or provider.

All or a portion of the benefits provided by this Plan may be paid to the institution or person rendering service, unless a Participant directs the Claims Administrator otherwise in writing, and the Plan Administrator consents, prior to the time of filing proof of loss.

The Claims Administrator will not be liable for any payment made in good faith.

9.06 Overpayments.

If a Participant receives benefits under the Plan that exceeds those which should have been paid or that should not have been paid at all, the Claims Administrator may:

(A) deduct the excess improper payment from any subsequent benefits payable for the Participant or

(B) recover such amounts by any other appropriate method that the Claims Administrator shall determine.

Each Participant is deemed, through his participation in the Plan, to authorize the foregoing actions in the event of benefit overpayments.

9.07 **Facility of Payment.**

Whenever a Participant or provider to whom payments are directed to be made is determined to be mentally, physically, or legally incapable of receiving or acknowledging receipt of such payments, neither the Employer nor any fiduciary shall be under any obligation to see that a legal representative is appointed or to make payments to such legal representative if appointed. A determination of payment made in good faith shall be conclusive on all persons. The Plan Administrator or his/her designee, or any fiduciary shall not be liable to any person as the result of payment made and shall be fully discharged from all future liability with respect to a payment made.

ARTICLE 10.0

PROTECTED HEALTH INFORMATION (PHI)

10.01 **Use and Disclosure of Protected Health Information (PHI).**

This Plan uses Protected Health Information to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, 'payment' for health care and 'health care operations', as described in Section 10.01.2, hereinbelow.

10.01.1 **"Payment".** For purposes of this Article 10.0, 'payment' includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(A) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and Co-payments as determined for an individual's claim);

(B) coordination of benefits;

(C) adjudication of health benefit claims (including appeals and other payment disputes);

(D) subrogation of health benefit claims;

(E) establishing Employee contributions;

(F) risk adjusting amounts due based on enrollee health status and demographic characteristics;

(G) billing, collection activities and related health care data processing;

(H) claims management and related health care data processing, including auditing payments, investigating and resolving 'payment' disputes and responding to Participant inquiries about 'payments';

(I) obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(J) medical necessity reviews or reviews of appropriateness of care or justification of charges;

(K) utilization review including pre-certification, preauthorization, concurrent review and retrospective review;

(L) disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

(M) reimbursement to the Plan.

10.01.2 **Health Care Operations.** For purposes of this Article 10.0, 'health care operations' include, but are not limited to, the following activities:

(A) quality assessment;

(B) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(C) rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(D) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

(E) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(F) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(G) business management and general administrative activities of the Plan, including, but not limited to:

(1) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or

(2) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;

(3) resolution of internal grievances; and

(4) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" as defined under HIPAA or, following completion of the sale or transfer, will become a covered entity.

10.02 The Plan Will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary.

Provided proper authorization is received or is deemed to be received by the Plan, the Plan will disclose PHI for purposes related to administration of the Plan.

10.03 Disclosure of PHI to the Plan Sponsor.

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions:

10.03.1 Plan Sponsor Agrees to Certain Conditions Regarding PHI.

The Plan Sponsor agrees:

(A) not to use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(B) to 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;

(C) not to use or disclose PHI for employment-related actions and decisions unless authorized by the individual who is the subject of the action or decision;

(D) to report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(E) to make PHI available to an individual in accordance with HIPAA's access requirements;

(F) to make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(G) to make available the information required to provide an accounting of disclosures;

(H) to make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the Secretary of the United States Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and

(I) if feasible, to 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 (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

10.03.2 **Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained.**

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

(A) the Director of the Lucas County Office of Management and Budget;

(B) staff designated by the Director of the Lucas County Office of Management and Budget; and

(C) the designated Lucas County Privacy Officer.

10.03.3 **Limitations of PHI Access and Disclosure**.

The persons described in Section 10.03.2 may only have access to, and use and disclose, PHI for plan administration functions that the Plan Sponsor performs for the Plan.

10.03.4 **Noncompliance Issues.**

The Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions for persons described in Section 10.03.2 who do not comply with the provisions of this Plan document.

ARTICLE 11.0

GENERAL PLAN PROVISIONS

11.01 **Plan Construction.**

This Plan shall be construed in accordance with applicable state and federal law.

Whenever any words are used herein in the masculine, they shall be construed as though they were in the feminine in all cases where they would so apply; and whenever any words herein are used in the singular, they shall be construed as though they were used in the plural in all cases where they would so apply.

11.02 **Plan Administrator Responsibilities.**

The Plan Administrator may delegate responsibilities for the operation and administration of the Plan as it, in its sole discretion, may deem necessary and/or proper. The Plan Administrator's responsibilities include those delegated to the Claims Administrator as set forth in an administration agreement and any addenda thereto.

11.03 **Plan Administrator Discretion.**

The Plan Administrator alone shall be the sole judge of the standards of proof required in any matter hereunder. In the application and interpretation of this Plan document, the decisions of the Plan Administrator shall be final and binding on the Participants, and all other persons and/or entities. The Plan Administrator shall have the full and exclusive power and authority, in its sole discretion, to determine all questions of coverage and eligibility for benefits, methods of providing or arranging for benefits and all other related matters. The Plan Administrator shall have the full power and authority, in its sole discretion, to construe and interpret the provisions and terms of this Plan document and all other written documents. Any such determination and any such construction adopted by the Plan Administrator in good faith shall be binding upon all the parties hereto and the beneficiaries thereof.

11.04 **Participant Obligations.**

The coverage provided to a Participant by the Plan shall be at least partially funded by the Employer. If an Employee-Participant elects to enroll an Eligible Dependent in the Plan, the Employee-Participant may be responsible for payment of all or portion of the Eligible Dependent's contributions suitable to cover such

enrollment. The Employer shall deduct such costs on a regular basis from the Employee-Participant's wages or salary.

11.05 **Failure to Enforce.**

Failure of the Plan Sponsor or Plan Administrator or their designate(s) to enforce any provisions of this Plan does not constitute a waiver or otherwise affect the Plan Administrator's right to enforce such a provision at another time, nor will such failure affect the right to enforce any other provision.

11.06 **Statements.**

In the absence of fraud, all statements made by a Participant will be deemed representations and not warranties. No such representation will void the Plan benefits. No such representation may be used in defense of a claim under the Plan unless a copy of the instrument containing such representation is or has been furnished to the Participant.

11.07 **Plan Amendments and Termination.**

The Plan Sponsor establishes this Plan with the intention of maintaining it for an indefinite period of time. However, the Plan Sponsor reserves the right to amend or terminate this Plan at any time, in compliance with the following provisions:

(A) The Plan Sponsor shall have the right to amend this Plan in whole or in part. Amendments shall be made by a resolution of the Plan Sponsor.

(B) The Plan Sponsor reserves the right at any time to terminate the Plan by a written resolution of the Plan Sponsor.

11.08 **Assignment, Change and Waiver.**

No assignment of a Participant's interest hereunder shall be binding on the Plan Sponsor. The terms of this Plan shall not be waived or changed except as provided in Section 11.07, hereinabove.

11.09 **Plan Is Not A Contract.**

The establishment and maintenance of this Plan shall not be construed as conferring, and does not confer, any legal rights on any Employee to be

continued in the employ of the Employer nor shall this Plan interfere in any way with the right of the Employer to discharge any employee.

This Plan document shall not give Participants any claim, right, action or cause of action against the Plan for acts or omissions of any provider which renders services to Participants. The Plan Administrator does not furnish services but will pay for Covered Expenses incurred for services rendered by providers to Participants.

11.10 **Records.**

By accepting coverage under this Plan, a Participant agrees that all information and records concerning diagnosis and treatment of any condition for which coverage is provided will be available to the Plan Administrator or its designee and its designated Claims Administrator for purposes of determining liability and/or for statistical analysis. Participants are required to furnish specific releases of medical information as necessary for the purposes of determining the Plan's liability.

11.11 **Headings.**

The heading of articles and sections herein are included solely for convenience of reference and shall not affect the meaning of any of the provisions of the Plan.

11.12 **Savings and Severability**

This Plan is intended to be in conformity with all applicable federal, state and local laws and regulations. To the extent any Plan provision is found to be invalid or unenforceable, such provision will be modified to the extent possible to reflect the Plan Sponsor's intentions. All remaining provisions of the Plan will remain in full force and effect unless otherwise determined by the Plan Administrator.

Adopted by Resolution No. _____________, this 22nd day of March, 2011.

BOARD OF COUNTY COMMISSIONERS,
LUCAS COUNTY, OHIO

____
Pete Gerken, President

____
Tina Skeldon Wozniak, Commissioner

____
Carol Contrada, Commissioner

APPROVED AS TO FORM:

____
JULIA R. BATES
LUCAS COUNTY PROSECUTING ATTORNEY
By: Peter N. Kanios