Medical Plans
(PPO, PPO Assist, HDHP)

A component of the OhioHealth Corporation Welfare Benefits Plan

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Plan Document and
Summary Plan Description

Effective Date (PPO Plans): January 1, 2020
Effective Date (HDHP): January 1, 2017
Restatement Date: January 1, 2023

OHIOHEALTH MEDICAL PLANS
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

ESTABLISHMENT OF THE PLAN

OhioHealth Corporation (the “Employer” or the “Plan Sponsor”) has adopted this amended and restated Plan Document and Summary Plan Description effective as of January 1, 2023 (hereinafter referred to as the “Plan”), as set forth herein for the exclusive benefit of its eligible Associates and their eligible Dependents. The PPO Plans were originally adopted by the Employer effective as of January 1, 2020. The HDHP was originally adopted by the Employer effective as of January 1, 2017.

The Plan Sponsor has established the Plan for eligible Associates and eligible Dependents, on the terms and conditions described herein. The Plan Sponsor’s purpose in establishing the Plan is to help to protect Associates and their families by offsetting some of the financial costs that may arise from an Injury or Illness. To accomplish this purpose, the Plan Sponsor must attempt to control health care costs through effective plan design and the Plan Administrator must abide by the terms of the Plan, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to manage their healthcare costs.

The purpose of this document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain health care expenses. Please read this document carefully and contact the Plan Administrator with any questions.

The Plan Administrator has retained the services of independent Third Party Administrators to process claims and handle other duties for this self-funded Plan. The Third Party Administrators do not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator and are not fiduciaries.

The Employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Associates help cover some of the costs of Covered Benefits through contributions, Deductibles, out-of-pocket costs, Copayments, and Coinsurance amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits. The Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974, as amended, and its implementing regulations and other applicable guidance (“ERISA”).

The Plan is not a contract of employment between the Associate and the Employer and does not give the Associate the right to be retained in the service of the Employer.

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document and Summary Plan Description as the written description of the Plan. This document serves as the Summary Plan Description, which is required by ERISA. This Plan amends and replaces any prior statement of the health care coverage contained in any predecessor document.

IMPORTANT CONTACT INFORMATION

For questions, comments, concerns about benefits or coverage, or Precertification, contact OhioHealthy:

OhioHealthy Member Advocates	1-888-841-5670
OhioHealthy Health Care Management (Precertification)	1-888-845-3580
Website (claim information)	www.ohiohealthyplans.com

OhioHealthy is the Preferred Provider Organization (PPO) Network utilized by this Plan.

OhioHealthy Member Advocates	1-888-841-5670
Website (look up participating Providers)	www.ohiohealthyplans.com
OhioHealthy Specialty Pharmacy	1-614-566-3322

Express Scripts (ESI) is the Pharmacy Benefit Manager (PBM) that is responsible for the Pharmacy benefits under this Plan. (non-specialty drugs)

Express Scripts Customer Service	1-800-428-0529
Express Scripts Website	www.express-scripts.com

Archimedes is the administrator of the Specialty Drug Management Program

Archimedes Customer Service	1-888-504-5563
Prior Authorization Forms	www.archimedesrx.com/resources
Archimedes Email	Memberservices@archimedesrx.com
ArcadiaHealth (specialty drug pharmacy)	1-844-484-6926

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SECTION I: PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK

OhioHealth Corporation and OhioHealthy have joined forces to create an expanded network of health care Providers. This Network is called a Preferred Provider Organization (PPO) Network. The PPO Network should be contacted prior to services being rendered to determine if Providers being utilized are participating in the PPO Network. However, there is no requirement to use a participating Provider. The choice of Provider is entirely up to the Covered Person but use of an Out-of-Network Provider will generally result in a greater cost to the Covered Person.

ACCURATE PROVIDER DIRECTORY INFORMATION

The Plan has established a process to update and verify the accuracy of Provider directory information and a protocol for responding to requests by telephone and electronic communication from a participant, beneficiary, or enrollee about a Provider's network participation status, as explained in this section.

The Plan's Provider directory is available at www.ohiohealthyplans.com. The Provider directory contains a list of each Provider with which the Plan has a direct or indirect contractual relationship for furnishing items and services under the Plan, and Provider information with respect to each such Provider. The Plan has established a process to update and verify the accuracy of Provider directory information, as required by applicable law.

If a Covered Person requests information through the telephone regarding whether a Provider has a contractual relationship to furnish items or services under the Plan, the Plan will respond to the request as soon as practicable and in no case later than one (1) business day after such call is received. Responses will be provided verbally, or through a written electronic or print communication, as requested. The Plan will retain such communication in the Covered Person's file for at least two (2) years following the Plan's response. This is known as the Plan's "response protocol" for purposes of this section.

If a Covered Person receives an item or service from an Out-of-Network Provider, and was provided inaccurate information by the Plan under the required Provider directory or response protocol which stated the Provider was an In-Network Provider, then the Plan will not impose a cost-sharing amount that is greater than the benefit level that would be imposed for items and services furnished by an In-Network Provider, and will count such amounts toward any In-Network Deductible or Out-of-Pocket Maximum.

FREE CHOICE OF PHYSICIAN AND TREATMENT

The Covered Person shall have free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. The Covered Person, together with their Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of such care. Except for OhioHealthy, Providers of health care services, including hospitals, institutions, facilities, or agencies, are independent contractors and are neither agents nor Associates of OhioHealthy or its affiliates. The Plan shall not be liable for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice on the part of any officer or Associate or on the part of any Physician in the course of performing services for the Covered Persons.

The Covered Associates and their covered Dependents have the choice of using any Provider for healthcare services. Utilizing the services of participating PPO Providers will save the Covered Person money.

PRIMARY CARE PHYSICIANS

To access Network benefits, a Covered Person is encouraged to select a Primary Care Physician (PCP) from the Network of Providers at the time of enrollment. Each covered family member may select their own PCP. If a Dependent is a minor, or otherwise incapable of selecting a PCP, the Associate should select a PCP on their behalf. The Associate may select a pediatrician as their child's PCP.

A Covered Person may search online for the most current list of Network Providers in their area by using the online Provider directory at www.ohiohealthyplans.com. Providers located outside of the Greater Columbus Ohio Service Area use the same online Provider Directory for PHCS Providers at www.ohiohealthyplans.com. A Covered Person can choose a PCP based on geographic location, group practice, medical specialty, language spoken, or Hospital affiliation. A PCP may be a general practitioner, family Physician, internist, or pediatrician.

The PCP will coordinate medical care, as appropriate either by providing treatment or may direct the Covered Person to other Network Providers for other Covered Services and supplies. The PCP can also order lab tests and X-rays, prescribe medicines or therapies, and arrange Hospitalization.

PPO NETWORK BENEFITS

When a Covered Person receives services from Providers in the PPO Network, their expenses may include a Deductible, a Copayment, or a fixed percentage (i.e. Coinsurance) that is applied to the contracted rates with the PPO Providers. The Covered Person is not responsible for billed charges that are above the contracted rates. Not all Providers based in network Hospitals or medical facilities are participating Providers. The attending Physician should be contacted by the Covered Person prior to services being rendered to determine if any additional Providers may be used for Ancillary Services (e.g. assistant surgeons or co-surgeons), and to verify their PPO Network status. Out-of-Network Provider charges will be reimbursed at the Out-of-Network benefit level, unless otherwise indicated below.

A current list of PPO Providers is available, without charge, from the Plan Administrator (see “Important Contact Information” above).

OUT-OF-NETWORK BENEFITS

When services are performed by a Provider who is not in the PPO Network, the Covered Person’s expenses include a Deductible and a fixed percentage (i.e. Coinsurance) of the Maximum Allowable Amount (as defined by this Plan). The Maximum Allowable Amount may often be less than the amount a Provider bills for service and therefore could result in the Covered Person receiving a bill for the difference (called “Balance Billing”), if not prohibited by law. **In these situations, the Covered Person will be responsible for charges in excess of the Maximum Allowable Amount.** Charges that exceed the Maximum Allowable Amount are not covered and do not apply to the annual Out-of-Pocket Maximum.

OUT-OF-NETWORK EXCEPTIONS

In the following situations, services rendered by an Out-of-Network Provider will be considered at the In-Network benefit level:

1. When a Covered Person uses an In-Network Physician’s office and that office utilizes an Out-of-Network provider for the reading and interpretation of x-rays and laboratory tests.
2. When a Covered Person uses ground Ambulance Transportation:
    a. for an Emergency Medical Condition requiring immediate care.
    b. for Medically Necessary ground transportation (non-emergency) (Precertification is required).
3. When a Covered Person has no choice of an In-Network Provider in the specialty they are seeking (i.e. wigs, durable medical equipment, etc.) (approved referral required).

As required by the No Surprises Act, the following services rendered by an Out-of-Network Provider will be considered at the In-Network benefit level and will apply towards the In-Network Deductible and In-Network Out-of-Pocket Maximum, to the extent such services would be covered if provided by an In-Network Provider; additionally, Provider Balance Billing would not be permitted:

1. When a Covered Person receives Emergency Services from an Out-of-Network Emergency Facility for an Emergency Medical Condition – including certain post-stabilization services.
2. When a Covered Person uses an Out-of-Network air ambulance (for emergency and non-emergency situations) (non-emergency use of an air ambulance requires Precertification).
3. When there is no choice of an In-Network Provider at an In-Network facility who can furnish an item or service the Covered Person is seeking.
4. When a Covered Person receives items or services from an Out-of-Network Provider at an In-Network facility and does not consent to Balance Billing (to the extent permitted by the No Surprises Act).
5. When a Covered Person receives Ancillary Services* by an Out-of-Network Provider at an In-Network facility. (In-Network facility includes office visits.)
6. When a Covered Person receives items or services from an Out-of-Network Provider at an In-Network facility as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

***Ancillary Services** means, with respect to an In-Network facility, (i) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or non-physician practitioner, (ii) items and services provided by assistant surgeons, hospitalists, and intensivists; (iii) diagnostic services (including radiology and laboratory services); and (iv) items and services provided by an Out-of-Network Provider if there is no In-Network Provider who can furnish such item or service at such facility.*

Out-of-Network Providers are paid at the In-Network level of benefits, but payment is based on the Maximum Allowable Amount, and not billed charges, unless otherwise approved by the Plan Administrator or required by applicable law. If the Out-of-Network Provider will not agree to accept the Maximum Allowable Amount as the Out-of-Network Rate, then the Plan Administrator may negotiate and pay a different amount to the Out-of-Network Provider to avoid the independent dispute resolution process required by the No Surprises Act or as a result of using the independent dispute resolution process. The Plan will comply with the deadlines for payment and notice required by the No Surprises Act for Out-of-Network Providers and facilities.

Out-of-Network Providers cannot Balance Bill the Covered Person for services required to be paid at the In-Network benefit level under the No Surprises Act, unless the Covered Person gives written consent and gives up their protections not to be Balance Billed for these services (to the extent permitted under the No Surprises Act). See section "Rights and Protections Against Surprise Medical Bills" for additional information.

If a Covered Person believes their claim has been paid incorrectly, the Covered Person may submit an appeal. See Section "Appeal of Adverse Benefit Determination" for more information on how to appeal a decision.

NETWORK EXCEPTION REQUEST

There are times when a Covered Person may want to see an Out-of-Network Provider outside of the existing Out-of-Network exceptions listed above. In these situations, a **Network Exception Request Form needs to be submitted prior Out-of-Network service being rendered.** A network exception is only available in the following situations:

- Network services are not available within the required treatment timeframe, which will jeopardize the life, health or ability to regain maximum function, or in the opinion of the treating physician would subject the Covered Person to severe pain that could not adequately be managed without the care or treatment by an Out-of-Network Provider. If approved, services must transition to a Network Provider within 90 days. **The date in which network services were available is required to be documented on the Network Exception Request Form.**

- The Covered Person is newly enrolled (within 90 days of their effective date of coverage) in this Plan and Out-of-Network treatment is in process and has not yet transitioned to a Network Provider. **The Network Exception Request form must be received within 30 days of the effective date.** If approved, services must transition to a Network Provider within 90 days.

- The required treatment is not available by an OhioHealthy Network Provider. If approved, the Network Exception will be applicable for up to 180 days.

The Network Exception Request Form can be found here: https://www.ohiohealthyplans.com.

Completed forms can be returned to OhioHealthy through email, fax, mail, or web portal:

OhioHealthy
Attn: Network Exception Request
PO Box 2582
Hudson, OH 44236-2582
OhioHealthy-NetworkExceptions@memberadvocate.com
https://www.ohiohealthyplans.com (Web Portal)
330-656-1194 (Fax)

Incomplete forms will NOT be considered for a Network exception. Faxed cover sheets or any other form of documentation will not be accepted.

SECTION II: SCHEDULE OF BENEFITS (PPO PLAN)

This medical plan option has a three-tier provider network. Covered Members have the ability to choose which three-tier provider to use for care. More information is available at www.ohiohealthyplans.com.

Referral may be required. If a Covered Person requires services that cannot be performed by an OhioHealthy Network Provider and wishes to see a provider outside the OhioHealthy Network, an approved referral form is **REQUIRED** in order for benefits to be paid at the In-Network level of benefit. The form must be clear and indicate the reason for the referral. A referral form can be found at www.ohiohealthyplans.com under the member portal. If an approved referral form is not on file with the Plan, benefits will be paid at the Out-of-Network level of benefits. For additional information or questions regarding referrals, contact a Member Advocate at the number listed on the Associate's ID card.

(Unless otherwise state, Deductibles, Copayments and Coinsurance reflect the Covered Person's responsibility)			
Plan Limits	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Calendar Year Deductible (Medical only)	Associate: $500 Associate + 1: $750 Family: $1,000	Associate: $1,500 Associate + 1: $2,250 Family: $3,000	Associate: $3,000 Associate + 1: $4,500 Family: $6,000
Calendar Year Out-of-Pocket (OOP) Maximum (Includes Deductible and applies to Medical and Prescription Drugs)	Associate: $3,000 Associate + 1: $4,500 Family: $6,000	Associate: $5,000 Associate + 1: $7,500 Family: $10,000	Unlimited
Common Medical Event	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Physician Services			
Office Visit – Primary Care Physician & Pediatrician (Office charge only)	$20 Copayment	$35 Copayment	50% after Deductible
Office Visit – OBGYN (Office charge only; prenatal visits covered at 100% at an In-Network provider)	$30 Copayment	$50 Copayment	50% after Deductible
Office Visit – Specialist Physician (Office charge only)	$30 Copayment	$50 Copayment	50% after Deductible
Teladoc Virtual Visit	$10 Copayment	Not Applicable	Not Applicable
Office Visit – Injections (Other than Allergy)	10% after Deductible	30% after Deductible	50% after Deductible
Office Visit – Facility	10% after Deductible	30% after Deductible	50% after Deductible
Additional Services Performed During an Office Visit	10% after Deductible	30% after Deductible	50% after Deductible
Allergy Testing, Treatment, & Injections	10% after Deductible	30% after Deductible	50% after Deductible
Physician – Inpatient Services	10% after Deductible	30% after Deductible	50% after Deductible
Physician – Outpatient Services	10% after Deductible	30% after Deductible	50% after Deductible
Anesthesiologist	10% after Deductible	30% after Deductible	50% after Deductible
Complex Imaging and Testing (Outpatient, Physician Office, or Free-standing Facility)	10% after Deductible	30% after Deductible	50% after Deductible
Diagnostic Testing (Inpatient, Outpatient, Physician Office, or Independent Lab)	10% after Deductible	30% after Deductible	50% after Deductible

Common Medical Event	In-Network (Tier 1)	In-Network (Tier 2)	Out-of-Network (Tier 3)
Physician Services			
Injectable and Infused Medications (Inpatient, Outpatient, Physician Office, or Covered Person's home when part of Skilled Nursing care; Coinsurance would be in additional to any applicable office visit Copayment)	10% after Deductible	30% after Deductible	50% after Deductible
Laboratory and Pathology (Inpatient, Outpatient, Physician Office, or Independent Lab)	10% after Deductible	30% after Deductible	50% after Deductible
Radiology (Inpatient, Outpatient, or Physician Office)	10% after Deductible	30% after Deductible	50% after Deductible
Surgery - Inpatient, Outpatient or Physician Office	10% after Deductible	30% after Deductible	50% after Deductible
Preventive Care / Wellness Services			
Annual Physical Examination (Ages 3 and older)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Well Woman Examination (Annually, includes gynecological exam & pap smear)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Well Baby Care (8 visits from newborn to age 1)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Well Child Care (6 visits from age 1 to age 3)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Bone Density Screening (Ages 55-64: baseline test; ages 65+ limited to 1 screening every 2 years; no age limit for at risk)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Breast Feeding Supplies (One purchase of a non-hospital grade breast pump and pump supplies covered once per pregnancy.) (Rental of an electric, heavy-duty, hospital-grade pump is covered according to the Durable Medical Equipment (DME) benefit.)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Colorectal Cancer (Screening) - Sigmoidoscopy (Age 45+; Sigmoidoscopy is limited to 1 every 5 years; benefit includes Fecal Occult blood testing limited to 1 every Calendar Year and DNA cancer screening [aka Cologuard] limited to 1 every 3 years)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Colorectal Cancer (Screening & Diagnostic) - Colonoscopy (Age 45+; includes related surgeon, facility, anesthesia, pathology, prescription for prep, and related office visit charges)	No member responsibility, plan pays 100% for 1st colonoscopy each Calendar Year Subsequent diagnostic colonoscopy: 10% after Deductible	No member responsibility, plan pays 100% for 1st colonoscopy each Calendar Year Subsequent diagnostic colonoscopy: 30% after Deductible	50% after Deductible

	Subsequent screening colonoscopy: No member responsibility, plan pays 100%	Subsequent screening colonoscopy: No member responsibility, plan pays 100%	
Common Medical Event	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Preventive Care / Wellness Services			
Depression Screening (Age 12+)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Diabetic Counseling	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Family Planning / Contraceptive Counseling, Services & Supplies (Includes contraceptive devices and elective sterilization for women only)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
HPV Testing (for females) (Age 30+; limited to 1 every 3 years) (Testing under age 30 will be covered subject to Deductible and Coinsurance)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Immunizations (recommended) (does not include travel immunizations)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Lactation Support & Counseling Services (Group or individual setting; limited to 6 visits per 12 months; additional visits will be subject to traditional office visit benefit)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Nutritional Counseling (Based on recommended frequency & age; limited to 3 visits per Calendar Year)	No member responsibility, plan pays 100% Applies to services for diagnoses related to diabetes, obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor. All other diagnoses: 10% after Deductible	No member responsibility, plan pays 100% Applies to services for diagnoses related to diabetes, obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor. All other diagnoses: 30% after Deductible	50% after Deductible
Exercise Consultation (Limited to 3 visits per Calendar Year)	No member responsibility, plan pays 100% Applies to services for diagnoses related to diabetes, obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor. All other diagnoses: 10% after Deductible	No member responsibility, plan pays 100% Applies to services for diagnoses related to diabetes, obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor. All other diagnoses: 30% after Deductible	Not Covered
Preventive Counseling for Alcohol & Substance Abuse (Based on recommended frequency & age)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible

Preventive Counseling for Tobacco Use (Based on recommended frequency & age)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	Not Covered
Preventive/Routine Screening Services (Based on recommended frequency, age & gender)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Common Medical Event	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Preventive Care / Wellness Services			
Prostate Cancer Screening / PSA Test (age 45+; limited to 1 per Calendar Year)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Recommended Routine Screening Laboratory Testing (Based on recommended frequency, age & gender)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Screening Vision Exam (Limited to 1 per Calendar Year – including refractions)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%
Screening Hearing Exam (Birth through age 21; limited to 1 per Calendar Year)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Screening Mammography (Ages 35 – 39: 1 baseline; ages 40+ limited to 1 per Calendar Year; includes 3D mammogram)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Facility Services			
Inpatient Semi-Private Room & Board (Includes ICU, ancillary charges & Observations exceeding 48 hours unless a longer time is approved by the Plan; Inpatient private Room & Board paid at Hospital's average semi-private room rate; includes Long Term Acute Care Hospital Stays [LTACH])	10% after Deductible	30% after Deductible	50% after Deductible
Birthing Center	10% after Deductible	30% after Deductible	50% after Deductible
Skilled Nursing Facility (Following Inpatient Hospital care in lieu of Hospitalization; limited to 120 days per Calendar Year)	10% after Deductible	30% after Deductible	50% after Deductible
Routine Newborn Stay	10% after Deductible	30% after Deductible	50% after Deductible
Outpatient Ambulatory Surgery Center	$0 Copayment plus 10% after Deductible	$50 Copayment plus 30% after Deductible	50% after Deductible
Outpatient Surgery Acute Care Hospital	$300 Copayment plus 10% after Deductible	$500 Copayment plus 30% after Deductible	50% after Deductible
Outpatient Complex Imaging and Testing	10% after Deductible	30% after Deductible	50% after Deductible
Outpatient Diagnostic Testing & Procedures	10% after Deductible	30% after Deductible	50% after Deductible
Outpatient Hospital	10% after Deductible	30% after Deductible	50% after Deductible
Outpatient Laboratory & Pathology	10% after Deductible	30% after Deductible	50% after Deductible
Outpatient Observation (Up to 48 hours unless a longer time is approved by the Plan)	10% after Deductible	30% after Deductible	50% after Deductible

Emergency Services			
Emergency Department Facility (copayment waived if admitted)	$300 Copayment plus 10% after Deductible	$300 Copayment plus 10% after Deductible	Covered the same as Tier 2 In-Network
Emergency Department Physician	10% after Deductible	30% after Deductible	Covered the same as Tier 2 In-Network
Common Medical Event	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Emergency Services			
Ground Ambulance Transportation (For emergent and Medically Necessary non-emergent)	10% after Deductible	30% after Deductible	50% after Deductible
Air Ambulance Transportation (For emergent and Medically Necessary non-emergent)	10% after Deductible	30% after Deductible	50% after Deductible
Urgent Care (For Urgent Medical Care Services; if transferred from an Urgent Care Center to an Emergency Department, the Emergency Department benefit will apply)	$25 Copayment	$45 Copayment	50% after Deductible
Urgent Care (For non-urgent use; routine medical and preventive care services not covered at an Urgent Care, except for flu shots)	Not Covered	Not Covered	Not Covered
Behavioral Health Services (Mental Health Disorders & Substance Use Disorders)			
Inpatient Behavioral Health (Includes ICU, ancillary charges & Observations exceeding 48 hours unless a longer time is approved by the Plan; Inpatient private Room & Board paid at Hospital's average semi-private room rate; includes a Residential Treatment Facility)	10% after Deductible	Covered the same as Tier 1 In-Network	50% after Deductible
Outpatient Behavioral Health Services	10% after Deductible	Covered the same as Tier 1 In-Network	50% after Deductible
Partial Hospitalization, Intensive Outpatient, Ambulatory Detoxification, and Electro-Convulsive Therapy	10% after Deductible	Covered the same as Tier 1 In-Network	50% after Deductible
Behavioral Health Office Visit (Counseling/Therapy)	$10 Copayment	Covered the same as Tier 1 In-Network	50% after Deductible
Behavioral Health Virtual Visit (e.g. Teladoc, Lyra)	$10 Copayment	Covered the same as Tier 1 In-Network	50% after Deductible
Other Covered Services			
Acupuncture (Only services performed by a certified acupuncturist for the relief of migraines or back/neck pain; limited to 15 visits per Calendar Year)	10% after Deductible	30% after Deductible	50% after Deductible
Bariatric Surgery (Maximum benefit $30,000 per lifetime for all OhioHealth plans)	10% after Deductible	30% after Deductible	50% after Deductible
Cardiac Rehabilitation (Phase I & Phase II only)	10% after Deductible	30% after Deductible	50% after Deductible

Chiropractic/Spinal Manipulations (Only services performed by a Chiropractor, MD, or DO are covered; limited to 20 visits per Calendar Year)	50% after Deductible	50% after Deductible	50% after Deductible
Common Medical Event	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Other Covered Services			
Dental Services (see "What is Covered Section for details")	10% after Deductible	30% after Deductible	50% after Deductible
Diabetic Education (Including in-person outpatient self-management training and education including medical nutrition therapy diabetic education by a registered dietician or pharmacist.)	No member responsibility, plan pays 100% Applies to services for diagnoses related to diabetes, obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor.	No member responsibility, plan pays 100% Applies to services for diagnoses related to diabetes, obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor.	50% after Deductible
Diabetic Supplies (Includes insulin pumps and pump infusion sets/supplies; testing supplies are covered under the Prescription Drug Benefit)	10% after Deductible	30% after Deductible	50% after Deductible
Dialysis	10% after Deductible	30% after Deductible	50% after Deductible
Durable Medical Equipment (Includes Orthotics & Prosthetic Devices)	10% after Deductible	30% after Deductible	50% after Deductible
Gender Confirmation Treatment	10% after Deductible	30% after Deductible	50% after Deductible
Home Health Care (Includes RN visits. PT/OT/ST in the home counts against Outpatient therapy limit)	10% after Deductible	30% after Deductible	50% after Deductible
Hospice Services	10% after Deductible	30% after Deductible	50% after Deductible
Hyperbaric Oxygen Therapy	10% after Deductible	30% after Deductible	50% after Deductible
Infertility – Diagnostic & Treatment of underlying condition	10% after Deductible	30% after Deductible	50% after Deductible
Infertility Treatments–Assisted Reproductive Technologies (maximum benefit $10,000 per lifetime for all OhioHealth plans)	10% after Deductible	30% after Deductible	50% after Deductible
Jaw Joint Disorder (also known as TMJ) & Oral and Maxillofacial Treatment	10% after Deductible	30% after Deductible	50% after Deductible
Medical & Surgical Supplies	10% after Deductible	30% after Deductible	50% after Deductible
Obesity Treatment (non-surgical) Coverage only provided for the Medical Weight Management Program at the McConnell Heart Health Center, Pickerington Medical Campus, and Delaware Health Center	10% after Deductible	Not Covered	Not Covered
Organ Transplants	10% after Deductible	30% after Deductible	Not Covered
Physical, Occupational, & Speech Therapy	10% after Deductible	30% after Deductible	50% after Deductible

(Limited to a combined maximum of 50 visits per Calendar Year)			
Pulmonary, Vascular, & Vestibular Rehabilitation	10% after Deductible	30% after Deductible	50% after Deductible
Travel and Lodging Reimbursement	No member responsibility, after deductible	Covered the same as Tier 1 In-Network	Not Applicable
Weight Loss Treatment as provided through the OhioHealth Medical Weight Management Program	10% after Deductible	Not Applicable	Not Applicable
Common Medical Event	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network[1] (Tier 3)**
Other Covered Services			
Wigs (Limited to 1 wig per Calendar Year)	10% after Deductible	30% after Deductible	50% after Deductible
All Other Covered Benefits	10% after Deductible	30% after Deductible	50% after Deductible

Important Information:

- **The benefits outlined in this Schedule of Benefits are subject to all Plan provisions, including Medical Necessity, Experimental/Investigational, and the Exclusions/Limitations. Refer to the specific section in this document for additional details.**

- **The Deductible is not aggregated. This means that the Plan will begin to pay benefits once a Covered Person satisfies the individual Deductible even if that Covered Person is enrolled in Associate + 1 coverage or family coverage and the family Deductible limit has not yet been satisfied.**

- **The Out-of-Pocket Maximum is not aggregated. This means that for Associate +1 or Family coverage, when an individual within the family reaches the individual Out-of-Pocket Maximum amount, that family member's Covered Benefits are covered for the rest of the Plan Year.**

- **The Deductible will comingle between the Tier 1 Network and the Tier 2 Network, it does not comingle with the Tier 3 Out-of-Network.**

- **The Out-of-Pocket Maximum will comingle between the Tier 1 Network and the Tier 2 Network, it does not comingle with the Tier 3 Out-of-Network.**

- **Certain medical services require precertification. Failure to precertify can result in reduced benefits or denial of coverage (see "Managed Care Program" section for additional information).**

- **Benefits are based on the Maximum Allowable Amount. This means that either a negotiated or contracted amount, a Recognized Amount, or the Usual, Reasonable, and Customary Charge.**

- **All claims must be submitted within twelve (12) months from the date of service. Any requests for additional information must be provided within the initial twelve (12) months.**

TRAVEL AND LODGING BENEFIT REIMBURSEMENT

If a Covered Person is unable to obtain In-Network covered services from an OhioHealthy Network Provider and/or facility within 60 miles of their documented residence, this Plan may provide the Covered Person with travel and lodging benefits up to a maximum amount. These benefits are not available if there is a Network Provider/facility within 60 miles from the Covered Person's home address.

Travel and lodging benefits require prior Plan approval.

Approval of the Travel and Lodging Benefit reimbursement is not a guarantee of coverage for the medical services or treatment that necessitated the travel. Medical services or treatments are a separate benefit from the travel and lodging benefit and may require precertification.

Eligible expenses are reimbursed after prior plan approval, completed claim form, and all applicable receipts and documentation. Approvals are valid for 365 days from the date of authorization per reimbursement request.

Overall Travel & Lodging Limitations	• $10,000 calendar year benefit reimbursement maximum • Limited to expense incurred primarily for, and essential to, medical care and to days appropriate for the medical services or treatment

Lodging**	• One (1) room, double occupancy**
	  o One (1) adult companion allowed when traveling with an adult **OR**
	  o Two (2) adult companions allowed when traveling with a patient less than 18 years old
	
	***Limited reimbursement of up to $200 per night, which may exceed IRS guidelines. If so, this may result in imputed income being reported on Form W-2.*

Transportation*	• Automobile mileage for the most direct route between the Covered Person's home and the designated Provider, reimbursed at the standard medical mileage rate (currently $0.22/mile) • Bus, taxi, train, eTaxis • Economy or coach airfare
Not included in the travel and lodging assistance:	• Apartment furnishings, including cooking utensils, appliances, and furniture • Convenience items, including telephone and fax services • Entertainment items, including movies, books, and video rentals • Gratuities • Laundry items, services, or dry cleaning • Meals, including restaurant items and groceries • Personal hygiene products or toiletries

Travel and lodging assistance is only provided when permitted under applicable law, which may include laws of the state in which the medical services are provided as well as laws of the state in which the Covered Person resides. For more information or for assistance with travel and lodging, contact the Plan Administrator.

**Reimbursement is paid up to the IRS guidelines*
***Limited reimbursement of up to $200 per night, which may exceed IRS guidelines. If so, this may result in imputed income being reported on Form W-2.*

Travel Reimbursement (Pre and Post Travel Requests) *(If approved, reimbursement will be made at the Tier 1 In-Network level of benefits, subject to any Deductible and Out-of-Pocket Maximum)*	Travel reimbursement forms can be found on the OhioHealthy website: https://www.ohiohealthyplans.com. Completed travel forms can be returned to OhioHealthy through email, fax, or mail: OhioHealthy Attn: Network Exception Request PO Box 2582 Hudson, OH 44236-2582 OhioHealthy-NetworkExceptions@memberadvocate.com 330-656-1194 (Fax)

SECTION III: PRESCRIPTION DRUGS SCHEDULE OF BENEFITS (PPO PLAN)

Prescription Drug coverage is subject to exclusions and limitations. **See the "Prescription Drug Benefit" section of this Plan for additional information.** This Plan has a closed formulary and covers a specific list of drugs and medications. Drugs not included on the Plan's formulary will not be covered. Penalties for not using a Participating Pharmacy or charges for non-covered Prescription Drugs will NOT be counted towards the Covered Person's Out-of-Pocket Maximum.

Contact the Pharmacy Benefit Manager (PBM), Express Scripts, at www.express-scripts.com or the number located on the Associates' ID card to verify covered non-specialty drugs, excluded drugs, or with any other questions.
For questions about Specialty Drugs, contact Archimedes at 1-888-504-5563.

	OhioHealth Pharmacies	Participating Pharmacies	Non-Participating Pharmacies
Prescription Drugs *(Unless otherwise state, Copayments and Coinsurance reflect the Covered Person's responsibility)*			
Tier 1 Drugs (Deductible will accumulate towards the medical Annual Out-of-Pocket maximum; the Deductible for OhioHealth & Participating Pharmacies will not cross-accumulate)	**Calendar Year Deductible (Tier 1 Drugs Only):** Individual: $100 / Family: $300 (embedded) Up to a 30-day supply: Deductible then $10 Copayment 31 to 90-day supply: Deductible then $20 Copayment		**Calendar Year Deductible (Tier 1 Drugs Only):** Individual: $100 / Family: $300 (embedded) Deductible then Tier 1 Copayment plus the difference between the Maximum Allowable Amount and the Copayment
Tier 2 Drugs	20% Coinsurance (no Deductible)		Tier 2 Copayment plus the difference between the Maximum Allowable Amount and the Copayment
Tier 3 Drugs	30% Coinsurance (no Deductible)		Tier 3 Copayment plus the difference between the Maximum Allowable Amount and the Copayment
Note: Maintenance medications can be obtained from any network retail pharmacy, including OhioHealth owned pharmacies. Some drugs qualify for mail order through Express Scripts or OhioHealth owned pharmacies.			
Specialty Drugs	20% Coinsurance (no Deductible) $500 maximum Copayment. Prior Authorization Required	20% Coinsurance (no Deductible) $500 maximum Copayment	Not Covered

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. The Specialty Drug List can be found at https://archimedesrx.com/resources/ and is updated periodically.

Up to a 30-day supply of specialty drugs will be covered at a time. Specialty drugs are ONLY available through the approved Archimedes specialty pharmacy network. However, not all specialty drugs are covered under this Prescription Drug Benefit, some specialty drugs may be covered under the medical portion of this Plan. In these situations, a Covered Person may be required to obtain select specialty medications at the most cost-effective site of care. Additionally, select specialty medications, that would normally be covered under the medical benefit, or are administered by a health care professional, may be required to be obtained through the Prescription Drug Benefit. See Care Management section for additional information.

Copayment Assistance: If the drug has Copayment assistance available, the amount a Covered Person will pay for select medications may be set to the maximum of the current benefit design, $0 (zero dollars), or the amount determined by the

manufacturer-funded Copayment assistance program. Specialty pharmacy requires the use of Copayment assistance through Archimedes if a manufacturer-funded Copayment assistance program is available. Once Copayment assistance is exhausted, the amount a Covered Person will pay will be no more than the stated Copayments in this Plan. Dollars used from the Copayment assistance programs will not be considered member out-of-pocket costs and will not count toward the Covered Person's Deductible and/or Maximum Out-of-Pocket.

Drugs are classified in tiers generally by their cost to the Plan, with Tier 1 drugs having the lowest cost to the Plan and Tier 3 having the highest cost to the Plan. To determine the Tier in which a drug is classified by this Plan, log into https://www.Archimedes.com/resources/members/. The Tier classifications are updated periodically.

The Pharmacy Deductible will comingle between the OhioHealth Pharmacies and Participating Pharmacies, it does not comingle with the Non-Participating Pharmacies.

	OhioHealth Pharmacies	Participating Pharmacies	Non-Participating Pharmacies
Prescription Drugs *(Unless otherwise state, Copayments and Coinsurance reflect the Covered Person's responsibility)*			
Diabetes and Asthma Medications	The plan will pay 100% of the cost for program approved In-Network medications for the treatment of Diabetes and/or Asthma if the OhioHealth Wellness Programrequirements are met and the prescription is filled at an OhioHealth pharmacy. This does not apply at any other pharmacy. Standard Copayments will apply if the Covered Person fails to meet the Condition Management requirements.	Copayment based upon medication Tier.	Copayment based upon medication Tier copayment plus the difference between the Maximum Allowable Amount and the Copayment.
Diabetic Testing Supplies Needles, and Syringes (Testing supplies include test strips, lancets, lancet devices, blood glucose monitors and control solution.)	The plan will pay 100% of the cost for program approved In-Network medications for the treatment of Diabetes and/or Asthma if the OhioHealth Wellness Program requirements are met and the prescription is filled at an OhioHealth pharmacy. This does not apply at any other pharmacy. Standard Copayments will apply if the Covered Person fails to meet the Condition Management requirements.	Copayment based upon medication Tier.	Copayment based upon medication Tier Copayment plus the difference between the Maximum Allowable Amount and the Copayment.
Insulin Pumps	Tier 2 Copayment		Tier 2 Copayment plus the difference between the Maximum Allowable Amount and the Copayment
Fertility Drugs (The fertility drug maximum benefit is the most the Plan will pay for fertility drug covered benefits in each Calendar Year. The maximum applies separately to each Covered Person.)	40% Coinsurance (no Deductible) Maximum of $2,000 in prescription drug coverage per Calendar Year combined for all OhioHealth plans.		Not Covered

	OhioHealth Pharmacies	Participating Pharmacies	Non-Participating Pharmacies
Wellness Benefits and Preventive Care Services *(Unless otherwise state, Copayments and Coinsurance reflect the Covered Person's responsibility)*			
Family Planning Services: Female Contraceptives (identified on the PBM's preventive care list)	No Charge		Difference between the Maximum Allowable Amount and the Copayment
Family Planning Services: Female Contraceptives (NOT identified on the PBM's preventive care list)	Subject to the Tier 1, Tier 2, and Tier 3 Copayments listed above.		Applicable Tier Copayment plus the difference between the Maximum Allowable Amount and the Copayment
Tobacco Cessation Medications: available at retail, mail, order, RMB and Marion General Hospital Ambulatory	No Charge		Difference between the Maximum Allowable Amount and the Copayment

Mandatory Generic: The Plan requires pharmacies to dispense Generic Drugs when available. When a Generic Drug is available, but the Pharmacy dispenses a brand name Drug per the Covered Person's or prescribing Physician's request, the Covered Person will be charged the generic Copayment plus the difference between the brand name Drug and the Generic Drug. The difference will not be counted towards the Covered Person's Out-of-Pocket Maximum.

Contraceptives: Depo-Provera, an injectable contraceptive, or similar type of contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per calendar year.

Recently Approved FDA Drugs: Covered Person's will be charged the out-of-network Prescription Drug cost sharing for Prescription Drugs recently approved by the FDA, but which have not yet been reviewed by the Pharmacy Benefit Administrator's Pharmacy Committee.

Condition Management: OhioHealth Wellness Disease Management: The plan will pay 100% of the cost for program approved In-Network medications and testing supplies for the treatment of Diabetes and/or Asthma if the member actively participates in the OhioHealth Wellness Program and prescriptions are filled through an OhioHealth pharmacy. This does not apply at any other In-Network pharmacy. The medical deductible must be met prior to receiving 100% coverage. Failure to meet the OhioHealth Wellness Program participation requirements will result in the Covered Person paying the standard copayments. Refer to the Care Management section for more information.

SECTION II: SCHEDULE OF BENEFITS (PPO ASSIST PLAN)

This medical plan option has a three-tier provider network. Covered Members have the ability to choose which three-tier provider ot use for care. More information is available at www.ohiohealthyplans.com.

Referral may be required. If a Covered Person requires services that cannot be performed by an OhioHealthy Network Provider and wishes to see a provider outside the OhioHealthy Network, an approved referral form is **REQUIRED** in order for benefits to be paid at the In-Network level of benefit. The form must be clear and indicate the reason for the referral. A referral form can be found at www.ohiohealthyplans.com under the member portal. If an approved referral form is not on file with the Plan, benefits will be paid at the Out-of-Network level of benefits. For additional information or questions regarding referrals, contact a Member Advocate at the number listed on the Associate's ID card.

(Unless otherwise state, Deductibles, Copayments and Coinsurance reflect the Covered Person's responsibility)			
Plan Limits	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Calendar Year Deductible (Including Medical only)	Associate: $125 Associate + 1: $200 Family: $275	Associate: $150 Associate + 1: $225 Family: $300	Associate: $1,800 Associate + 1: $2,800 Family: $3,600
Calendar Year Out-of-Pocket (OOP) Maximum (includes Deductible and applies to Medical and Prescription Drugs)	Associate: $900 Associate + 1: $1,400 Family: $1,900	Associate: $1,000 Associate + 1: $1,500 Family: $2,000	Unlimited
Common Medical Event	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Physician Services			
Office Visit – Primary Care Physician & Pediatrician (Office charge only)	$20 Copayment	$20 Copayment	50% after Deductible
Office Visit – OBGYN (Office charge only; prenatal visits covered at 100% at an In-Network provider)	$25 Copayment	$25 Copayment	50% after Deductible
Office Visit – Specialist Physician (office charge only)	$25 Copayment	$25 Copayment	50% after Deductible
Teladoc Virtual Visit	$10 Copayment	Not Applicable	Not Applicable
Office Visit – Injections (Other than Allergy)	10% after Deductible	10% after Deductible	50% after Deductible
Office Visit – Facility	10% after Deductible	10% after Deductible	50% after Deductible
Additional Services Performed During an Office Visit	10% after Deductible	10% after Deductible	50% after Deductible
Allergy Testing, Treatment, & Injections	10% after Deductible	10% after Deductible	50% after Deductible
Physician – Inpatient Services	10% after Deductible	10% after Deductible	50% after Deductible
Physician – Outpatient Services	10% after Deductible	10% after Deductible	50% after Deductible
Anesthesiologist	10% after Deductible	10% after Deductible	50% after Deductible
Complex Imaging and Testing (Outpatient, Physician Office,	10% after Deductible	10% after Deductible	50% after Deductible

or Free-standing Facility)			
Common Medical Event	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Physician Services			
Diagnostic Testing (Inpatient, Outpatient, Physician Office, or Independent Lab)	10% after Deductible	10% after Deductible	50% after Deductible
Injectables and Infused Medications (Inpatient, Outpatient, Physician Office, or Covered Person's home when part of Skilled Nursing care; Coinsurance would be in additional to any applicable office visit Copayment)	10% after Deductible	10% after Deductible	50% after Deductible
Laboratory and Pathology (Inpatient, Outpatient, Physician Office, or Independent Lab)	10% after Deductible	10% after Deductible	50% after Deductible
Radiology (Inpatient, Outpatient, or Physician Office)	10% after Deductible	10% after Deductible	50% after Deductible
Surgery - Inpatient, Outpatient or Physician Office	10% after Deductible	10% after Deductible	50% after Deductible
Preventive Care / Wellness Services			
Annual Physical Examination (Ages 3 and older)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Well Woman Examination (Annually, includes gynecological exam & pap smear)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Well Baby Care (8 visits from newborn to age 1)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Well Child Care (6 visits from age 1 to age 3)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Bone Density Screening (Ages 55-64: baseline test; ages 65+ limited to 1 screening every 2 years; no age limit for at risk)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Breast Feeding Supplies (One purchase of a non-hospital grade breast pump and pump supplies covered per once pregnancy.) (Rental of an electric, heavy-duty, hospital-grade pump is covered according to the Durable Medical Equipment (DME) benefit.)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Colorectal Cancer (Screening) - Sigmoidoscopy (Age 45+; Sigmoidoscopy is limited to 1 every 5 years) (benefit includes Fecal Occult blood testing limited to 1 every	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible

Calendar Year and DNA cancer screening (aka Cologuard) limited to 1 every 3 years)			
Common Medical Event	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Preventive Care / Wellness Services			
Colorectal Cancer (Screening & Diagnostic) - Colonoscopy (Age 45+; includes related surgeon, facility, anesthesia, pathology, prescription for prep, and related office visit charges)	No member responsibility, plan pays 100% for 1st colonoscopy each Calendar Year Subsequent diagnostic colonoscopy: 10% after Deductible Subsequent screening colonoscopy: No member responsibility, plan pays 100%	No member responsibility, plan pays 100% for 1st colonoscopy each Calendar Year Subsequent diagnostic colonoscopy: 10% after Deductible Subsequent screening colonoscopy: No member responsibility, plan pays 100%	50% after Deductible
Depression Screening (age 12+)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Diabetic Counseling	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Family Planning / Contraceptive Counseling, Services & Supplies (Includes contraceptive devices and elective sterilization for women only)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
HPV Testing (for females) (Age 30+; limited to 1 every 3 years) (Testing under age 30 will be covered subject to Deductible and Coinsurance)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Immunizations (recommended) (does not include travel immunizations)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Lactation Support & Counseling Services (Group or individual setting; limited to 6 visits per 12 months; additional visits will be subject to traditional office visit benefit)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Nutritional Counseling (Based on recommended frequency & age; limited to 3 visits per Calendar Year)	No member responsibility, plan pays 100% Applies to services for diagnoses related to diabetes, obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor. All other diagnoses: 10% after Deductible	No member responsibility, plan pays 100% Applies to services for diagnoses related to diabetes, obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor. All other diagnoses: 10% after Deductible	50% after Deductible
Exercise Consultation (Limited to 3 visits per Calendar Year)	No member responsibility, plan pays 100% Applies to services for diagnoses related to diabetes,	No member responsibility, plan pays 100% Applies to services for diagnoses related to diabetes,	Not Covered

	obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor. All other diagnoses: 10% after Deductible	obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor. All other diagnoses: 10% after Deductible	
Common Medical Event	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Preventive Care / Wellness Services			
Preventive Counseling for Alcohol & Substance Abuse (Based on recommended frequency & age)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Preventive Counseling for Tobacco Use (Based on recommended frequency & age)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	Not Covered
Preventive/Routine Screening Services (Based on recommended frequency, age & gender)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Prostate Cancer Screening / PSA Test (age 45+; limited to 1 per Calendar Year)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Recommended Routine Screening Laboratory Testing (Based on recommended frequency, age & gender)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Screening Vision Exam (Limited to 1 per Calendar Year – including refractions)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%
Screening Hearing Exam (Birth through age 21; limited to 1 per Calendar Year)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Screening Mammography (Ages 35 – 39: 1 baseline; ages 40+ limited to 1 per Calendar Year; includes 3D mammogram)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Facility Services			
Inpatient Semi-Private Room & Board (Includes ICU, ancillary charges & Observations exceeding 48 hours unless a longer time is approved by the Plan; Inpatient private Room & Board paid at Hospital's average semi-private room rate; includes Long Term Acute Care Hospital Stays [LTACH])	10% after Deductible	10% after Deductible	50% after Deductible
Birthing Center	10% after Deductible	10% after Deductible	50% after Deductible
Skilled Nursing Facility (Following Inpatient Hospital care in lieu of Hospitalization; limited to 120 days per Calendar Year)	10% after Deductible	10% after Deductible	50% after Deductible
Routine Newborn Stay	10% after Deductible	10% after Deductible	50% after Deductible

Outpatient Ambulatory Surgery Center	10% after Deductible	10% after Deductible	50% after Deductible
Outpatient Surgery Acute Care Hospital	10% after Deductible	10% after Deductible	50% after Deductible
Outpatient Complex Imaging and Testing	10% after Deductible	10% after Deductible	50% after Deductible
Common Medical Event	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Facility Services			
Outpatient Diagnostic Testing & Procedures	10% after Deductible	10% after Deductible	50% after Deductible
Outpatient Hospital	10% after Deductible	10% after Deductible	50% after Deductible
Outpatient Laboratory & Pathology	10% after Deductible	10% after Deductible	50% after Deductible
Outpatient Observation (Up to 48 hours unless a longer time is approved by the Plan)	10% after Deductible	10% after Deductible	50% after Deductible
Emergency Services			
Emergency Department Facility (copayment waived if admitted)	$150 Copayment	$150 Copayment	Covered the same as Tier 2 In-Network
Emergency Department Physician	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	Covered the same as Tier 2 In-Network
Ground Ambulance Transportation (For emergent and Medically Necessary non-emergent)	10% after Deductible	10% after Deductible	50% after Deductible
Air Ambulance Transportation (For emergent and Medically Necessary non-emergent)	10% after Deductible	10% after Deductible	50% after Deductible
Urgent Care (For Urgent Medical Care Services; if transferred from an Urgent Care Center to an Emergency Department (ED), the ED benefit will apply)	$20 Copayment	$20 Copayment	50% after Deductible
Urgent Care (For non-urgent use; routine medical and preventive care services not covered at an Urgent Care, except for flu shots)	Not Covered	Not Covered	Not Covered
Behavioral Health Services **(Mental Health Disorders & Substance Use Disorders)**			
Inpatient Behavioral Health (Includes ICU, ancillary charges & Observations exceeding 48 hours unless a longer time is approved by the Plan; Inpatient private Room & Board paid at Hospital's average semi-private room rate; includes a Residential Treatment Facility)	10% after Deductible	Covered the same as Tier 1 In-Network	50% after Deductible
Outpatient Behavioral Health Services	10% after Deductible	Covered the same as Tier 1 In-Network	50% after Deductible
Partial Hospitalization, Intensive Outpatient, Ambulatory Detoxification,	10% after Deductible	Covered the same as Tier 1 In-Network	50% after Deductible

and Electro-Convulsive Therapy			
Behavioral Health Office Visit (Counseling/Therapy)	$10 Copayment	Covered the same as Tier 1 In-Network	50% after Deductible
Behavioral Health Virtual Visit (e.g. Teladoc, Lyra)	$10 Copayment	Covered the same as Tier 1 In-Network	50% after Deductible

Common Medical Event	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Other Covered Services			
Acupuncture (Only services performed by a certified acupuncturist for the relief of migraines or back/neck pain; limited to 15 visits per Calendar Year)	10% after Deductible	10% after Deductible	50% after Deductible
Bariatric Surgery (Maximum benefit $30,000 per lifetime for all OhioHealth plans)	10% after Deductible	10% after Deductible	50% after Deductible
Cardiac Rehabilitation (Phase I & Phase II only)	10% after Deductible	10% after Deductible	50% after Deductible
Chiropractic/Spinal Manipulations (Only services performed by a Chiropractor, MD, or DO are covered; limited to 20 visits per Calendar Year)	10% after Deductible	10% after Deductible	50% after Deductible
Dental Services	10% after Deductible	10% after Deductible	50% after Deductible
Diabetic Education (Including in-person outpatient self-management training and education including medical nutrition therapy diabetic education by a registered dietician or pharmacist.)	No member responsibility, plan pays 100% Applies to services for diagnoses related to diabetes, obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor.	No member responsibility, plan pays 100% Applies to services for diagnoses related to diabetes, obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor.	50% after Deductible
Diabetic Supplies (Includes insulin pumps and pump infusion sets/supplies; testing supplies are covered under the Prescription Drug Benefit)	10% after Deductible	10% after Deductible	50% after Deductible
Dialysis	10% after Deductible	10% after Deductible	50% after Deductible
Durable Medical Equipment (Includes Orthotics & Prosthetic Devices)	10% after Deductible	10% after Deductible	50% after Deductible
Gender Confirmation Treatment	10% after Deductible	10% after Deductible	50% after Deductible
Home Health Care (Includes RN visits. PT/OT/ST in the home counts against Outpatient therapy limit)	10% after Deductible	10% after Deductible	50% after Deductible
Hospice Services	10% after Deductible	10% after Deductible	50% after Deductible
Hyperbaric Oxygen Therapy	10% after Deductible	10% after Deductible	50% after Deductible
Infertility – Diagnostic	10% after Deductible	10% after Deductible	50% after Deductible
Infertility – Treatment and Assisted Reproductive Technologies	10% after Deductible	10% after Deductible	50% after Deductible

(Includes Artificial Insemination, IVF, GIFT/ZIFT; maximum benefit $10,000 per lifetime for all OhioHealth plans)			
Jaw Joint Disorder (also known as TMJ) & Oral and Maxillofacial Treatment	10% after Deductible	10% after Deductible	50% after Deductible
Medical & Surgical Supplies	10% after Deductible	10% after Deductible	50% after Deductible
Common Medical Event	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Other Covered Services			
Obesity Treatment (non-surgical) Coverage only provided for the Medical Weight Management Program at the McConnell Heart Health Center, Pickerington Medical Campus, and Delaware Health Center	10% after Deductible	Not Covered	Not Covered
Organ Transplants	10% after Deductible	10% after Deductible	Not Covered
Physical, Occupational, & Speech Therapy (Limited to a combined maximum of 50 visits per Calendar Year)	10% after Deductible	10% after Deductible	50% after Deductible
Pulmonary, Vascular, & Vestibular Rehabilitation	10% after Deductible	10% after Deductible	50% after Deductible
Wigs (Limited to 1 wig per Calendar Year)	10% after Deductible	10% after Deductible	50% after Deductible
All Other Covered Benefits	10% after Deductible	10% after Deductible	50% after Deductible
Travel and Lodging Reimbursement	No member responsibility, after deductible	Covered the same as Tier 1 In-Network	Not Applicable
Weight Loss Treatment as provided through the OhioHealth Medical Weight Management Program	10% after Deductible	Not Applicable	Not Applicable

Important Information:

- **The benefits outlined in this Schedule of Benefits are subject to all Plan provisions, including Medical Necessity, Experimental/Investigational, and the Exclusions/Limitations. Refer to the specific section in this document for additional details.**
- **The Deductible is not aggregated. This means that the Plan will begin to pay benefits once a Covered Person satisfies the individual Deductible even if that Covered Person is enrolled in Associate + 1 coverage or family coverage and the family Deductible limit has not yet been satisfied.**
- **The Out-of-Pocket Maximum is not aggregated. This means that for Associate +1 or Family coverage, when an individual within the family reaches the individual Out-of-Pocket Maximum amount, that family member's Covered Benefits are covered for the rest of the Plan Year.**
- **The Deductible will comingle between the Tier 1 Network and the Tier 2 Network, it does not comingle with the Tier 3 Out-of-Network.**
- **The Out-of-Pocket Maximum will comingle between the Tier 1 Network and the Tier 2 Network, it does not comingle with the Tier 3 Out-of-Network.**
- **Certain medical services require precertification. Failure to precertify can result in reduced benefits or denial**

of coverage (see "Managed Care Program" section for additional information).

- **Benefits are based on the Maximum Allowable Amount. This means that either a negotiated or contracted amount, a Recognized Amount, or the Usual, Reasonable, and Customary Charge.**

- **All claims must be submitted within twelve (12) months from the date of service. Any requests for additional information must be provided within the initial twelve (12) months.**

TRAVEL AND LODGING BENEFIT REIMBURSEMENT

If a Covered Person is unable to obtain In-Network covered services from an OhioHealthy Network Provider and/or facility within 60 miles of their documented residence, this Plan may provide the Covered Person with travel and lodging benefits up to a maximum amount. These benefits are not available if there is a Network Provider/facility within 60 miles from the Covered Person's home address.

Travel and lodging benefits require prior Plan approval.

Approval of the Travel and Lodging Benefit reimbursement is not a guarantee of coverage for the medical services or treatment that necessitated the travel. Medical services or treatments are a separate benefit from the travel and lodging benefit and may require precertification.

Eligible expenses are reimbursed after prior plan approval, completed claim form, and all applicable receipts and documentation. Approvals are valid for 365 days from the date of authorization per reimbursement request.

Overall Travel & Lodging Limitations	• $10,000 calendar year benefit reimbursement maximum • Limited to expense incurred primarily for, and essential to, medical care and to days appropriate for the medical services or treatment
Lodging**	• One (1) room, double occupancy** o One (1) adult companion allowed when traveling with an adult **OR** o Two (2) adult companions allowed when traveling with a patient less than 18 years old ***Limited reimbursement of up to $200 per night, which may exceed IRS guidelines. If so, this may result in imputed income being reported on Form W-2.*
Transportation*	• Automobile mileage for the most direct route between the Covered Person's home and the designated Provider, reimbursed at the standard medical mileage rate (currently $0.22/mile) • Bus, taxi, train, eTaxis • Economy or coach airfare
Not included in the travel and lodging assistance:	• Apartment furnishings, including cooking utensils, appliances, and furniture • Convenience items, including telephone and fax services • Entertainment items, including movies, books, and video rentals • Gratuities • Laundry items, services, or dry cleaning • Meals, including restaurant items and groceries • Personal hygiene products or toiletries

Travel and lodging assistance is only provided when permitted under applicable law, which may include laws of the state in which the medical services are provided as well as laws of the state in which the Covered Person resides . For more information or for assistance with travel and lodging, contact the Plan Administrator.

**Reimbursement is paid up to the IRS guidelines*
***Limited reimbursement of up to $200 per night, which may exceed IRS guidelines. If so, this may result in imputed income being reported on Form W-2.*

Travel Reimbursement (Pre and Post Travel Requests) *(If approved, reimbursement will be made at the Tier 1 In-Network level of benefits, subject to any Deductible and Out-of-Pocket Maximum)*	Travel reimbursement forms can be found on the OhioHealthy website: https://www.ohiohealthyplans.com. Completed travel forms can be returned to OhioHealthy through email, fax, or mail: OhioHealthy Attn: Network Exception Request PO Box 2582 Hudson, OH 44236-2582 OhioHealthy-NetworkExceptions@memberadvocate.com 330-656-1194 (Fax)

SECTION III: PRESCRIPTION DRUGS SCHEDULE OF BENEFITS (PPO ASSIST PLAN)

Prescription Drug coverage is subject to exclusions and limitations. **See the "Prescription Drug Benefit" section of this Plan for additional information.** This Plan has a closed formulary and covers a specific list of drugs and medications. Drugs not included on the Plan's formulary will not be covered. Penalties for not using a Participating Pharmacy or charges for non-covered Prescription Drugs will NOT be counted towards the Covered Person's Out-of-Pocket Maximum.

Contact the Pharmacy Benefit Manager (PBM), Express Scripts, at www.express-scripts.com or the number located on the Associates' ID card to verify covered non-specialty drugs, excluded drugs, or with any other questions.
For questions about Specialty Drugs, contact Archimedes at 1-888-504-5563.

	OhioHealth Pharmacies	Participating Pharmacies	Non-Participating Pharmacies
Prescription Drugs *(Unless otherwise state, Copayments and Coinsurance reflect the Covered Person's responsibility)*			
Tier 1 Drugs	Up to a 30-day supply: $5 Copayment (no Deductible) 31 to 60-day supply: $10 Copayment (no Deductible) 61 to 90-day supply: $12.50 Copayment (no Deductible)		Tier 1 Copayment plus the difference between the Maximum Allowable Amount and the Copayment
Tier 2 Drugs	15% Coinsurance (no Deductible) Maximum of $30 per 30-day supply		Tier 2 Copayment plus the difference between the Maximum Allowable Amount and the Copayment
Tier 3 Drugs	25% Coinsurance (no Deductible) Maximum of $60 per 30-day supply		Tier 3 Copayment plus the difference between the Maximum Allowable Amount and the Copayment
Note: Maintenance medications can be obtained from any network retail pharmacy, including OhioHealth owned pharmacies. Some drugs qualify for mail order through Express Scripts or OhioHealth owned pharmacies.			
Specialty Drugs	20% Coinsurance (no Deductible) $500 maximum Copayment. Prior Authorization Required.	20% Coinsurance (no Deductible) $500 maximum Copayment	Not Covered

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. The Specialty Drug List can be found at https://archimedesrx.com/resources/and is updated periodically. .

Up to a 30-day supply of specialty drugs will be covered at a time. Specialty drugs are ONLY available through the approved Archimedes specialty pharmacy network. However, not all specialty drugs are covered under this Prescription Drug Benefit, some specialty drugs may be covered under the medical portion of this Plan. In these situations, a Covered Person may be required to obtain select specialty medications at the most cost-effective site of care. Additionally, select specialty medications, that would normally be covered under the medical benefit, or are administered by a health care professional, may be required to be obtained through the Prescription Drug Benefit. See Care Management section for additional information.

Copayment Assistance: If the drug has Copayment assistance available, the amount a Covered Person will pay for select medications may be set to the maximum of the current benefit design, $0 (zero dollars), or the amount determined by the manufacturer-funded Copayment assistance program. Specialty pharmacy requires the use of Copayment assistance through Archimedes if a manufacturer-funded Copayment assistance program is available. Once Copayment assistance is exhausted, the amount a Covered Person will pay will be no more than the stated Copayments in this Plan. Dollars used from the Copayment assistance programs will not be considered member out-of-pocket costs and will not count toward the Covered Person's Deductible and/or Maximum Out-of-Pocket.

Drugs are classified in tiers generally by their cost to the Plan, with Tier 1 drugs having the lowest cost to the Plan and Tier 3 having the highest cost to the Plan. To determine the Tier in which a drug is classified by this Plan, log into https://www.Archimedes.com/resources/members/. The Tier classifications are updated periodically.

The Pharmacy Deductible will comingle between the OhioHealth Pharmacies and Participating Pharmacies, it does not comingle with the Non-Participating Pharmacies.

	OhioHealth Pharmacies	Participating Pharmacies	Non-Participating Pharmacies
Prescription Drugs *(Unless otherwise state, Copayments and Coinsurance reflect the Covered Person's responsibility)*			
Diabetes and Asthma Medications	The plan will pay 100% of the cost for program approved In-Network medications for the treatment of Diabetes and/or Asthma if the OhioHealth Wellness Program requirements are met and the prescription is filled at an OhioHealth pharmacy. This does not apply at any other pharmacy. Standard Copayments will apply if the Covered Person fails to meet the Condition Management requirements.	Copayment based upon medication Tier	Copayment based upon medication Tier plus the difference between the Maximum Allowable Amount and the Copayment
Diabetic Testing Supplies Needles, and Syringes (Testing supplies include test strips, lancets, lancet devices, blood glucose monitors and control solution.)	The plan will pay 100% of the cost for program approved In-Network medications for the treatment of Diabetes and/or Asthma if the OhioHealth Wellness Program requirements are met and the prescription is filled at an OhioHealth pharmacy. This does not apply at any other pharmacy. Standard Copayments will apply if the Covered Person fails to meet the Condition Management requirements.	Copayment based upon medication Tier	Copayment based upon medication Tier plus the difference between the Maximum Allowable Amount and the Copayment
Insulin Pumps	Tier 2 Copayment		Tier 2 Copayment plus the difference between the Maximum Allowable Amount and the Copayment
Fertility Drugs (The fertility drug maximum benefit is the most the Plan will pay for fertility drug covered benefits in each Calendar Year. The maximum applies separately to each Covered Person.)	40% Coinsurance (no Deductible) Maximum of $2,000 in prescription drug coverage per Calendar Year combined for all OhioHealth plans.		Not Covered

	OhioHealth Pharmacies	Participating Pharmacies	Non-Participating Pharmacies
Wellness Benefits and Preventive Care Services *(Unless otherwise state, Copayments and Coinsurance reflect the Covered Person's responsibility)*			
Family Planning Services: Female Contraceptives (identified on the PBM's preventive care list)	No Charge		Difference between the Maximum Allowable Amount and the Copayment
Family Planning Services: Female Contraceptives (NOT identified on the PBM's preventive care list)	Subject to the Tier 1, Tier 2, and Tier 3 Copayments listed above.		Applicable Tier Copayment plus the difference between the Maximum Allowable Amount and the Copayment
Tobacco Cessation Medications: available at retail, mail, order, RMB and Marion General Hospital Ambulatory	No Charge		Difference between the Maximum Allowable Amount and the Copayment

Mandatory Generic: The Plan requires pharmacies to dispense Generic Drugs when available. When a Generic Drug is available, but the Pharmacy dispenses a brand name Drug per the Covered Person's or prescribing Physician's request, the Covered Person will be charged the generic Copayment plus the difference between the brand name Drug and the Generic Drug. The difference will not be counted towards the Covered Person's Out-of-Pocket Maximum.

Contraceptives: Depo-Provera, an injectable contraceptive, or similar type of contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per calendar year.

Recently Approved FDA Drugs: Covered Person's will be charged the out-of-network Prescription Drug cost sharing for Prescription Drugs recently approved by the FDA, but which have not yet been reviewed by the Pharmacy Benefit Administrator's Pharmacy Committee.

Condition Management: OhioHealth Wellness Disease Management: The plan will pay 100% of the cost for program approved In-Network medications and testing supplies for the treatment of Diabetes and/or Asthma if the member actively participates in the OhioHealth Wellness Program and prescriptions are filled through an OhioHealth pharmacy. This does not apply at any other In-Network pharmacy. Failure to meet the OhioHealth Wellness Program participation requirements will result in the Covered Person paying the standard copayments. Refer to the Care Management section for more information.

SECTION II: SCHEDULE OF BENEFITS (HDHP PLAN)

This medical plan option has a three-tier provider network. Covered Members have the ability to choose which three-tier provider to use for care. More information is available at www.ohiohealthyplans.com.

Referral may be required. If a Covered Person requires services that cannot be performed by an OhioHealthy Network Provider and wishes to see a provider outside the OhioHealthy Network, an approved referral form is **REQUIRED** in order for benefits to be paid at the In-Network level of benefit. The form must be clear and indicate the reason for the referral. A referral form can be found at www.ohiohealthyplans.com under the member portal. If an approved referral form is not on file with the Plan, benefits will be paid at the Out-of-Network level of benefits. For additional information or questions regarding referrals, contact a Member Advocate at the number listed on the Associate's ID card.

(Unless otherwise state, Deductibles, Copayments and Coinsurance reflect the Covered Person's responsibility)			
Plan Limits	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Calendar Year Deductible (Medical and Prescription Drug)	Associate: $2,000 Associate + 1: $3,000 Family: $4,000	Associate: $3,000 Associate + 1: $4,500 Family: $6,000	Associate: $4,500 Associate + 1: $6,750 Family: $9,000
Calendar Year Out-of-Pocket (OOP) Maximum (includes Deductible and applies to Medical and Prescription Drugs) (Maximum of $7,150 for each individual in a family plan)	Associate: $4,500 Associate + 1: $6,750 Family: $9,000	Associate: $6,500 Associate + 1: $9,750 Family: $13,000	Unlimited
Common Medical Event	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Physician Services			
Office Visit – Primary Care Physician & Pediatrician (Office charge only)	10% after Deductible	30% after Deductible	50% after Deductible
Office Visit – OBGYN (Office charge only; prenatal visits covered at 100% at an In-Network provider)	10% after Deductible	30% after Deductible	50% after Deductible
Office Visit – Specialist Physician (Office charge only)	10% after Deductible	30% after Deductible	50% after Deductible
Teladoc Virtual Visit	10% after Deductible	Not Applicable	Not Applicable
Office Visit – Injections (Other than Allergy)	10% after Deductible	30% after Deductible	50% after Deductible
Office Visit – Facility	10% after Deductible	30% after Deductible	50% after Deductible
Additional Services Performed During an Office Visit	10% after Deductible	30% after Deductible	50% after Deductible
Allergy Testing, Treatment, & Injections	10% after Deductible	30% after Deductible	50% after Deductible
Physician – Inpatient Services	10% after Deductible	30% after Deductible	50% after Deductible
Physician – Outpatient Services	10% after Deductible	30% after Deductible	50% after Deductible
Anesthesiologist	10% after Deductible	30% after Deductible	50% after Deductible
Complex Imaging and Testing (Outpatient, Physician Office, or Free-standing Facility)	10% after Deductible	30% after Deductible	50% after Deductible

Common Medical Event	In-Network (Tier 1)	In-Network (Tier 2)	Out-of-Network (Tier 3)
Physician Services			
Diagnostic Testing (Inpatient, Outpatient, Physician Office, or Independent Lab)	10% after Deductible	30% after Deductible	50% after Deductible
Injectables and Infused Medications (Inpatient, Outpatient, Physician Office, or Covered Person's home when part of Skilled Nursing care; Coinsurance would be in additional to any applicable office visit Copayment)	10% after Deductible	30% after Deductible	50% after Deductible
Laboratory and Pathology (Inpatient, Outpatient, Physician Office, or Independent Lab)	10% after Deductible	30% after Deductible	50% after Deductible
Radiology (Inpatient, Outpatient, or Physician Office)	10% after Deductible	30% after Deductible	50% after Deductible
Surgery - Inpatient, Outpatient or Physician Office	10% after Deductible	30% after Deductible	50% after Deductible
Preventive Care / Wellness Services			
Annual Physical Examination (Ages 3 and older)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Well Woman Examination (Annually, includes gynecological exam & pap smear)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Well Baby Care (8 visits from newborn to age 1)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Well Child Care (6 visits from age 1 to age 3)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Bone Density Screening (Ages 55-64: baseline test; ages 65+ limited to 1 screening every 2 years; no age limit for at risk)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Breast Feeding Supplies (One purchase of a non-hospital grade breast pump and pump supplies covered once per pregnancy.)(Rental of an electric, heavy-duty, hospital-grade pump is covered according to the Durable Medical Equipment (DME) benefit.)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Colorectal Cancer (Screening) - Sigmoidoscopy (Age 45+; Sigmoidoscopy is limited to 1 every 5 years; benefit includes Fecal Occult blood testing limited to 1 every Calendar Year and DNA cancer screening [aka Cologuard] limited to 1 every 3 years)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Colorectal Cancer (Screening & Diagnostic) - Colonoscopy (Age 45+; includes related surgeon, facility, anesthesia,	No member responsibility, plan pays 100% for 1st colonoscopy each Calendar Year	No member responsibility, plan pays 100% for 1st colonoscopy each Calendar Year	50% after Deductible

pathology, prescription for prep, and related office visit charges)	Subsequent diagnostic colonoscopy: 10% after Deductible Subsequent screening colonoscopy: No member responsibility, plan pays 100%	Subsequent diagnostic colonoscopy: 30% after Deductible Subsequent screening colonoscopy: No member responsibility, plan pays 100%	
Common Medical Event	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Preventive Care / Wellness Services			
Depression Screening (age 12+)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Diabetic Counseling	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Family Planning / Contraceptive Counseling, Services & Supplies (includes contraceptive devices and elective sterilization for women only)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
HPV Testing (for females) (Age 30+; limited to 1 every 3 years) (Testing under age 30 will be covered subject to Deductible and Coinsurance)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Immunizations (recommended) (does not include travel immunizations)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Lactation Support & Counseling Services (Group or individual setting; limited to 6 visits per 12 months; additional visits will be subject to traditional office visit benefit)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Nutritional Counseling (Based on recommended frequency & age; limited to 3 visits per Calendar Year)	No member responsibility, plan pays 100% Applies to services for diagnoses related to diabetes, obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor. All other diagnoses: 10% after Deductible	No member responsibility, plan pays 100% Applies to services for diagnoses related to diabetes, obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor. All other diagnoses: 30% after Deductible	50% after Deductible
Exercise Consultation (Limited to 3 visits per Calendar Year)	No member responsibility, plan pays 100% Applies to services for diagnoses related to diabetes, obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor. All other diagnoses: 10% after Deductible	No member responsibility, plan pays 100% Applies to services for diagnoses related to diabetes, obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor. All other diagnoses: 30% after Deductible	Not Covered

Preventive Counseling for Alcohol & Substance Abuse (Based on recommended frequency & age)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Preventive Counseling for Tobacco Use (Based on recommended frequency & age)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	Not Covered
Preventive/Routine Screening Services (Based on recommended frequency, age & gender)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Prostate Cancer Screening / PSA Test (age 45+; limited to 1 per Calendar Year)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Common Medical Event	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Preventive Care / Wellness Services			
Recommended Routine Screening Laboratory Testing (based on recommended frequency, age & gender)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Screening Vision Exam (Limited to 1 per Calendar Year – including refractions)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%
Screening Hearing Exam (Birth through age 21; limited to 1 per Calendar Year)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Screening Mammography (Ages 35 – 39: 1 baseline; ages 40+ limited to 1 per Calendar Year; includes 3D mammogram)	No member responsibility, plan pays 100%	No member responsibility, plan pays 100%	50% after Deductible
Facility Services			
Inpatient Semi-Private Room & Board (includes ICU, ancillary charges & Observations exceeding 48 hours unless a longer time is approved by the Plan; Inpatient private Room & Board paid at Hospital's average semi-private room rate; includes Long Term Acute Care Hospital Stays [LTACH])	10% after Deductible	30% after Deductible	50% after Deductible
Birthing Center	10% after Deductible	30% after Deductible	50% after Deductible
Skilled Nursing Facility (Following Inpatient Hospital care in lieu of Hospitalization; limited to 120 days per Calendar Year)	10% after Deductible	30% after Deductible	50% after Deductible
Routine Newborn Stay	10% after Deductible	30% after Deductible	50% after Deductible
Outpatient Ambulatory Surgery Center	10% after Deductible	30% after Deductible	50% after Deductible
Outpatient Surgery Acute Care Hospital	10% after Deductible	30% after Deductible	50% after Deductible
Outpatient Complex Imaging and Testing	10% after Deductible	30% after Deductible	50% after Deductible
Outpatient Diagnostic Testing & Procedures	10% after Deductible	30% after Deductible	50% after Deductible
Outpatient Hospital	10% after Deductible	30% after Deductible	50% after Deductible

Common Medical Event	In-Network (Tier 1)	In-Network (Tier 2)	Out-of-Network (Tier 3)
Outpatient Laboratory & Pathology	10% after Deductible	30% after Deductible	50% after Deductible
Outpatient Observation (Up to 48 hours unless a longer time is approved by the Plan)	10% after Deductible	30% after Deductible	50% after Deductible
Emergency Services			
Emergency Department Facility	10% after Deductible	10% after Deductible	Covered the same as Tier 2 In-Network
Emergency Department Physician	10% after Deductible	10% after Deductible	Covered the same as Tier 2 In-Network
Ground Ambulance Transportation (For emergent and Medically Necessary non-emergent)	10% after Deductible	30% after Deductible	50% after Deductible
Air Ambulance Transportation (For emergent and Medically Necessary non-emergent)	10% after Deductible	30% after Deductible	Covered the same as Tier 2 In-Network
Common Medical Event	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**
Emergency Services			
Urgent Care (For Urgent Medical Care Services; if transferred from an Urgent Care Center to an Emergency Department, the Emergency Department benefit will apply)	10% after Deductible	30% after Deductible	50% after Deductible
Urgent Care (For non-urgent use; routine medical and preventive care services not covered at an Urgent Care, except for flu shots)	Not Covered	Not Covered	Not Covered
Behavioral Health Services (Mental Health Disorders & Substance Use Disorders)			
Inpatient Behavioral Health (Includes ICU, ancillary charges & Observations exceeding 48 hours unless a longer time is approved by the Plan; Inpatient private Room & Board paid at Hospital's average semi-private room rate; includes a Residential Treatment Facility)	10% after Deductible	Covered the same as Tier 1 In-Network	50% after Deductible
Outpatient Behavioral Health Services	10% after Deductible	Covered the same as Tier 1 In-Network	50% after Deductible
Partial Hospitalization, Intensive Outpatient, Ambulatory Detoxification, and Electro-Convulsive Therapy	10% after Deductible	Covered the same as Tier 1 In-Network	50% after Deductible
Behavioral Health Office Visit (Counseling/Therapy)	10% after Deductible	Covered the same as Tier 1 In-Network	50% after Deductible
Behavioral Health Virtual Visit (e.g. Teladoc, Lyra)	10% after Deductible	Covered the same as Tier 1 In-Network	50% after Deductible
Other Covered Services			
Acupuncture (Only services performed by a certified acupuncturist for the relief of migraines or back/neck pain; limited to 15 visits per Calendar Year)	10% after Deductible	30% after Deductible	50% after Deductible
Bariatric Surgery	10% after Deductible	30% after Deductible	50% after Deductible

(Maximum benefit $30,000 per lifetime for all OhioHealth plans)			
Cardiac Rehabilitation (Phase I & Phase II only)	10% after Deductible	30% after Deductible	50% after Deductible
Chiropractic/Spinal Manipulations (Only services performed by a Chiropractor, MD, or DO are covered; limited to 20 visits per Calendar Year)	50% after Deductible	50% after Deductible	50% after Deductible
Dental Services	10% after Deductible	30% after Deductible	50% after Deductible

Common Medical Event	In-Network (Tier 1)	In-Network (Tier 2)	Out-of-Network (Tier 3)
Other Covered Services			
Diabetic Education (Including in-person outpatient self-management training and education including medical nutrition therapy diabetic education by a registered dietician or pharmacist.)	No member responsibility, plan pays 100% Applies to services for diagnoses related to diabetes, obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor	No member responsibility, plan pays 100% Applies to services for diagnoses related to diabetes, obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor	50% after Deductible
Diabetic Supplies (Includes insulin pumps and pump infusion sets/supplies; testing supplies are covered under the Prescription Drug Benefit)	10% after Deductible	30% after Deductible	50% after Deductible
Dialysis	10% after Deductible	30% after Deductible	50% after Deductible
Durable Medical Equipment (Includes Orthotics & Prosthetic Devices)	10% after Deductible	30% after Deductible	50% after Deductible
Gender Confirmation Treatment	10% after Deductible	30% after Deductible	50% after Deductible
Home Health Care (Includes RN visits. PT/OT/ST in the home counts against Outpatient therapy limit)	10% after Deductible	30% after Deductible	50% after Deductible
Hospice Services	10% after Deductible	30% after Deductible	50% after Deductible
Hyperbaric Oxygen Therapy	10% after Deductible	30% after Deductible	50% after Deductible
Infertility – Diagnostic	10% after Deductible	30% after Deductible	50% after Deductible
Infertility – Treatment and Assisted Reproductive Technologies (Includes Artificial Insemination, IVF, GIFT/ZIFT; maximum benefit $10,000 per lifetime for all OhioHealth plans)	10% after Deductible	30% after Deductible	50% after Deductible
Jaw Joint Disorder (also known as TMJ) & Oral and Maxillofacial Treatment	10% after Deductible	30% after Deductible	50% after Deductible
Medical & Surgical Supplies	10% after Deductible	30% after Deductible	50% after Deductible
Obesity Treatment (non-surgical) Coverage only provided for the Medical Weight Management Program at the McConnell Heart Health Center, Pickerington Medical Campus, and Delaware Health Center	10% after Deductible	Not Covered	Not Covered
Organ Transplants	10% after Deductible	30% after Deductible	Not Covered
Physical, Occupational, & Speech Therapy (Limited to a combined maximum of 50 visits per Calendar Year)	10% after Deductible	30% after Deductible	50% after Deductible
Pulmonary, Vascular, & Vestibular Rehabilitation	10% after Deductible	30% after Deductible	50% after Deductible
Common Medical Event	**In-Network (Tier 1)**	**In-Network (Tier 2)**	**Out-of-Network (Tier 3)**

Other Covered Services			
Wigs (Limited to 1 wig per Calendar Year)	10% after Deductible	30% after Deductible	50% after Deductible
All Other Covered Benefits	10% after Deductible	30% after Deductible	50% after Deductible
Travel and Lodging Reimbursement	No member responsibility, after deductible	Covered the same as Tier 1 In-Network	Not Applicable
Weight Loss Treatment as provided through the OhioHealth Medical Weight Management Program	10% after Deductible	Not Applicable	Not Applicable

Important Information:

- **The benefits outlined in this Schedule of Benefits are subject to all Plan provisions, including Medical Necessity, Experimental/Investigational, and the Exclusions/Limitations. Refer to the specific section in this document for additional details.**

- **The Deductible is not aggregated. This means that the Plan will begin to pay benefits once a Covered Person satisfies the individual Deductible even if that Covered Person is enrolled in Associate + 1 coverage or family coverage and the family Deductible limit has not yet been satisfied.**

- **The Out-of-Pocket Maximum is not aggregated. This means that for Associate + 1 or Family coverage, when an individual within the family reaches the individual Out-of-Pocket Maximum amount, that family member's Covered Benefits are covered for the rest of the Plan Year.**

- **The Deductible will comingle between the Tier 1 Network and the Tier 2 Network, it does not comingle with the Tier 3 Out-of-Network.**

- **The Out-of-Pocket Maximum will comingle between the Tier 1 Network and the Tier 2 Network, it does not comingle with the Tier 3 Out-of-Network.**

- **Certain medical services require precertification. Failure to precertify can result in reduced benefits or denial of coverage (see "Managed Care Program" section for additional information).**

- **Benefits are based on the Maximum Allowable Amount. This means that either a negotiated or contracted amount, a Recognized Amount, or the Usual, Reasonable, and Customary Charge.**

- **All claims must be submitted within twelve (12) months from the date of service. Any requests for additional information must be provided within the initial twelve (12) months.**

<table>
<tr><th colspan="2">TRAVEL AND LODGING BENEFIT REIMBURSEMENT</th></tr>
<tr><td colspan="2">If a Covered Person is unable to obtain In-Network covered services from an OhioHealthy Network Provider and/or facility within 60 miles of their documented residence, this Plan may provide the Covered Person with travel and lodging benefits up to a maximum amount. These benefits are not available if there is a Network Provider/facility within 60 miles from the Covered Person's home address.

Travel and lodging benefits require prior Plan approval.

Approval of the Travel and Lodging Benefit reimbursement is not a guarantee of coverage for the medical services or treatment that necessitated the travel. Medical services or treatments are a separate benefit from the travel and lodging benefit and may require precertification.

Eligible expenses are reimbursed after prior plan approval, completed claim form, and all applicable receipts and documentation. Approvals are valid for 365 days from the date of authorization per reimbursement request.</td></tr>
<tr><td>Overall Travel & Lodging Limitations</td><td>• $10,000 calendar year benefit reimbursement maximum
• Limited to expense incurred primarily for, and essential to, medical care and to days appropriate for the medical services or treatment</td></tr>
<tr><td>Lodging**</td><td>• One (1) room, double occupancy**
    o One (1) adult companion allowed when traveling with an adult OR
    o Two (2) adult companions allowed when traveling with a patient less than 18 years old

**Limited reimbursement of up to $200 per night, which may exceed IRS guidelines. If so, this may result in imputed income being reported on Form W-2.</td></tr>
<tr><td>Transportation*</td><td>• Automobile mileage for the most direct route between the Covered Person's home and the designated Provider, reimbursed at the standard medical mileage rate (currently $0.22/mile)
• Bus, taxi, train, eTaxis
• Economy or coach airfare</td></tr>
<tr><td>Not included in the travel and lodging assistance:</td><td>• Apartment furnishings, including cooking utensils, appliances, and furniture
• Convenience items, including telephone and fax services
• Entertainment items, including movies, books, and video rentals
• Gratuities
• Laundry items, services, or dry cleaning
• Meals, including restaurant items and groceries
• Personal hygiene products or toiletries</td></tr>
<tr><td colspan="2">Travel and lodging assistance is only provided when permitted under applicable law, which may include laws of the state in which the medical services are provided as well as laws of the state in which the Covered Person resides. For more information or for assistance with travel and lodging, contact the Plan Administrator.

*Reimbursement is paid up to the IRS guidelines
**Limited reimbursement of up to $200 per night, which may exceed IRS guidelines. If so, this may result in imputed income being reported on Form W-2.</td></tr>
<tr><td>Travel Reimbursement
(Pre and Post Travel Requests)

(If approved, reimbursement will be made at the Tier 1 In-Network level of benefits, subject to any Deductible and Out-of-Pocket Maximum)</td><td>Travel reimbursement forms can be found on the OhioHealthy website: https://www.ohiohealthyplans.com.

Completed travel forms can be returned to OhioHealthy through email, fax, mail, or web portal:

OhioHealthy
Attn: Network Exception Request
PO Box 2582
Hudson, OH 44236-2582
OhioHealthy-NetworkExceptions@memberadvocate.com
https://www.ohiohealthyplans.com (Web Portal)
330-656-1194 (Fax)</td></tr>
</table>

SECTION III: PRESCRIPTION DRUGS SCHEDULE OF BENEFITS (HDHP PLAN)

Prescription Drug coverage is subject to exclusions and limitations. **See the "Prescription Drug Benefit" section of this Plan for additional information.** This Plan has a closed formulary and covers a specific list of drugs and medications. Drugs not included on the Plan's formulary will not be covered. Penalties for not using a Participating Pharmacy or charges for non-covered Prescription Drugs will NOT be counted towards the Covered Person's Out-of-Pocket Maximum.

Contact the Pharmacy Benefit Manager (PBM), Express Scripts, at www.express-scripts.com or the number located on the Associates' ID card to verify covered non-specialty drugs, excluded drugs, or with any other questions.
For questions about Specialty Drugs, contact Archimedes at 1-888-504-5563.

	OhioHealth Pharmacies	Participating Pharmacies	Non-Participating Pharmacies
Plan Limits			
Calendar Year Deductible	Medical Plan Deductible		
Calendar Year Out-of-Pocket (OOP) Maximum	Medical Plan Out-of-Pocket Maximum		
Prescription Drugs *(Unless otherwise state, Copayments and Coinsurance reflect the Covered Person's responsibility)*			
Tier 1 Drugs	10% after Medical Plan Deductible		Tier 1 Coinsurance plus the difference between the Maximum Allowable Amount and the Negotiated Charge
Tier 2 Drugs	10% after Medical Plan Deductible		Tier 2 Coinsurance plus the difference between the Maximum Allowable Amount and the Negotiated Charge
Tier 3 Drugs	10% after Medical Plan Deductible		Tier 3 Coinsurance plus the difference between the Maximum Allowable Amount and the Negotiated Charge
Note: Maintenance medications can be obtained from any network retail pharmacy, including OhioHealth owned pharmacies. Some drugs qualify for mail order through Express Scripts or OhioHealth owned pharmacies.			
Specialty Drugs	20% after Medical Plan Deductible. Prior Authorization Required		Not Covered

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. The Specialty Drug List can be found at https://archimedesrx.com/resources/ and is updated periodically.

Up to a 30-day supply of specialty drugs will be covered at a time. Specialty drugs are ONLY available through the approved Archimedes specialty pharmacy network. However, not all specialty drugs are covered under this Prescription Drug Benefit, some specialty drugs may be covered under the medical portion of this Plan. In these situations, a Covered Person may be required to obtain select specialty medications at the most cost-effective site of care. Additionally, select specialty medications, that would normally be covered under the medical benefit, or are administered by a health care professional, may be required to be obtained through the Prescription Drug Benefit. See Care Management section for additional information.

Copayment Assistance: If the drug has Copayment assistance available, the amount a Covered Person will pay for select medications may be set to the maximum of the current benefit design, $0 (zero dollars), or the amount determined by the manufacturer-funded Copayment assistance program. Specialty pharmacy requires the use of Copayment assistance through Archimedes if a manufacturer-funded Copayment assistance program is available. Once Copayment assistance is exhausted, the amount a Covered Person will pay will be no more than the stated Copayments in this Plan. Dollars used from the Copayment assistance programs will not be considered member out-of-pocket costs and will not count toward the Covered Person's Deductible and/or Maximum Out-of-Pocket.

Drugs are classified in tiers generally by their cost to the Plan, with Tier 1 drugs having the lowest cost to the Plan and Tier 3 having the highest cost to the Plan. To determine the Tier in which a drug is classified by this Plan, log into https://www.Archimedes.com/resources/members/ The Tier classifications are updated periodically.

The Pharmacy Deductible will comingle between the OhioHealth Pharmacies and Participating Pharmacies, it does not comingle with the Non-Participating Pharmacies.

	OhioHealth Pharmacies	Participating Pharmacies	Non-Participating Pharmacies
Prescription Drugs *(Unless otherwise state, Copayments and Coinsurance reflect the Covered Person's responsibility)*			
Diabetes and Asthma Medications	The plan will pay 100% of the cost, after plan deductible, for program approved In-Network medications for the treatment of Diabetes and/or Asthma if the OhioHealth Wellness Program requirements are met and the prescription is filled at an OhioHealth pharmacy. This does not apply at any other pharmacy. Standard Copayments will apply if the Covered Person fails to meet the Condition Management requirements.	Copayment based upon medication Tier	Copayment based upon medication Tier plus the difference between the Maximum Allowable Amount and the Copayment
Diabetic Testing Supplies Needles, and Syringes (Testing supplies include test strips, lancets, lancet devices, blood glucose monitors and control solution.)	The plan will pay 100% of the cost, after plan deductible, for program approved In-Network medications for the treatment of Diabetes and/or Asthma if the OhioHealth Wellness Program requirements are met and the prescription is filled at an OhioHealth pharmacy. This does not apply at any other pharmacy. Standard Copayments will apply if the Covered Person fails to meet the Condition Management requirements.	Copayment based upon medication Tier	Copayment based upon medication Tier plus the difference between the Maximum Allowable Amount and the Copayment
Insulin Pumps	The plan will pay 10% after deductible for approved In-Network Pumps available through the pharmacy benefit.		Copayment based upon medication Tier plus the difference between the Maximum Allowable Amount and the Copayment
Fertility Drugs (The fertility drug maximum benefit is the most the Plan will pay for fertility drug covered benefits in each Calendar Year. The maximum applies separately to each Covered Person.)	40% after Medical Plan Deductible Maximum of $2,000 in prescription drug coverage per Calendar Year combined for all OhioHealth plans.		Not Covered

	OhioHealth Pharmacies	Participating Pharmacies	Non-Participating Pharmacies
Prescription Drugs *(Unless otherwise state, Copayments and Coinsurance reflect the Covered Person's responsibility)*			
Family Planning Services: Female Contraceptives (identified on the PBM's preventive care list)	No Charge		Difference between the Maximum Allowable Amount and the Negotiated Charge
Family Planning Services: Female Contraceptives (NOT identified on the PBM's preventive care list)	10% after Medical Plan Deductible		Coinsurance plus the difference between the Maximum Allowable Amount and the Negotiated Charge
Tobacco Cessation Medications: available at retail, mail, order, RMB and Marion General Hospital Ambulatory	No Charge		Difference between the Maximum Allowable Amount and the Negotiated Charge

Mandatory Generic: The Plan requires pharmacies to dispense Generic Drugs when available. When a Generic Drug is available, but the Pharmacy dispenses a brand name Drug per the Covered Person's or prescribing Physician's request, the Covered Person will be charged the generic Copayment plus the difference between the brand name Drug and the Generic Drug. The difference will not be counted towards the Covered Person's Out-of-Pocket Maximum.

Contraceptives: Depo-Provera, an injectable contraceptive, or similar type of contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per calendar year.

Recently Approved FDA Drugs: Covered Person's will be charged the out-of-network Prescription Drug cost sharing for Prescription Drugs recently approved by the FDA, but which have not yet been reviewed by the Pharmacy Benefit Administrator's Pharmacy Committee.

Condition Management: OhioHealth Wellness Disease Management: The plan will pay 100% of the cost for program approved In-Network medications and testing supplies for the treatment of Diabetes and/or Asthma if the member actively participates in the OhioHealth Wellness Program and prescriptions are filled through an OhioHealth pharmacy. This does not apply at any other In-Network pharmacy. The medical deductible must be met prior to receiving 100% coverage. Failure to meet the OhioHealth Wellness Program participation requirements will result in the Covered Person paying the standard copayments. Refer to the Care Management section for more information.

SECTION IV: ENROLLMENT, ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS

ENROLLMENT PROCEDURES

The Associate is responsible for enrolling in the manner, form, and time frame prescribed by the Employer. The Plan's eligibility requirements and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. The Plan Administrator may request documentation from the Associate or their Dependents in order to make these determinations and ensure Plan terms are being followed. Coverage choices offered under this Plan will be the same choices offered to other similarly situated Associates.

ASSOCIATE ELIGIBILITY REQUIREMENTS

An Associate is eligible for coverage if they are in an eligible class. An eligible class is:

- a part-time or full-time Associate whose standard weekly hours are 24 or more, or who are eligible per the Affordable Care Act eligibility rules, as defined by the Employer.

The Plan Administrator holds the discretionary authority to determine who is and who is not eligible for coverage under this Plan.

Eligible Associates do not include:

- Temporary or leased Associates;
- An Independent Contractor (as defined in this Plan);
- A consultant who is paid on other than a regular wage or salary by the employer; and

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Associate may retain eligibility for coverage under this Plan if they are temporarily absent on an approved leave of absence, in accordance with the Employer's leave policy, with the expectation of returning to work following the approved leave and the Associate continues to pay any required contributions under the Plan during the period of approved leave of absence. The Employer's classification of an Associate is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not the Employer agrees to such reclassification, shall change a person's eligibility for benefits.

EFFECTIVE DATE OF ASSOCIATE'S COVERAGE

An Associate's coverage will begin on the later of one of the following:

1. When initially eligible for coverage an Associate will have 31 days to enroll themselves and their Dependents. Coverage will become effective the first day of the month following the date in which the enrollment information is received, and any required contribution is received by the Plan Administrator; or

2. If an eligible Associate does not enroll during the initial enrollment period, they will be able to enroll for coverage during the Plan's next annual open enrollment period. The Effective Date of coverage shall be January 1 following the annual open enrollment period; or

3. If an eligible Associate does not enroll during the initial enrollment period, they may be eligible to enroll later under the Special Enrollment Provision, and coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within thirty-one (31) days of the event.

DEPENDENT ELIGIBILITY REQUIREMENTS

An Eligible Dependent includes:

1. The Associate's legal Spouse. A "Spouse" shall mean any individual that is legally married to the Associate.

2. A Child who is under the age of 26. The term "Child" includes the following Dependents:

   - A natural biological Child of the Associate or Spouse;
   - A stepchild of the Associate, as long as the natural parent remains married to the Associate;
   - A legally adopted Child or a Child legally Placed for Adoption with the Associate or Spouse, as granted by action of a federal, state, or local governmental agency responsible for adoption administration or a court of law;
   - A foster Child of the Associate or Spouse;
   - A Child under the Associate's or Spouse's permanent or temporary Legal Guardianship as ordered by a court (including grandchildren if there is court-ordered custody);
   - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO);

   A Child will remain covered until the end of the month in which they reach their 26th birthday unless the Child is Totally Disabled (see "Extended Covered for Dependent Children" section).

3. A Dependent does NOT include the following:

   - Domestic partners;
   - Common law spouse;
   - An individual from whom the Associate has obtained a legal separation or divorce;
   - A grandchild of the Associate (unless considered a Child Dependent as set forth above; e.g., Legal Guardianship);
   - Any other relative or individual unless explicitly covered by this Plan; or
   - A Child who is covered as a Dependent of another Associate covered by this Plan.

NON-DUPLICATION OF COVERAGE

If both Spouses are Associates of the Employer, both may elect coverage, but only one may elect Dependent coverage. In no event may an individual be covered both as an Associate and as a Dependent under the Plan. Dependent children may be covered as Dependents of either Spouse, but not both, regardless of whether the Associates are married or unmarried

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS

The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. The Plan Administrator has the authority and discretion to terminate coverage if supporting documentation is requested and not provided within the timeframe specified by the Plan Administrator. The Associate and their Dependent have a notice obligation to notify the Plan should the Dependent's eligibility status change throughout the Calendar Year.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may continue coverage past the limiting age in the following circumstances:

- The Dependent Child is not able to earn their own living because of mental or physical handicap which started prior to the date they reached the maximum age for eligible children under the Plan; and

- The Dependent Child is chiefly dependent upon the Associate for support and maintenance.

Such Child's health coverage may continue beyond the day the Child would otherwise cease to be a Dependent under the terms of this Plan. The Associate must submit written proof that the Child is Totally Disabled within thirty-one (31) calendar days after the day coverage for the Dependent would normally end. The Plan may, for a period of two (2) years, ask for additional proof at any time, after which the Plan can ask for proof not more than once a year. Coverage can continue subject to the following minimum requirements:

- Proof of a Total Disability must be submitted as required; and
- The Dependent must continue to meet the definition of Child as defined by this Plan; and
- The Associate must still be covered under this Plan.

IMPORTANT: It is the Associate's responsibility to notify the Plan Administrator within sixty (60) days if their Dependent no longer meets eligibility criteria. If, at any time, the Dependent fails to meet the eligibility qualifications, the Plan has the right to be reimbursed from the Dependent or Associate for any medical claims paid by the Plan during the period that the Dependent did not qualify for coverage, to the extent permitted by applicable law.

EFFECTIVE DATE OF COVERAGE FOR DEPENDENTS

Dependent coverage will become effective on the later of:

1. The date the Associate's coverage with the Plan begins if the Dependent is enrolled at that time;
2. The date the Associate acquires a Dependent if application is made within 31 days of acquiring the Dependent;
3. January 1 following application during the annual open enrollment period;
4. If a Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision; or
5. The later of the date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

A contribution will be charged from the first day of coverage for the Dependent if additional contribution is required. In no event will the Dependent be covered prior to the day the Associate's coverage begins.

ANNUAL OPEN ENROLLMENT PROVISION

During the annual open enrollment period, eligible Associates will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Covered Associates previously enrolled under the Plan will be able to make a change in coverage for themselves and their eligible Dependents during the annual open enrollment period.

The annual open enrollment period will take place in advance of the Plan's renewal effective date. The Employer will give eligible Associates written notice prior to the start of an annual open enrollment period. The Effective Date of coverage shall be January 1 following the annual open enrollment period.

SPECIAL ENROLLMENT PROVISION

This Plan gives eligible persons special enrollment rights under this Plan if there is a loss of other health coverage, a change in family status or other circumstances as explained below. The coverage choices that will be offered to the Associate will be the same choices offered to other similarly situated Associates.

During this special enrollment period, eligible Associates will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Covered Associates will also be able to make a change in coverage for themselves and their eligible Dependents that is consistent with the circumstances in which they are eligible for special enrollment.

LOSS OF HEALTH COVERAGE

Current Associates and their Dependents may have a special opportunity to enroll for coverage under this Plan if there is a loss of other health coverage, provided that all of the following conditions are met or otherwise approved by the Plan Administrator:

1. The Associate and/or their Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan is offered;

2. The coverage under the other group health plan or health insurance policy was:

   - COBRA continuation coverage and that coverage was exhausted;
   - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy (e.g. termination of coverage; change in eligibility; death; divorce, annulment, or legal separation) and no substitute coverage is offered;
   - No longer receiving any monetary contribution toward the premium from the employer; or
   - A Medicaid plan or state child health plan and the Associate's and/or Dependents' coverage was terminated due to loss of eligibility;

3. The Associate or their Dependent request and apply for coverage under this Plan no later than 31 days after the date the other coverage ended.

   - If the loss of coverage was due to loss of eligibility under a Medicaid or state child health plan, the Associate must request coverage under this Plan within sixty (60) days after the date of termination of such coverage.

4. Evidence of termination of other coverage is provided to the Plan Administrator.

The Associate or their Dependents may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

1. Coverage was terminated due to failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact; or

2. The Associate or their Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

CHANGE IN FAMILY STATUS

Current Associates and their Dependents, COBRA Qualified Beneficiaries and other eligible persons have a special opportunity to enroll for coverage under this Plan if there is a change in family status.

If a person becomes an eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Associate, spouse and newly acquired Dependent(s) who are not already enrolled, may enroll for health coverage under this Plan during a special enrollment period. The Associate must request and apply for coverage within thirty-one (31) calendar days of marriage, birth, adoption, or Placement for Adoption.

Documentation will be required to verify a Dependent's status.

If a newly acquired Dependent is not enrolled within the thirty-one (31) daytime frame, the Associate must wait until the next Open Enrollment period to add the Dependent.

Enrollment Requirements for Newborn Children

A newborn child of a Covered Associate is automatically enrollment for thirty-one (31) days after birth. To continue coverage after thirty-one (31) days, the Associate will need to complete a change form and return it to the Plan Administrator within the thirty-one (31) day enrollment period.

QUAILFYING EVENT UNDER A SECTION 125 PLAN

IRS regulations require that benefit elections remain in effect throughout the full Plan Year. The only exception that permits a change an election during the year is if there is an "IRS Qualifying Event". If a current Associate and/or their Dependent experiences an event that would meet the definition of an "IRS Qualifying Event" under a Section 125 plan, a mid-year plan change may be allowed if approved by the Plan Administrator. The Associate must submit the request within 31 calendar days following the date of the event.

An "IRS Qualifying Event" would be the following:

- Change in marital status (marriage, divorce, legal separation, annulment, death of spouse);
- Change in number of Dependents (birth, adoption, Placement for Adoption, death of a dependent, or court appointed Legal Guardianship);
- Change in Dependent's eligibility (child reaching limiting age, no longer meet eligibility requirements under the Plan);
- Change in employment status of an Associate, Spouse or Dependent resulting in a gain or loss of eligibility (commencement or termination of employment, strike or lockout, change in worksite, commencement or return from an unpaid leave of absence, or change in eligibility status (such as a change from full-time to part-time[less than 24 standard hours per pay], and not otherwise eligible under the Affordable Care Act));
- Significant change in coverage or in cost of coverage;
- Change in residence of the Associate, Spouse or Dependent that effects eligibility;

NEWLY ELIGIBLE FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

Current Associates and their Dependents may be eligible for a Special Enrollment period if the Associate and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Associate must request coverage under this Plan within sixty (60) days after the date the Associate and/or Dependent is determined to be eligible for such assistance. Evidence of eligibility must be provided to the Plan Administrator.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Federal law requires the Plan, under certain circumstances, to provide coverage for an Associate's Child(ren). The Plan Administrator shall enroll for immediate coverage under this Plan any Child, who is the subject of a "qualified medical child support order" ("QMCSO").

If an Associate is ordered to provide such coverage for a Child and is not enrolled in the Plan at the time the Plan Administrator receives a QMCSO, the Plan Administrator shall also enroll the Associate for immediate coverage under this Plan. Coverage under the Plan will be effective as of the later of the date specified in the order or the date the Plan Administrator determines that the order is a QMCSO. Any required contribution for coverage pursuant to this section will be deducted from the Associate's pay in accordance with the Employer's payroll schedule and policies.

A QMCSO is defined as a child support decree or order issued by a court (or a state administrative agency that has the force and effect of law under applicable state law) that obligates an individual to support or provide health care coverage to their Child and includes certain information concerning such coverage.

The Plan Administrator will determine whether any child support order it receives constitutes a QMCSO.

Except for QMCSO's, no Child is eligible for Plan coverage, even if the Associate is required to provide coverage for that Child under the terms of a separation agreement or court order, unless the Child is an eligible Child under this Plan. Procedures for determining a QMCSO may be obtained, free of charge, by contacting the Plan Administrator.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective:

1. In the case of marriage, coverage will begin the first day of the month following the date of marriage;
2. In the case of a Dependent's birth, on the date of such birth;
3. In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption;
4. In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the date the approved request for coverage is received;
5. In the case of a court or administrative order, on the date provided in such order; or
6. In the case of loss of coverage, on the first day of the month following the coverage termination.

TERMINATION

For information about continuing coverage beyond the date on which coverage would be terminated under this section, refer to the COBRA section of this Plan.

ASSOCIATE'S COVERAGE

The Associate's coverage under this Plan will terminate on the earliest of:

1. The end of the period for which the last contribution is made, if the Associate fails to make any required contribution towards the cost of coverage when due (after any applicable grace period);
2. The last day of the month after the date this Plan is canceled;
3. The last day of the month in which the Associate is no longer eligible for coverage;
4. The last day of the month in which the Associate advises the Plan to cancel their coverage, if they are voluntarily canceling coverage while remaining eligible because of change in status or special enrollment;
5. The end of the Plan Year if the Associate elects to waive Plan coverage for the subsequent Plan Year as part of the annual open enrollment period;
6. The day the Associate becomes covered under another plan offered by the Employer;
7. The last day of the month in which the Associate's employment ends; or
8. The date the Associate submits a false claim or is involved in any other form of fraudulent act related to this Plan or any other group plan, to the extent permitted by applicable law.

DEPENDENT'S COVERAGE

Coverage for a Dependent will terminate on the earliest of:

1. The end of the period for which the last contribution is made, if there is failure to make any required contribution toward the cost of a Dependent's coverage when due (after any applicable grace period);
2. The same day in which the Associate's coverage ends;

3. The date Dependent coverage is no longer offered under this Plan;
4. The last day of the month in which a Dependent Child no longer satisfies a required eligibility criterion listed in the Eligibility and Enrollment Section (including failure to submit required dependent eligibility documentation);
5. If a Dependent Child qualifies as Totally Disabled, the last day of the month in which the Dependent Child is no longer deemed Totally Disabled under the terms of the Plan;
6. The last day of the month in which a Dependent is no longer the Associate's legal spouse due to legal separation or divorce, as determined by the law of the state where the Associate resides;
7. The last day of the month in which the Plan is advised to cancel a Dependent's coverage if an Associate is voluntarily canceling it while remaining eligible because of change in status or special enrollment;
8. The end of the Plan Year if the Associate elects to cancel a Dependent's coverage for the subsequent Plan Year as part of the annual open enrollment period;
9. The last day of the month in which the Dependent becomes covered as an Associate under this Plan; or
10. The date the Associate or their Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan, to the extent permitted by applicable law.

RESCISSION OF COVERAGE

As permitted by the Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact. In the case of such fraud or intentional misrepresentation, a Covered Person will receive a notice and will be provided with an opportunity to appeal the recession, as required by law. An advance notice and an opportunity to appeal is not required by law due to a Covered Person's failure to timely pay a required contribution or the ineligibility of a Covered Person (that was not an error of the Plan Administrator).

If the Plan Administrator finds that a Covered Person has performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact, the Plan has the right to demand that the Covered Person pay back all Benefits paid to that individual, or paid in that individuals name, during the time the individual was incorrectly covered under the Plan, to the extent permitted by law.

REINSTATEMENT OF COVERAGE

If coverage ends due to termination of employment, leave of absence, reduction of hours or lay-off and the Associate qualifies for eligibility under this Plan again within 30 days of coverage termination, the Associate's coverage will be automatically reinstated as of XXX (without having to satisfy any applicable Waiting Period). If the Associate qualifies for eligibility under this Plan after 30 days from termination of coverage, the Associate will be required to re-enroll. Refer to the sections on Family and Medical Leave Act or Uniformed Services Employment and Reemployment Act for possible exceptions or contact the Plan Administrator.

COVERAGE AFTER TERMINATION

If a Covered Person is an Inpatient when coverage is terminated, Covered Benefits will be paid as follows:

- For facility claims the entire claim will be paid even if the Covered Person remains an Inpatient after termination of coverage.
- For Physician claims, claims will be paid based on date of service. Dates of service after the Covered Person's termination date will not be covered.

SECTION V: NOTICE OF COBRA CONTINUATION OF COVERAGE RIGHTS & RESPONSIBILITIES

Important: Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This summary generally explains COBRA continuation coverage, when it may become available to a Covered Person, and what they need to do to protect the right to receive it. This summary provides a general notice of a Covered Person's rights under COBRA but is not intended to satisfy all of the requirements of federal law. The employer or the COBRA Administrator will provide additional information to the Covered Person as required.

The COBRA Administrator for this Plan is:

HealthEquity
1-866-747-0039
www.mybenefits.wageworks.com

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries, the right to continue their health care benefits beyond the date that their coverage might otherwise terminate. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee which in total cannot exceed 102% of the monthly health plan premium. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would otherwise terminate because of a life event known as a Qualifying Event, outlined below. When a Qualifying Event causes (or will cause) a Loss of Coverage, then the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, the Associate, their covered Spouse, and their Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

An Associate will become a Qualified Beneficiary if coverage under the Plan is lost because either one (1) of the following Qualifying Events happens:

Associate Qualifying Event	Length of Continuation
• The Associate's employment ends for any reason other than gross misconduct	up to eighteen (18) months
• The Associate's hours of employment are reduced	up to eighteen (18) months

(There are two (2) ways in which this eighteen (18) month period of COBRA continuation coverage can be extended. See the section below entitled "The Right to Extend Coverage" for more information.)

The Spouse of an Associate will become a Qualified Beneficiary if coverage is lost under the Plan because any of the following Qualifying Events happen:

Spouse Qualifying Event	Length of Continuation
• The Associate dies	up to thirty-six (36) months
• The Associate's hours of employment are reduced	up to eighteen (18) months
• The Associate's employment ends for any reason other than gross misconduct	up to eighteen (18) months
• The Associate becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to thirty-six (36) months
• The spouse becomes divorced or legally separated from the Associate	up to thirty-six (36) months

The Dependent Children of an Associate become Qualified Beneficiaries if coverage is lost under the Plan because any of the following Qualifying Events happen:

Dependent Children Qualifying Event	Length of Continuation
• The parent-Associate dies	up to thirty-six (36) months
• The parent-Associate's employment ends for any reason other than their gross misconduct	up to eighteen (18) months
• The parent-Associate's hours of employment are reduced	up to eighteen (18) months
• The parent-Associate becomes entitled to Medicare benefits (Part A, Part B, or both)	up to thirty-six (36) months
• The parents become divorced or legally separated	up to thirty-six (36) months
• The Child stops being eligible for coverage under the plan as a Dependent	up to thirty-six (36) months

Note: A Spouse or Dependent Child newly acquired (newborn or adopted) during a period of COBRA continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during COBRA continuation coverage. A Dependent, other than a newborn or newly adopted Child, acquired and enrolled after the original Qualifying Event is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

COBRA NOTICE PROCEDURES

THE NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

To be eligible to receive COBRA continuation coverage, Covered Associates and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Associate and Spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrators, either the

employer or the COBRA Administrator. A Qualified Beneficiary's written notice must include all of the following information:

1. The Qualified Beneficiary's name, their current address and complete phone number;
2. The group number, name of the employer that the Associate was with;
3. Description of the Qualifying Event (i.e., the life event experienced); and
4. The date that the Qualifying Event occurred or will occur.

A form to notify the COBRA Administrator is available from the Plan Administrator upon request.

Send all notices or other information required to be provided by this Plan Document and Summary Plan Description in writing to:

HealthEquity
1-866-747-0039
www.mybenefits.wageworks.com

For purposes of the deadlines described in this Plan Document and Summary Plan Description, the notice must be postmarked by the deadline. In order to protect the Associate's family's rights, the Plan Administrator should be informed of any changes in the addresses of family members. Keep a copy of any notices sent to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The employer will give notice to the COBRA Administrator when coverage terminates due to Qualifying Events that are the Associate's termination of employment or reduction in hours, death of the Associate, or the Associate becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). The employer will notify the COBRA Administrator within thirty (30) calendar days when these events occur.

ASSOCIATE OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of other Qualifying Events that are divorce or legal separation of the Associate and a Spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The Covered Associate or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the sixty (60) calendar day period that begins on the latest of:

1. The date of the Qualifying Event;
2. The date on which there is a Loss of Coverage (or would lose coverage); or
3. The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Plan Document and Summary Plan Description or the General COBRA Notice.

The COBRA Administrator will provide an election notice to each Qualified Beneficiary within fourteen (14) calendar days of receiving notice of the Qualifying Event.

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that must be completed to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the sixty (60) day election period.

The election period ends sixty (60) calendar days after the later of:

1. The date Plan coverage terminates due to a Qualifying Event; or
2. The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing to continue group health coverage and must make the required payments when due in order to remain covered. If the Qualified Beneficiary does not choose COBRA continuation coverage within the sixty (60) day election period, group health coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the sixty (60) day election period, group health coverage will be reinstated back to the date coverage was lost, provided that the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the sixty (60) day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will be effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Associate contribution. This may also include a 2% additional fee to cover administrative expenses (or in the case of the eleven (11) month extension due to disability, a 50% additional fee). Fees are subject to change at least once a year.

If the employer offers annual open enrollment opportunities for active Associates, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The initial payment is due no later than forty-five (45) calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the forty-five (45) day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage, however the Qualified Beneficiary will receive specific payment information including due dates, when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, then the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or has discrepancies regarding the information on the check (i.e., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary and allow them fourteen (14) days to send in a corrected check. If a corrected check is not received within the fourteen (14) day timeframe, then the occurrence

will be treated as non-payment and the Qualified Beneficiary(s) will be termed from the Plan in accordance with the plan language above.

Note: Payment will not be considered made if a check is returned for non-sufficient funds.

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause the Covered Person to lose important rights under COBRA.

In addition, after any of the following events occur, written notice to the COBRA Administrator is required within thirty (30) calendar days of:

1. The date any Qualified Beneficiary marries. Refer to the Special Enrollment Provision section of this Plan for additional information regarding special enrollment rights;
2. The date a Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment Provision section of this Plan for additional information regarding special enrollment rights;
3. The date of a final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled; or
4. The date any Qualified Beneficiary becomes covered by another group health plan.

If the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information within thirty (30) calendar days.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Plan Document and Summary Plan Description:

1. For Associates and Dependents. Eighteen (18) months from the Qualifying Event if due to the Associate's termination of employment or reduction of work hours. (If an active Associate enrolls in Medicare before their termination of employment or reduction in hours, then the covered Spouse and Dependent Children would be entitled to COBRA continuation coverage for up to the greater of eighteen (18) months from the Associate's termination of employment or reduction in hours, or thirty-six (36) months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)

2. For Dependents only. Thirty-six (36) months from the Qualifying Event if coverage is lost due to one (1) of the following events:

   - Associate's death;
   - Associate's divorce or legal separation;
   - Former Associate becomes enrolled in Medicare; or
   - A Dependent Child no longer being a Dependent as defined in the Plan.

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided that written notice to the COBRA Administrator is given as soon as possible but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Associates and Dependents): A Qualified Beneficiary may be granted an eleven (11) month extension to the initial eighteen (18) month COBRA continuation period, for a total maximum of twenty-nine (29) months of COBRA in the event that the Social Security Administration determines the Qualified Beneficiary to be disabled some time before the 60th day of COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for thirty-six (36) months.

If the Qualified Beneficiary has non-disabled family members who are also Qualifying Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must give the COBRA Administrator a copy of the Social Security Administration letter of disability determination within sixty (60) days of the later of:

1. The date of the SSA disability determination;
2. The date the Qualifying Event occurs;
3. The date the Qualified Beneficiary loses (or would lose) coverage due to the Qualifying Event or the date that Plan coverage was lost; or
4. The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Plan Document and Summary Plan Description or the General COBRA Notice.

Note: Premiums may be higher after the initial eighteen (18) month period for persons exercising this disability extension provision available under COBRA, which in total cannot exceed 150% of the monthly health plan premium.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan of that fact within thirty (30) days after the Social Security Administration's determination.

Second Qualifying Events: (Dependents Only) If an Associate's family experiences another Qualifying Event while receiving eighteen (18) months of COBRA continuation coverage, the Spouse and Dependent Children who are Qualified Beneficiaries can receive up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the Spouse or Dependent Children who are Qualified Beneficiaries if the Associate or former Associate dies, becomes entitled to Medicare (Part A, Part B or both) or is divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event. A Dependent acquired during COBRA continuation (other than newborns and newly adopted Children) is not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will only lead to the extension when the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

The Associate or their Dependents must provide the notice of a second Qualifying Event to the COBRA Administrator within a sixty (60) day period that begins to run on the latest of:

1. The date of the second Qualifying Event;
2. The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
3. The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Plan Document and Summary Plan Description or the General COBRA Notice.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

1. The employer ceases to maintain a group health plan for any Associates. (Note that if the employer terminates the group health plan that the Qualified Beneficiary is under, but still maintains another group health plan for other similarly-situated Associates, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same);
2. The required contribution for the Qualified Beneficiary's coverage is not paid on time;
3. After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled with Medicare;
4. The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one (1) month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled; or
5. Termination for cause, such as submitting fraudulent claims.

HEALTH COVERAGE TAX CREDIT PROGRAM (HCTC)

If a Covered Associate has been determined to be an Eligible TAA Recipient or an Eligible Alternative TAA Recipient, as those terms are defined in the Trade Act of 2002, such Covered Associate and their Dependents who lost coverage under the Plan due to a job loss that qualified such Associate for TAA assistance shall be entitled to a second sixty (60) day election period (if continuation coverage was not elected during the period described above) beginning on the first day of the month in which the Covered Associate is determined to be TAA eligible, provided such election is made within six (6) months of the original loss of coverage. If elected under this provision, coverage shall begin on the first day of the month in which the Covered Associate is determined to be TAA eligible.

DEFINITIONS

Qualified Beneficiary means a person covered by this group health Plan immediately before the Qualifying Event who is the Associate, the Spouse of a Covered Associate, or the Dependent Child of a Covered Associate. This includes a Child who is born to or Placed for Adoption with a Covered Associate during the Associate's COBRA coverage period if the Child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted Children. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one (1) of the following:

1. The death of the Covered Associate;
2. Voluntary or involuntary termination of the Covered Associate's employment (other than for gross misconduct);
3. A reduction in work hours of the Covered Associate;
4. Divorce or legal separation of the Covered Associate from the Associate's Spouse. (Also, if an Associate terminates coverage for their spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within sixty (60) calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation);
5. The covered former Associate becomes enrolled in Medicare; or
6. A Dependent Child no longer being a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before the Qualifying Event. Loss of Coverage includes change in coverage terms, change in plans, termination of coverage, partial Loss of Coverage, increase in Associate cost, as well as other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after the Qualifying Event, but it must always occur within the applicable eighteen (18) or thirty-six (36) month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

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

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

If provisions under the Plan change while an Associate is on FMLA Leave, the changes will be effective for them on the same date as they would have been had they not taken leave.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in loss of coverage as a result of active duty. Associates on leave for military service must be treated like they are on leave of absence and are entitled to any other rights and benefits accorded to similarly situated Associates on leave of absence or furlough. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Associates on military leave.

COVERAGE

The maximum length of health care continuation coverage required under USERRA is the lesser of:

1. Twenty-four (24) months beginning on the day that the Uniformed Service leave begins, or
2. A period beginning on the day that the Service leave begins and ending on the day after the Associate fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Associate or an appropriate officer of the uniformed service in which their service is to be performed must notify the employer that the Associate intends to leave the employment position to perform service in the uniformed services. An Associate should provide notice as far in advance as is reasonable under the circumstances. The Associate is excused from giving notice due to military necessity, or if it is otherwise impossible or unreasonable under all the circumstances.

Upon notice of intent to leave for uniformed services, Associates will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election, payment, and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Section, to the extent these COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of thirty (30) days or less, the Associate is not required to pay more than the amount they would have paid as an active Associate. For periods of thirty-one (31) days or longer, if an Associate elects to continue health coverage pursuant to USERRA, such Associate and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENT

Associates and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Associate on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Associate will generally be extended. Coverage under both laws will run concurrently. Dependents that choose to independently elect extended coverage will only be deemed eligible for COBRA extension because they are not eligible for a separate, independent right of election under USERRA.

CONTINUATION OF PLAN COVERAGE DUE TO APPROVED LEAVE OF ABSENCE

Medical and Prescription Drug coverage will be continued by the Employer for the Associate and any covered Dependents in the event of an approved leave of absence. Coverage may be continued for up to 12 weeks.

If the leave qualifies under the Family and Medical Leave Act (FMLA), any continuation of coverage provided under this provision will run concurrent with FMLA.

Coverage under this provision will continue in accordance with the same terms and conditions of an active Associate. If a COBRA qualifying event occurs, any period of continued coverage under this section will reduce the maximum time for which a Qualified Beneficiary may elect to continue coverage under COBRA. Please refer to the Notice of COBRA Continuation of Coverage Rights & Responsibility section for additional information.

SECTION VI: MEDICAL BENEFITS

If a Covered Person incurs covered medical expenses for Medically Necessary services due to a non-Occupational Injury or Illness, the Plan will consider charges up to the Maximum Allowable Amount and pay benefits as shown in the Schedule of Benefits. The benefits payable are subject to all General Limitations and Exclusions and Provisions of the Plan.

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, or disability.

COPAYMENT

A Copayment is the amount the Covered Person must pay to the Provider each time certain services are received. The Copayment is shown on the Schedule of Benefits.

DEDUCTIBLE

Deductible means the amount of Covered Expenses Incurred by a Covered Person in a Calendar Year before any other Covered Expenses can be considered for payment at the percentages stated in the Schedule of Benefits and this Plan.

An individual Deductible is the amount that each individual Covered Person must pay during a Calendar Year before the Plan begins paying benefits for that person. A family Deductible limit is the maximum amount that all family members who are covered under the same Covered Associate must pay in Deductible expense in a Calendar Year. Once this cumulative family Deductible is reached, the Deductible will be considered satisfied for all family members covered under the Plan during the remainder of the Calendar Year. However, the Plan will begin to pay benefits once a Covered Person satisfies the individual Deductible even if that Covered Person is enrolled in Associate + 1 coverage or family coverage and the family Deductible limit has not yet been satisfied.

When a new Calendar Year begins, a new Deductible must be satisfied. Deductible amounts are shown on the Schedule of Benefits.

The Deductibles satisfied for In-Network and Out-of-Network Provider services are not integrated. This means the In-Network and Out-of-Network Deductible amounts listed in the Schedule of Benefits must be separately satisfied.

COINSURANCE

After the Covered Person satisfies the Deductible, the Covered Person, and the Plan each pay a percentage of the Covered Expenses until the Covered Person's (or family's, if applicable) annual Out-of-Pocket Maximum is reached. The Plan Coinsurance is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the Provider after the Plan has paid its portion of the Covered Expense. Once the annual Out-of-Pocket Maximum has been satisfied, the Plan will pay 100% of the Covered Expenses for the remainder of the Calendar Year.

Any payment for an expense that is owed to a Provider and not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUM

The Annual Out-of-Pocket Maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as any Deductible, Copayment and Coinsurance expense, will be used to satisfy the Covered Person's (or family's, if applicable) Annual Out-of-Pocket Maximum.

An individual Out-of-Pocket Maximum is the maximum amount that each individual Covered Person will pay during a Calendar Year. A family Out-of-Pocket Maximum is the maximum amount that all family members who are covered under the same Covered Associate will pay during a Calendar Year. However, the Plan will pay 100% of Covered Expenses once a Covered Person satisfies the individual Out-of-Pocket Maximum even if that Covered Person is enrolled in Associate + 1 or family coverage and the family Out-of-Pocket Maximum has not yet been satisfied.

When a new Calendar Year begins, a new Out-of-Pocket Maximum must be satisfied. Out-of-Pocket Maximums are shown on the Schedule of Benefits.

The Out-of-Pocket Maximum satisfied for In-Network and Out-of-Network Provider services are not integrated. This means the In-Network and Out-of-Network Annual Out-of-Pocket Maximums listed in the Schedule of Benefits must be separately satisfied.

Not all Covered Expenses are eligible to accumulate towards the Out-of-Pocket Maximum. The following will not be used to meet the Out-of-Pocket Maximums:

- Penalties, legal fees, and interest charged by a Provider;
- Expenses for non-Covered Services;
- Any amounts paid for Out-of-Network services (except Emergency Services);
- Any charges above the limits specified elsewhere in this document;
- Balance billing amounts from Out-of-Network Providers;
- Precertification penalties; or
- Any amounts over the Usual, Customary and Reasonable (UCR) Allowance, the Maximum Allowable Amount, Negotiated Rate, or established fee schedule.

HIGH DEDUCTIBLE HEALTH PLANS (HDHP) WITH A HEALTH SAVINGS ACCOUNTS (HSA)

High Deductible Health Plans (HDHP) that satisfy certain statutory requirements with respect to minimum Deductibles and Out-of-Pocket Maximums are called Qualified High Deductible Health Plans (QHDHP). Associates enrolled in a QHDHP are generally eligible to have a Health Savings Account (HSA). An HSA allows the Associate the opportunity to make pre-tax contributions from each paycheck in this account to pay current eligible out-of-pocket health care expenses and save for future medical expenses, including those Incurred during retirement. The OhioHealthy HDHP with the HSA is a Qualified High Deductible Health Plan (QHDHP).

The combination of a QHDHP with an HSA provides the Associate with comprehensive coverage for high cost medical events and a tax-advantaged way to help build savings for future medical expenses, which in turn gives Associates greater control over how health care benefits are used. The maximum amount an Associate is allowed to contribute to an HSA is set by the U.S. Department of Treasury (IRS) and is indexed each year for inflation. These limits will be communicated to Associates through the Plan Administrator. An HSA is not an ERISA governed benefit, and specific information regarding the provisions of the HSA will be communicated in a different document. Regulations govern how a QHDHP coordinates with other health plans, if a Covered Person is covered under more than one group health plan, the Covered Person should reach out to the Plan Administrator for additional information.

COVERED BENEFITS

This Plan provides coverage for the following Covered Benefits if services are authorized by a Physician and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions, or other Plan provisions in this document.

The Schedule of Benefits includes additional information regarding these benefits.

1. **Abortion**. Abortion is covered in the first twelve (12) weeks of pregnancy. After twelve (12) weeks abortion is covered if the mother's life is at risk, or if there are major fetal abnormalities, or in the case of rape or incest. Covered will also be subject to the state law in which the service is performed.

2. **Acupuncture Services.** Charges for services performed by a certified acupuncturist are covered limited to relief of migraines or back/neck pain, subject to the limits shown in the Schedule of Benefits.

3. **Allergy Treatment.** Charges for allergy testing, serum, and injections.

4. **Ambulance Transportation.** Professional ambulance service to transport the Covered Person.

   <u>Ground Ambulance</u> - Covered Benefits include transportation:

   - From home to Hospital for covered inpatient or Outpatient treatment when other means of transportation would be considered unsafe due to the Covered Person's medical condition. Transport is limited to 100 miles.
   - From Hospital to home or to another facility when other means of transportation would be considered unsafe due to the Covered Person's medical condition.
   - From one Hospital to another Hospital in a medical Emergency when the first Hospital does not have the required services or facilities to treat the Covered Person's condition.
   - To the first Hospital where treatment is given in a medical Emergency.
   - When during a covered inpatient stay at a Hospital, Skilled Nursing Facility or acute rehabilitation Hospital, an Ambulance is required to transport the Covered Person safely and adequately to or from inpatient or Outpatient Medically Necessary treatment.

   <u>Air or Water Ambulance</u> - Covered Benefits include charges for transportation to a Hospital by air or water Ambulance when:

   - Ground Ambulance Transportation is not available; and
   - In a medical Emergency, transportation from one Hospital to another Hospital; when the first Hospital does not have the required services or facilities to treat the Covered Person's condition and the individual needs to be transported to another Hospital; and
   - The Covered Person's condition is unstable and requires medical supervision and rapid transport.

   Professional ambulance charges for convenience are not covered. Transportation services provided by an ambulette or wheelchair van are not covered services.

5. **Ambulatory Surgical Center.** Services and supplies provided by an Ambulatory Surgical Center.

6. **Anesthetics and their Administration.** Anesthetics and their professional administration.

7. **Applied Behavioral Analysis (ABA).** Charges for applied behavioral analysis for the treatment of Autism. Therapy limits do not apply to ABA.

8. **Blood and Blood Derivatives.** Administration of blood and blood products, but not the cost of the blood or blood products.

9. **Cardiac Rehabilitation.** Cardiac rehabilitation benefits are available as part of an inpatient Hospital stay. A limited course of Outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The Plan will cover charges in accordance with a treatment plan as determined by the Covered Person's risk level when recommended by a Physician.

10. **Cataract or Aphakia Surgery.** One (1) pair of glasses following cataract surgery or aphakia surgery.

11. **Chemotherapy.** Services and supplies related to chemotherapy. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as Outpatient care. Inpatient Hospitalization for chemotherapy is limited to the initial dose while hospitalized for the diagnosis of cancer and when a Hospital stay is otherwise Medically Necessary based on the Covered Person's health status

12. **Chiropractic Care/Spinal Manipulation.** Skeletal adjustments, manipulation, or other treatment in for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

13. **Circumcision.** Services and supplies related to circumcision. Circumcision performed while Hospital confined following birth will be considered as a newborn expense.

14. **Cleft Palate and Cleft Lip:** Services and supplies related to cleft palate and cleft lip. Cleft palate is defined as a birth deformity in which the palate (the roof of the mouth) fails to close, and cleft lip is defined as a birth deformity in which the lip fails to close. Eligible expenses include the following when provided by a Physician, or other professional Provider:

    a. Oral and facial Surgery, surgical management and follow-up care by plastic surgeons and oral surgeons.
    b. Habilitative speech therapy.
    c. Otolaryngology treatment.
    d. Audiological assessments and treatment.
    e. Orthodontic Treatment.
    f. Prosthodontic treatment.
    g. Prosthetic treatment such as obturators, speech appliances and feeding appliances.

15. **Complex Imaging and Testing Expenses (Diagnostic).** The Plan covers charges made on an Outpatient basis by a Physician, Hospital or a licensed imaging or radiological facility for complex imaging services to diagnose an Illness or Injury, including:

    - Computerized Axial Tomography (CT Scans);
    - Computerized Axial Tomography Angiogram (CTA Scans);
    - Genetic Testing (when deemed Medically Necessary);
    - Magnetic Resonance Angiography (MRA);
    - Magnetic Resonance Imaging (MRI);
    - Positron Emission Tomography (PET Scans); and
    - Sleep studies (when deemed Medically Necessary).

16. **Compression Leg Stockings.** Compression leg stockings when prescribed by Physician and fitted to the patient. Maximum of two (2) pairs per every six (6) months.

17. **Contraceptives.** This Plan provides benefits for Prescription contraceptives regardless of purpose. Prescription contraceptives that a Covered Person self-administers will be processed under the Pharmacy plan (oral tablets, patches, and self-insertable vaginal devices containing contraceptive hormones). Contraceptives that require a Physician to administer a hormone shot or insert a device will be processed under the Covered Medical Benefits in this Plan.

18. **Cosmetic or Reconstructive Surgery and Supplies.** Reconstructive services and supplies, including:

    - Surgery needed to improve a significant functional impairment of a body part.
    - Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an Illness or Injury) when:

- o The defect results in severe facial disfigurement, or
  - o The defect results in significant functional impairment and the surgery is needed to improve function.
- Surgery to correct the result of an Accidental Injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original Injury. For a covered child, the time period for coverage may be extended through age 18.
- Surgery to correct the result of an Injury that occurred during a covered surgical procedure provided that the Reconstructive Surgery occurs no more than 24 months after the original Injury.

19. **Dental Services.** Charges for Injury to or care of the mouth, teeth, gums, and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

- Excision of benign bony growths of the jaw and hard palate;
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;
- External incision and drainage of cellulitis;
- Incision of accessory sinuses, salivary glands, or ducts;
- Inpatient Hospital, Outpatient Hospital, or dentist office services for removal of teeth prior to radiation therapy for a covered medical condition;
- Reduction of fractures and dislocations of the jaw, unless otherwise excluded;
- Services for the treatment of a dental Injury to a sound natural tooth, including but not limited to extraction and initial replacement; or
- Surgery needed to correct Accidental injuries to the jaws, cheeks, lips, tongue, floor, and roof of the mouth.
- Accidental Injury to teeth that results from a medical condition or from domestic violence.

No charge will be covered under Medical Benefits resulting from chewing, or for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

General anesthesia and Hospital expenses are covered for eligible dental care services that would require the service be performed in a Hospital to monitor the patient due to the patient's age, a serious underlying medical condition, such as heart condition, blood disorder, etc. or is necessary due to Accidental Injury to sound natural teeth.

20. **Diabetes Education and Treatment.** Charges Incurred for the treatment of diabetes, for elevated blood glucose levels during pregnancy, nutritional counseling, and diabetic self-management education programs provided by a licensed health care Provider certified in diabetes self-management training. Insulin, needles, and syringes are required to be obtained through the Pharmacy plan.

21. **Dialysis Treatment.** Charges for dialysis for the treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis.

22. **Durable Medical Equipment (DME).** Covered Charges include charges by a DME supplier for the rental of equipment or, in lieu of rental:

- The initial purchase of DME if:
  - o Long term care is planned; and
  - o The equipment cannot be rented or is likely to cost less to purchase than to rent.
- Repair of purchased equipment.
- Replacement of purchased equipment if:
  - o The replacement is needed because of a change in the Covered Person's physical condition;
  - o Due to the growth or development of a Dependent Child;
  - o Because of deterioration caused from normal wear and tear; and
  - o It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The equipment must meet the definition of Durable Medical Equipment. The equipment must be prescribed by a Physician, including any repairs or replacement. The Plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. The Covered Person is responsible for the entire cost of any additional pieces of the same or similar equipment purchased or rent for personal convenience or mobility. In all cases, repairs, or replacement due to abuse or misuse, as determined by the Plan, are not covered.

Covered DME includes those items covered by Medicare unless specifically listed as excluded in this Plan. The Plan Administrator reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided.

The decision to rent or purchase is also at the discretion of the Plan Administrator. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will benefit reimbursement for the rental cost of Durable Medical Equipment exceed the purchase price of the item.

23. **Emergency Room Hospital and Physician Services.** Emergency room services for Stabilization or initiation of treatment of an Emergency Medical Condition provided at a Health Care Facility. The Plan does not require prior authorization for Emergency Services, regardless of whether provided by an In-Network Provider or an Out-of-Network Provider. For Emergency Services provided by an Out-of-Network Provider, this Plan does not impose any administrative requirements or benefit limitations that are more restrictive than those administrative requirements or benefit limitations that apply under the Plan to Emergency Services provided by an In-Network Provider or In-Network Emergency Facility. This Plan will cover Emergency Services without regard to any other term or condition of coverage, other than Plan exclusions or coordination of benefits (to the extent not inconsistent with benefits for an Emergency Medical Condition), an affiliation or Waiting Period (if any), and applicable cost sharing, consistent with applicable law. However, an Out-of-Network Provider of Emergency Services may Balance Bill the Covered Person, unless prohibited by law.

24. **Foot Care (Podiatry).** Care and services recommended by a Physician as a result of an infection. The following charges for Foot Care will also be covered:

    - Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet, when surgery is performed.
    - Treatment of corns, calluses, and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
    - Physician office visit for diagnosis of bunions. Treatment of bunions when an open cutting operation or arthroscopy is performed.
    - Covered charges do not include palliative foot care.

25. **Gender Confirmation Treatment**. Medically Necessary services are covered the same as any other Injury or Illness. Coverage includes the following services for the treatment of Gender Dysphoria:

    - Cross-sex hormone therapy administered by a medical Provider during an office visit or dispensed from a Pharmacy. Puberty suppressing medication is not cross-sex hormone therapy.
    - Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
    - Psychotherapy for Gender Dysphoria and Associated co-morbid psychiatric diagnoses.
    - Surgery for the treatment of Gender Dysphoria, including the surgeries listed below.

    <u>Female to Male</u>

    - Bilateral mastectomy or breast reduction
    - Hysterectomy (removal of uterus)
    - Metoidioplasty (creation of penis, using clitoris)

- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Male to Female

- Clitoroplasty (creation of clitoris)
- Labiaplasty (creation of labia)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Urethroplasty (reconstruction of female urethra)
- Vaginoplasty (creation of vagina)
- Breast implants

Specific documentation and written psychological assessments from one or more Qualified Behavioral Health Providers experienced in treating Gender Dysphoria are required prior to approval for a bilateral mastectomy, breast reduction surgery, or genital surgery.

26. **Home Health Care.** Services rendered by a home healthcare agency for treatment due to an Injury or Illness provided the Covered Person is homebound or transitioning from a Hospital (or other Inpatient facility), and the services are in lieu of a continued Inpatient stay.

Home healthcare nursing services must be established and approved in writing by the attending Physician and must be rendered following a Hospital confinement and/or after documented certification of Medical Necessity is made by the attending Physician. A visit occurs each time an Associate of a Home Healthcare Agency visits the patient.

Each four (4) hours or less of home healthcare services will be considered one (1) home healthcare visit, with a daily maximum of three (3) visits. This maximum will not apply to care given by an R.N. or L.P.N. when:

- Care is provided within 10 days of discharge from a Hospital or Skilled Nursing Facility as a full-time inpatient; and
- Care is needed to transition from the Hospital or Skilled Nursing Facility to home care.

When the above criteria are met, Covered Benefits include up to 12 hours of continuous care by an R.N. or L.P.N. per day.

Home healthcare services consist of:

- Care by or under the supervision of a registered nurse (R.N.) or licensed practical nurse (L.P.N.);
- Part-time or intermittent home health aide services primarily for the care of the Covered Person as long as the Covered Person is receiving either skilled nursing care or physical, speech, respiratory, or occupational therapy by a Home Healthcare Agency;
- Physical, speech, respiratory or occupational therapy provided in the Covered Person's home by a Home Healthcare Agency; and
- Medical supplies, laboratory services, and drugs and medicines prescribed by a Physician.

No home healthcare benefits are payable for:

- Services performed by a member of the Covered Person's family or a person residing in the Covered Person's home;
- Transportation services; or
- Services or supplies rendered during any period in which the Covered Person is not under the regular care of a Physician.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or Custodial Care service does not cause the service to become covered. If the Covered Person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

27. **Hospice Care Services**. Health care services provided to a Terminally Ill Covered Person. Hospice services must be provided through a Hospice Facility or a Hospice Care Provider sponsored by a Hospital or Home Health Care Agency. Hospice services may be received by the Covered Person in a private residence.

    Benefits for Hospice services are available when the prognosis of life expectancy is twelve (12) months or less.

    The following services and supplies are eligible (precertification may be required for some items):

    - All covered Home Health Care services, except nursing services which may be authorized for up to eight (8) hours within a twenty-four (24) hours a day;
    - Room and board while in a Hospice Facility;
    - Medical social services which include assessment of the social and emotional factors relating to the Covered Person's Terminal Illness, need for care, response to treatment, adjustment to care and action to obtain casework services to assist in resolving problems in these areas;
    - Professional services of a registered or licensed practical nurse;
    - Consultation or case management services by a Physician;
    - Psychological counseling;
    - Medical and surgical supplies;
    - Prescription Drugs (these Prescription Drugs must be required in order to relieve the symptoms of a condition, or to provide supportive care);
    - Oxygen and its administration;
    - Dietary counseling;
    - Medical social services, such as the counseling of patients;
    - Physical and occupational therapy;
    - Home health aide visits;
    - Acute inpatient Hospice services;
    - Respite care; and
    - Durable Medical Equipment.

    A treatment plan must be developed and submitted to the Plan by the Covered Person's Physician and the Provider of the Hospice services. The treatment plan must be approved by the Plan.

    Non-covered Hospice services include, but are not limited to:

    - Services provided by the spouse, child, brother, sister or parent of the Covered Person or their spouse;
    - Spiritual counseling;
    - Homemaker services;

- Food or home delivered meals;
- Custodial Care, rest care or care which is provided solely for someone's convenience;
- Funeral services or arrangements; or
- Chemotherapy or radiation therapy if other than palliative treatment is not covered under Hospice Care but may be covered elsewhere.

28. **Hospital Services (Includes Inpatient Services, Surgery Centers and Birthing Centers).** The following benefits are covered:

    - Semi-private room and board. Private room charges that exceed the Hospital's Semi-Private Room Rate are not covered unless a private room is required because of a contagious Illness or immune system problem. If the Hospital has no semi-private rooms, the Plan will allow the private room rate subject to Usual, Customary, and Reasonable Allowance or the Negotiated Rate, whichever is applicable.
        - Room and board also includes: admission and other fees; general and special diets; services of the Hospital's nursing staff; and sundries and supplies.
    - Intensive care unit room and board.
    - Discharge planning.
    - Intravenous (IV) preparations.
    - Operating and recovery rooms.
    - Oxygen and oxygen therapy.
    - Speech therapy, physical therapy, and occupational therapy (see Therapy Services).
    - Administration of blood and blood products, but not the cost of the blood or blood products.
    - Other miscellaneous and Ancillary Services.

29. **Hospital Services (Outpatient).** Services and supplies furnished while being treated on an Outpatient basis by the Outpatient department of a Hospital.

30. **Infertility.** Infertility services (includes Assisted Reproductive Technologies (ART) (in-vitro fertilization, artificial insemination, etc.)). Covered Charges are limited to the maximum shown in the Schedule of Benefits; verification of Infertility is not required. Covered Charges include services listed below; the person receiving treatment must be a Covered Person under the Plan.

    <u>Contraception and Reproductive Procedures</u>

    - Artificial Insemination: intra-cervical;
    - Artificial Insemination: intra-uterine;
    - Sperm washing for artificial insemination.

    <u>Fertility Diagnostic Services</u>

    A medically treatable condition may exist that results in the inability for person(s) to conceive. While this condition causes Infertility, the condition is a medical condition and its diagnosis and treatment is considered to be a medical condition. Diagnostic services to determine or cure the underlying medical conditions are covered in the same manner as any other Medically Necessary services.

    <u>Infertility Treatment Services</u>

    - Assisted oocyte fertilization, microtechnique; greater than 10 oocytes;
    - Assisted oocyte fertilization, microtechnique: less than or equal to 10 oocytes;
    - Culture of oocytes(s)/embryo(s), less than 4 days
    - Extended culture of oocyte(s)/embryo(s), 4-7 days;
    - Insemination of oocytes;

- Sperm isolation: complex prep (e.g., Percoli gradient, albumin gradient) for insemination or diagnosis with semen analysis;
- Sperm isolation: simple prep (e.g., sperm wash and swim-up) for insemination or diagnosis with semen analysis.

Miscellaneous Prostate Procedures

- Electroejaculation

Procedural Components: In-Vitro Fertilization

- Frozen embryo transfer, egg transfer, embryo transfer, intrauterine;
- Thawing of frozen embryos;
- Follicle puncture for oocyte retrieval, any method;
- Gamete, zygote, or embryo intrafallopian transfer, any method.
- Cryopreservation or storage of cryopreserved eggs and embryos covered in limited circumstances such as cancer and other fertility-threatening medical conditions.

Fertility medications are covered as shown in the Schedule of Benefits or as shown under the Prescription Drug Plan.

31. **Infusion Therapy (Outpatient).** Services, supplies, and equipment necessary for infusion therapy provided:

    a. By a free-standing facility;
    b. By an Outpatient department of a Hospital;
    c. By a Physician in his/her office; or
    d. In the Covered Person's home.

    Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of the patient's course of treatment. Charges for the following Outpatient infusion therapy services and supplies are Covered Charges:

    a. The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
    b. Professional services;
    c. Total parenteral nutrition (TPN);
    d. Chemotherapy;
    e. Drug therapy (includes antibiotic and antivirals);
    f. Pain management (narcotics); and
    g. Hydration therapy (includes fluids, electrolytes, and other additives).

    Coverage for inpatient infusion therapy is provided under the Inpatient Hospital and Skilled Nursing Facility Benefits. Benefits payable for infusion therapy will not count toward any applicable Home Health Care maximums.

32. **Laboratory or Pathology Tests.** Laboratory and pathology tests, including interpretation charges for Covered Benefits.

33. **Magnetic Resonance Guided Focused Ultrasound Surgery.** Charges for Magnetic Resonance Guided Focused Ultrasound Surgery (MRgFUS).

34. **Maternity Benefits.** Expenses Incurred by Covered Persons for:

- Prenatal and postnatal care;
- Hospital or Birthing Center room and board;
- Obstetrical fees for routine prenatal care;
- Vaginal delivery or cesarean section;
- Diagnostic testing when Medically Necessary;
- Abdominal operation for intrauterine pregnancy or miscarriage;
- Outpatient Birthing Centers; and
- Certified midwives in an office or facility setting.

Maternity benefit coverage is also provided to a Covered Person who is acting as a surrogate.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

35. **Medical and Surgical Supplies.** Casts, splints, trusses, braces, crutches, orthotics, dressings, and other Medically Necessary supplies ordered by a Physician.

36. **Mental Health Disorders and Substance Use Disorders.** Treatment of Mental Health Disorders and Substance Abuse Disorders, subject to limits shown in the Schedule of Benefits. Medical services include individual and group psychotherapy, psychological testing, family counseling and convulsive therapy.

Treatment of Mental Disorders

Covered Charges include charges made for the treatment of Mental Disorders by Behavioral Health Providers. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan supervised by a Physician or licensed Provider; and
- The plan is for a condition that can favorably be changed.

Benefits are payable for charges Incurred in a Hospital, Psychiatric Hospital, Residential Treatment Facility or Behavioral Health Provider's office for the treatment of Mental Disorders as follows:

<u>Inpatient Treatment</u>

Covered Charges include charges for room and board at the Semi-Private Room Rate**,** and other services and supplies provided during a stay in a Hospital, Psychiatric Hospital or Residential Treatment Facility. Inpatient benefits are payable only if the Covered Person's condition requires services that are only available in an inpatient setting.

<u>Partial Confinement Treatment</u>

Covered Charge include charges made for Partial Confinement Treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a Mental Disorder. Such benefits are payable if the Covered Person's condition requires services that are only available in a Partial Confinement Treatment setting.

Outpatient Treatment

Covered Charges include charges for treatment received while not confined as a full-time inpatient in a Hospital, Psychiatric Hospital or Residential Treatment Facility.

The Plan covers partial Hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial Hospitalization will only be covered if the Covered Person would need inpatient care if the Covered Person were not admitted to this type of facility.

Treatment of Substance Abuse

Covered Benefits include charges made for the treatment of Substance Abuse by Behavioral Health Providers. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan supervised by a Physician or licensed Provider; and
- The plan is for a condition that can be favorably changed.

Inpatient Treatment

This Plan covers room and board at the Semi-Private Room Rate and other services and supplies provided during a Covered Person's stay in a Psychiatric Hospital or Residential Treatment Facility, appropriately licensed by the state Department of Health or its equivalent.

Coverage includes:

- Treatment in a Hospital for the medical complications of Substance Abuse.
- "Medical complications" include detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a Hospital is covered only when the Hospital does not have a separate treatment facility section.

Outpatient Treatment

Outpatient treatment includes charges for treatment received for Substance Abuse while not confined as a full-time inpatient in a Hospital, Psychiatric Hospital or Residential Treatment Facility.

This Plan covers partial Hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcohol or drug abuse. The partial Hospitalization will only be covered if the Covered Person would need inpatient treatment if the Covered Person were not admitted to this type of facility.

Partial Confinement Treatment

Covered Charges include charges made for Partial Confinement Treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of Substance Abuse.

Such benefits are payable if the Covered Person's condition requires services that are only available in a Partial Confinement Treatment setting.

37. **Modifiers/Reducing Modifiers.** Charges for multiple surgical procedures will be a Covered Charge subject to the following provisions unless a Network agreement overrides these provisions:

    a. If multiple surgical procedures are performed by one (1) surgeon, the primary procedures will be 100% of the Maximum Allowable Amount plus 50% of the Maximum Allowable Amount for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures.

    b. For bilateral surgical procedures, the total amount covered will be the Maximum Allowable Amount for the operation or procedure bearing the highest Maximum Allowable Amount plus 50% for each additional procedure.

    c. If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Maximum Allowable Amount for each surgeon's primary procedure, unless the procedure is normally only performed by one (1) surgeon.

    d. If an MD assistant surgeon is required, they will be paid at 25% of the primary surgeon's Maximum Allowable Amount. If a non-MD assistant surgeon is used, they will be paid at 16% of the primary surgeon's Maximum Allowable Amount.

38. **Nursery and Newborn Expenses.** Newborn care including Hospital nursery expenses and pediatric care while confined following birth will be covered as follows:

    - If the birthing parent is enrolled (i.e. mother), charges for newborn care will be paid under the mother's plan for the first 31 days following birth.
    - If the birthing parent is NOT enrolled, charges for newborn care will be paid under the newborn's plan for the first 31 days following birth.

    Coverage will continue past the first 31 days following birth only if the newborn is properly enrolled in the Plan.

    Precertification requirements will apply for any newborn needing non-routine care.

35. **Obesity & Morbid Obesity**. Covered Charges include charges made by a Physician, licensed, or certified dietician, nutritionist, or Hospital for the non-surgical treatment of obesity for the following Outpatient weight management services:

    - An initial medical history and physical exam; and
    - Diagnostic tests given or ordered during the first exam.

    Covered Charges include charges made by a Hospital or a Physician for the surgical treatment of Morbid Obesity of a Covered Person. Covered Charges includes the following as long as they are Incurred within a two-year period:

    - One follow-up visit;
    - One Morbid Obesity surgical procedure including complications directly related to the surgery;
    - Pre-surgical visits; and
    - Related Outpatient services.

    This two (2) year period begins with the date of the first Morbid Obesity surgical procedure, unless a multi-stage procedure is planned.

Complications, other than those directly related to the surgery, will be covered under the related covered medical benefit, subject to plan limitations and maximums.

Note: The Plan provides coverage for the Medical Weight Treatment Program only at OhioHealth Medical Weight Treatment Program facilities. For a current listing of applicable facilities, call the OhioHealthy Member Advocates. (The Medical Weight Treatment Program is an OhioHealth operated program for weight-loss.)

36. **Observation.** Charges made by a Hospital for observation. Limited to 48 hours unless additional hours are approved by the Plan.

37. **Occupational Therapy.** (See Therapy Services)

38. **Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth).** Charges made by a Physician, a Dentist and Hospital for:

- Hospital services and supplies received for a stay required because of the Covered Person's condition.
- Dental work, surgery and Orthodontic Treatment needed to remove, repair, restore or reposition:
  - Natural teeth damaged, lost, or removed; or
  - Other body tissues of the mouth fractured or cut due to Injury**;**
  - Any such teeth must have been free from decay or in good repair and are firmly attached to the jawbone at the time of the Injury.
- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.
- Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, and jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:
  - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement;
  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement, or repair of teeth;
  - Cut out cysts, tumors, or other diseased tissues;
  - Treat a fracture, dislocation, or wound.

If crowns, dentures, bridges, or in-mouth appliances are installed due to Injury, Covered Charges only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of Orthodontic Treatment after the Injury.

39. **Orthotic Appliances and Devices.** Including custom-fitted or custom-made braces and custom molded shoe inserts, splints, casts, orthopedic braces, supports and other devices used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body when prescribed by a Qualified Health Care Professional. Orthotics do not include over-the-counter inserts of any kind or orthotics and special shoes, or devices to protect the feet unless the device is a permanent part of an orthopedic leg brace.

40. **Outpatient Surgery**. Services provided by a Provider in a freestanding Ambulatory Surgery Center or a Hospital Outpatient surgical facility. The following Outpatient surgery expenses are covered: services and supplies provided by the Hospital or Surgery Center on the day of the procedure; services of another Physician for related post-operative care and administration of anesthesia (this does not include a local anesthetic); and the operating Physician's services for performing the procedure, related pre-and post-operative care, and administration of anesthesia

41. **Oxygen and the Administration.** Charges for oxygen including the administration.

42. **Parental Nutrition, Enteral Nutrition & Nutritional Therapy.** The following benefits are covered under this Plan:

    Parental Nutrition (e.g. hyperalimentation, total parenteral nutrition, and TPN). Includes nutrition that is administered via an intravenous infusion.

    Enteral Nutrition. Includes a nutritional formula, and specific supplies and equipment, to administer this formula through either a gastrointestinal artificial opening or a nasogastric tube.

    Nutritional therapy for Inbome Errors of Metabolism. Medical food, as defined by the FDA, formulated to be administered orally or enterally under the supervision of a Physician and which is intended for the specific management of inborne errors of metabolism which are present at birth, and permanent in nature.

43. **Penile Implants.** Penile prosthesis is covered when Medically Necessary.

44. **Physical Therapy.** (See Therapy Services)

45. **Physician/Practitioner Services.** Services of a Physician or Practitioner for medical care or Surgery. The visit may be at the Physician/Practitioner's office, in the Covered Person's home, in a Hospital, in a school (except for Physicians/Practitioners employed by the school), or other facility. Services include but are not limited to consultation with another Physician to obtain a second opinion prior to a surgery, examinations, x-ray, and laboratory tests (including the reading or processing of the tests), supplies, cast application, minor Surgery, and pre-/post-operative visits.

46. **Preoperative Testing (Outpatient).** Prior to a scheduled covered surgery, Covered Charges include charges made for tests performed by a Hospital, Surgery Center, Physician, or licensed diagnostic laboratory provided the charges for the surgery are Covered Benefits and the tests are:

    - Completed within 14 days before the Covered Person's surgery;
    - Covered if the Covered Person were an inpatient in a Hospital;
    - Not repeated in or by the Hospital or Surgery Center where the surgery will be performed;
    - Performed on an Outpatient basis;
    - Related to the Covered Person's surgery, and the surgery takes place in a Hospital or Surgery Center;
    - Test results should appear in the Covered Person's medical record kept by the Hospital or Surgery Center where the surgery is performed.

47. **Prescription Medications.** Medication which is administered or dispensed as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility or Skilled Nursing Facility) and that require a Physician's Prescription. This does not include paper (script) claims obtained at a retail Pharmacy, which are covered under the Pharmacy plan.

39. **Preventive Care/Routine Care.** If a Covered Person incurs eligible expenses for Preventive Care and screenings, the Plan will consider charges and pay benefits, subject to specific age and risk factors, as shown in the Schedule of Benefits. The Schedule of Benefits is not an inclusive list of Preventive Care or Routine Care covered under the health plan. A list of the preventive services covered under this section, and as required by the Affordable Care Act, is available at the following website(s) or can be delivered upon request:

    https://www.healthcare.gov/coverage/preventive-care-benefits/

    http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

    Eligible preventive services have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations and are updated annually to include any new

recommendations or guidelines. To the extent the below does not cover any preventive service required to be covered by the U.S. Department of Health and Human Services (HHS) the below shall be deemed to be amended to cover such preventive service to the extent required by the HHS.

The following services will be covered, when rendered by a Network Provider, without any Deductible, Copayment, or Coinsurance requirement that would otherwise apply, subject to limits shown in the Schedule of Benefits:

General Preventive Care
Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF). Items include, but not limited to:

- Routine physical exams.
- Routine hearing screenings.
- Routine vision screenings (including charges made by a legally-qualified ophthalmologist or optometrist). Coverage includes refraction and glaucoma testing, does not include a contact lens exam.
- Routine cancer screenings.
- Routine radiology.
- Routine laboratory.

Immunizations
Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Preventive Care for Children
For infants, children, and adolescents, this includes evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive Care for Women
For women, this includes such additional Preventive Care and screenings not described in "General Preventive Care", but as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. A list of what women's preventive services are required to be covered can be found here: https://www.hrsa.gov/womens-guidelines-2016/index.html

Covered Services include the following:

- Breastfeeding support, supplies, and counseling (group or individual setting) in conjunction with each birth including comprehensive lactation support and counseling from trained Providers during pregnancy and/or in the postpartum period and breast pump supplies. The "postpartum period" means the one-year period directly following the child's date of birth.

  The following type of breast pumps are eligible for coverage:

  - The purchase of an electric breast pump (non-hospital grade).
  - The purchase of a manual breast pump.

  Limitations: The purchase of an electric breast pump OR manual breast pump is covered once per pregnancy

  Hospital Grade Breast Pump Benefit: Rental of an electric, heavy-duty, hospital-grade pump is covered according to the Durable Medical Equipment (DME) benefit. Coverage is provided for the rental

of a hospital-grade electric pump for a newborn child following delivery upon the documented recommendation of the patient's lactation consultant, obstetrician, pediatrician, or primary care Physician.

The Plan reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of the Plan Administrator.

- Breast pumps supplies will be covered as follows:
  - Initial breast pump supplies will be covered with the purchase or rental of breast feeding equipment. Replacement supplies will be covered during the course in which the mother is breastfeeding.

    The Plan reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided.

- Contraceptive methods and counseling including: Food and Drug Administration-approved contraceptive methods, female sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs.
- Screening and Counseling for domestic and interpersonal violence including annual screening and counseling for all women.
- Screening for gestational diabetes including screening for women between 24 and 28 weeks pregnant, and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
- Human Immunodeficiency Virus (HIV) including annual screening and counseling for sexually active women.
- Human Papillomavirus (HPV) DNA Test including: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
- Sexually Transmitted Infections (STI) including annual counseling for sexually active women.
- Well-woman visits to obtain recommended preventive services for women. Visits will be provided at least annually. Additional visits are covered if needed to obtain all recommended preventive services.

Charges for Mammograms under Routine Well Adult Care are subject to the frequency limits as stated in the Schedule of Benefits.

48. **Prosthetic Devices.** Charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by Illness, Injury, or congenital defect. Covered Charges also include instruction and incidental supplies needed to use a covered prosthetic device.

The Plan covers the first prosthesis a Covered Person needs that temporarily or permanently replaces all or part of a body part lost or impaired as a result of Illness, Injury or congenital defects as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

Covered Charges also include replacement of a prosthetic device if:

- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable; or
- The replacement is needed because of a change in the Covered Person's physical condition; or normal growth or wear and tear.

The list of covered devices includes but is not limited to:

- A breast implant after a mastectomy;
- A cardiac pacemaker and pacemaker defibrillators;
- A durable brace that is custom made for and fitted for the Covered Person;
- An artificial arm, leg, hip, knee, or eye;
- Eye lens;
- Foot orthotics, orthopedic shoes, or other devices to support the feet, including orthopedic shoe that is an integral part of a covered leg brace;
- Lymphedema compression devices;
- Mastectomy bras or camisole: either 2 prosthetic bras or 2 prosthetic camisoles initially (not both), then 1 prosthetic garment every 3 months thereafter, and mastectomy prosthetic/form: 1 per side per year (or with bilateral mastectomy; 1 form for each side per year);
- Ostomy supplies, urinary catheters, and external urinary collection devices; and
- Speech generating device.

The Plan will not cover expenses and charges for, or expenses related to:

- Therapeutic shoes; or
- Trusses, corsets, and other support items; or
- Any item listed as not covered under this Plan.

49. **Pulmonary Rehabilitation.** Covered when in connection with a loss of function as a result of a pulmonary condition, provided that it is delivered in an approved, hospital-based pulmonary rehabilitation program under the direct supervision of a licensed therapist or pulmonologist, and the services are deemed Medically Necessary.

50. **Qualified Clinical Trials.** Expenses Incurred for the prevention, detection, or treatment of cancer or any other Life Threatening Condition for a Qualifying Individual enrolled in a Qualified Clinical Trial. Benefits will ONLY be provided for Routine Patient Costs that are otherwise consistent with the terms of the Plan and would be covered if the Covered Person did not participate in the Qualified Clinical Trial. All Plan limitations and exclusions will be applied.

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

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

    1. The study or investigation is approved or funded (which may include funding though in-kind contributions) by one or more of the following:

        a. The National Institutes of Health;
        b. The Centers for Disease Control and Prevention;
        c. The Agency for Health Care Research and Quality;
        d. The Centers for Medicare & Medicaid Services;
        e. A cooperative group or center of one of the entities described in (1) through (4) above;
        f. A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants; or
        g. The Department of Veteran Affairs; the Department of Defense or the Department of Energy, if (i) the study or investigation has been reviewed and approved through a system of peer review that the

Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

"Qualifying Individual" means any Covered Person who is eligible to participate in a Qualified Clinical Trial according to the trial protocol for treatment of cancer or any other Life Threatening Condition that makes their participation in the program appropriate, as determined based on either (i) a conclusion of a referring health care professional or (ii) medical and scientific information.

"Routine Patient Costs" means all health care services that are otherwise covered under the Plan for a Covered Person who is not enrolled in any stage of a Qualified Clinical Trial. Routine patient costs do not include the Investigational item, device, or service itself; items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Notwithstanding the above, Qualified Clinical Trial expenses do not include any of the following:

- Costs Associated with managing the research Associated with the Qualified Clinical Trial;
- An item or drug provided by the Qualified Clinical Trial sponsors free of charge for a Qualified Individual;
- An item or drug that is the subject of the Qualified Clinical Trial;
- Transportation, lodging, food, or other expenses for the Qualified Individual, or a family member or companion of the Qualified Individual, that are Associated with the travel to or from a facility providing the Qualified Clinical Trial;
- Costs that would not be covered for non-Experimental and/or Investigational treatments;
- An Experimental or Investigational drug or device that has not been approved for market by the United States Food and Drug Administration.

51. **Radiation Therapy.** Radiation therapy, radium, and X-ray therapy, including the Physician's charges for treatment using roentgen rays, radium rays, or the rays of other radioactive substance.

52. **Radiology and Interpretation Services.** Radiology, including interpretation charges for Covered Benefits.

53. **Reconstructive Breast Surgery.**

Cosmetic Procedures/Reconstructive Surgery. Cosmetic procedures or Reconstructive Surgery will be considered eligible only under the following circumstances:

a. For the correction of a congenital anomaly for a Dependent Child.
b. Any other Medically Necessary Surgery related to an Illness or Injury.
c. Charges for reconstructive breast Surgery following a mastectomy will be eligible as follows:

    i. Reconstruction of the breast on which the mastectomy has been performed;
    ii. Surgery and reconstruction of the other breast to produce symmetrical appearance; and
    iii. Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

The manner in which breast reconstruction is performed will be determined in consultation with the attending Physician and the Covered Person.

54. **Respiratory Therapy.** (See Pulmonary Rehabilitation)

55. **Skilled Nursing Facility.** Charges made by a Skilled Nursing Facility for the following services and supplies, up to the maximums shown in the Schedule of Benefits, including:

- Medical supplies;
- Other medical services and general nursing services usually given by a Skilled Nursing Facility (this does not include charges made for private or special nursing, or Physician's services);
- Oxygen and other gas therapy;
- Physical, occupational, or speech therapy;
- Radiological services and lab work;
- Room and board, up to the Semi-Private Room Rate. The Plan will cover up to the private room rate if it is needed due to an infectious Illness or a weak or compromised immune system; and
- Use of special treatment rooms.

56. **Speech Therapy.** (See Therapy Services)

40. **Sterilization Procedures.** Elective sterilization procedures for the Covered Associate and Spouse (this does not include reversal of sterilization). Elective sterilization procedures are covered in addition to and to the extent they are not otherwise included for coverage under the preventive services section of the Plan. Sterilization for a female is covered under the Preventive Care benefit.

41. **Temporomandibular Joint Disorder (TMJ).** Surgical and non-surgical treatment of Temporomandibular Joint Disorder (TMJ).

    The treatment of Jaw Joint Disorders (as defined) includes conditions of structures linking the jawbone and skull and complex muscles, nerves and other tissues related to the temporomandibular joint. Treatment shall include but is not limited to: orthodontics; physical therapy; and any appliance that is attached to or rests on the teeth.

57. **Therapy Services.** Charges for short-term therapy services when prescribed by a Physician as described below up to the benefit maximums listed in the Schedule of Benefits. The services have to be performed by:

- A Hospital, Skilled Nursing Facility, or Hospice Facility;
- A licensed or certified physical, occupational or speech therapist; or
- A Physician.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

Inpatient rehabilitation benefits for the services listed below will be paid as part of the Inpatient Hospital and/or Skilled Nursing Facility benefits provision in this Plan.

- **Cognitive therapy** Associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

- **Occupational therapy** (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute Illnesses and Injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute Illness, Injury or surgical procedure, or to relearn skills to significantly improve independence in the Activities of Daily Living. Occupational therapy does not include educational training or services designed to develop physical function, (except as provided for the treatment of Pervasive Developmental Disorders/Autism Spectrum Disorders). Additionally, coverage for occupational therapy is available for the treatment of Pervasive Developmental Disorders/Autism Spectrum Disorders (as an exception to the above non-chronic condition coverage criteria).

- **Physical therapy** is covered for non-chronic conditions and acute Illnesses and Injuries, provided the therapy expects to significantly improve, develop, or restore physical functions lost or impaired as a result of an acute Illness, Injury, or surgical procedure. Treatment includes massage therapy by a licensed physical therapist or Physician for Medically Necessary Treatment. Physical therapy does not include educational training or services designed to develop physical function, (except as provided for the treatment of Pervasive Developmental Disorders/Autism Spectrum Disorders). Additionally, coverage for physical therapy is available for the treatment of Pervasive Developmental Disorders/Autism Spectrum Disorders (as an exception to the above non-chronic condition coverage criteria).

- **Speech therapy** is covered for non-chronic conditions and acute Illnesses and Injuries and expected to restore the speech function or correct a speech impairment resulting from Illness or Injury; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words. Additionally, coverage for speech therapy is available for the treatment of Pervasive Developmental Disorders/Autism Spectrum Disorders and for developmental delays (both are exception(s) to the above non-chronic condition coverage criteria).

- **Vision therapy** (orthoptic training) is covered. Precertification required.

58. **Transcranial Magnetic Stimulation**. Charges for Transcranial Magnetic Stimulation (TMS).

59. **Transplant Services.** Services and supplies in connection with Medically Necessary Non-Experimental and/or non-Investigational transplant procedures.

    The Network level of benefits is paid only for a treatment received at a facility designated by the Plan Administrator as a contracted facility for the type of transplant being performed.

    The Plan covers:

- Charges for activating the donor search process with national registries.
- Charges made by a Hospital, Outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Charges made by a Physician or transplant team.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are the Covered Person's biological parents, siblings, or children.
- Inpatient and Outpatient expenses directly related to a transplant.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; Home Health Care expenses and home infusion services.

Exclusions:

1. Non-human and artificial organ transplants.
2. The purchase price of any of bone marrow, organ, tissue, or any similar items which are sold rather than donated.
3. Transplants which are not medically recognized and are Experimental, Investigational or Unproven in nature.

Covered transplant expenses are typically Incurred during the four (4) phases of transplant care described below. Expenses Incurred for one (1) transplant during these four (4) phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; **or** upon the date the Covered Person is discharged from the Hospital or Outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four (4) phases of one (1) transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation, and acceptance into a transplant facility's transplant program;
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;
3. Transplant event: Includes inpatient and Outpatient services for all covered transplant-related health services and supplies provided to the Covered Person and a donor during the one or more surgical procedures or medical therapies for a transplant; Prescription Drugs provided during an inpatient stay or Outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during an inpatient stay or Outpatient visit(s); cadaveric and live donor organ procurement; and
4. Follow-up care: Includes all covered transplant expenses; Home Health Care services; home infusion services; and transplant-related Outpatient services rendered within 180 days from the date of the transplant event.

The Plan will coordinate all organ and bone marrow transplants and other care needed. Covered Charges Incurred from a contracted transplant facility will be considered network care expenses. The transplant facility must be approved and designated by the Plan Administrator to perform the transplant procedure.

60. **Travel outside the United States.** Treatment for an Emergency Medical Condition will be paid at the In-Network benefit level based on billed charges and in accordance with the Plan provisions. When a Covered Person pays out-of-pocket for services Incurred while traveling out of the United States, a claim form and a copy of proof of payment must be submitted, along with any related invoice received from the Provider, so benefits can be determined based on the services rendered.

61. **Urgent Care Conditions.** Covered Benefits include charges made by a Hospital or Urgent Care Provider to evaluate and treat an Urgent Condition. Coverage includes: nursing staff services Physician services; radiologists, and pathologists services; the use of emergency room facilities when a Network Urgent Care facility is not available, and the Covered Person cannot reasonably wait to visit their Physician; and use of Urgent Care facilities.

    There is no coverage if an Urgent Care Provider is used for a non-Urgent Condition.

62. **Virtual Consults.** Virtual Consults will be covered when furnished by Providers who are approved by the Plan to provide services.

63. **Walk-In Clinics.** Services and supplies provided by a Walk-in Clinic.

64. **Wigs or Hairpiece.** Charges for a wig or artificial hairpiece purchased for loss of hair due to an Illness or disease (chemotherapy, radiation therapy, alopecia, burns, and cranial surgery), subject to the limits show in the Schedule of Benefits.

Special Note Regarding COVID-19: As required by applicable law, the Plan will cover certain items and services related to diagnostic testing for the detection of SARS-CoV-2 or the diagnosis of COVID-19 without imposing any cost-sharing or pre-authorization requirements during the public health emergency.

SECTION VII: CARE MANAGEMENT

PRECERTIFICATION AND UTILIZATION REVIEW

The Plan uses the services of OhioHealthy to provide the required Precertification and utilization review services to the Plan (called "Care Management"). The Plan provides Care Management services, including Precertification and utilization review. Care Management is designed to assist the Covered Person, their Physician, and their Hospital to contain costs, while providing the patient with full, Medically Necessary care.

PRECERTIFICATION

Precertification is a mandatory program requiring notification prior to certain services being rendered or within seventy-two (72) hours of emergency hospital admittance. It is the Covered Person's responsibility to make sure any required Precertification is completed by their Provider.

Whenever Precertification is required, the Covered Person's selected Network Provider will obtain the necessary approval. If the Covered Person does not choose an In-Network Provider for care, the Covered Person must obtain any necessary Precertification. **Precertification penalties do not apply if Network Provider failed to obtain Precertification.**

To precertify the service please call OhioHealthy at 1-888-845-3580. The Covered Person is responsible to ensure all required Precertifications have been approved prior to services being rendered.

The Plan requires all Covered Persons to obtain Precertification for the following:
(Note: MRI's CAT Scan, breast pumps, sleep studies, and pulmonary rehabilitation do NOT require precertification for Tier 1 and Tier 2 providers)

- Acupuncture for treatment for the relief of migraines or back or neck pain
- Advanced Imaging and Testing including MRI, CT scan, PET, MRA, CTA, Sleep studies (does not include SPECT scans, MRS, and Nuclear Cardiology)
- All Inpatient admissions (include medical & mental mealth and partial hospitalization)
- All Outpatient surgeries (except colonoscopies)
- All Skilled Nursing Facilities
- Ambulance (non-Emergency Services only)
- Bariatric surgery
- Biofeedback
- Chemotherapy
- Clinical Trials and studies
- DME & DME Supplies
    - Single item over $750
    - All rental items over $750
    - All repairs or replacements over $750
- Elective Transportation Services
- Electro-convulsive Therapy
- Genetic Testing
- Home Health Care
- Home IV Therapy
- Hospice Services
- Injectable/infused medications (including biologics and IV therapy medications)
- Insulin pumps/pump infusion sets/supplies
    - Includes glucometers when over $750

    - Insulin pumps and continuous glucose monitors (CGM) are required to be precertified on an annual basis
- Intensive Outpatient Programs (IOP) Mental Health
- Medications requiring pre-authorization (a separate vendor, Archimedes, provides utilization review services for designated specialty drugs paid under medical plan. See “Specialty Drug” section in the Prescription Drug Schedule of Benefits section for additional information.)
- Penile Implants
- Prosthetic appliances & components (all)
    - All repairs, fittings, and replacements
    - All artificial limbs
- Pulmonary, Vascular, and Vestibular Rehabilitation
- Radiation therapy
- Sleep studies
- Transplants
- Vision therapy

Note: Failure to obtain Precertification will/may result in a benefit reduction or total denial of coverage (see “Penalties for not Obtaining Precertification”).

The Care Management program will assist and coordinate the initial implementation of any services the patient will need post Hospitalization with the attending Physician and the facility. If the attending Physician feels that it is Medically Necessary for a patient to stay in the medical care facility for a greater length of time than has been precertified, the attending Physician or the medical facility must request the additional service or days.

Once the Inpatient setting has been precertified, the on-going review of the course of treatment becomes the focus of the program. Working directly with the Covered Person’s Physician, the program identifies and approves the most appropriate and cost-effective setting for the treatment as it progresses.

If Precertification is denied because the service or supply is not a Covered Benefit, or is determined to not be Medically Necessary, any claim submitted for that service or supply will be ineligible for benefits. See Section “Appeal of Adverse Benefit Determination” for more information on how to appeal a decision.

Precertification does not guarantee payment. Precertification is valid only when the patient is eligible for services on the date the service is provided. All charges for such services are subject to other Plan provisions (including, but not limited to Deductibles, Copayments, Coinsurance, Out-of-Pocket Maximums, benefit reimbursement levels, covered services and excluded services).

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other healthcare Provider.

Precertification does not verify or approve that services are In-Network or Out-of-Network. To verify a Provider’s Network status, contact the Member Advocate number on the back of the Associate’s ID card.

Questions about services that require Precertification and verification of benefits can be answered by contacting a Member Advocate. The Member Advocate telephone lines are staffed 8:30 A.M. - 5:00 P.M. (Eastern) Monday through Friday. The Covered Person or their Provider may call this number twenty-four (24) hours a day. For the caller’s convenience, they will reach a confidential mailbox after office hours and over weekends and holidays. The caller may leave a message which is dated and timed. Simply leave a telephone number with an area code where the caller, or a family member, can be reached to obtain the required information.

CONTACTING OHIOHEALTHY

It is important to contact OhioHealthy as soon as it has been determined that a Covered Person will be admitted to a medical facility as an inpatient or as soon as a Provider has recommended an Outpatient service that requires Precertification. Notification for elective admissions and Outpatient services should be made at least seven (7) days prior to admission or as soon as possible after the Provider has decided to admit the Covered Person or schedules them for an Outpatient service.

In many situations the Provider will reach out to the Plan on behalf of the Covered Person; however, it is the Covered Person's responsibility to make sure any required Precertification is completed by their Provider.

The Provider of service (Physician, Hospital, free standing surgical facility, Home Health Care Agency, etc.) will be notified at the time of the Precertification call if the requested medical service has been certified or if further review is required. A letter will be sent to the Covered Person and their Provider regarding all Precertification determinations.

Federal law does not allow group health plans to require Precertification for maternity admissions for mother or newborn child for hospital stays equal to or less than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a Cesarean section. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth. If the Covered Person experience an emergency situation, or complications of pregnancy requiring admission to a hospital, either as an inpatient, or the Mother or newborn's length of stay exceeds forty-eight (48) hours or ninety-six (96) hours as outlined above, the Covered Person is required to call the Plan within one (1) working day following the admission or extended stay.

PENALTIES FOR NOT OBTAINING PRECERTIFICATION

Failure to obtain Precertification will require a retrospective review. If the services are determined to be Medically Necessary, applicable benefits will be applied with no penalties. If services are determined to be NOT Medically Necessary, no benefits will be paid. Non-covered services will not be applied toward any Deductible or Out-of-Pocket Maximum.

Note: Precertification penalties do not apply if Network Provider failed to obtain Precertification.

CONTINUITY OF CARE

A Covered Person may be eligible to continue care with a Provider that leaves the Plan's Provider In-Network (or if there is a change in the contract with that Provider that would result in a loss of benefits with respect to the Provider) if the Covered Person is a Continuing Care Patient of that Provider at the time the Provider leaves the PPO Network (or at the time the contract change is effective). This provision does not apply if the contract is terminated for failure to meet applicable quality standards or for fraud.

If the Plan Administrator, or its designee, determines that a Covered Person may be eligible for continued care pursuant to this section, then the Plan Administrator, or its designee, will notify the Covered Person and provide the Covered Person with an opportunity to elect to continue care. If the Covered Person makes such election, care may be continued for up to 90 days from the date the Covered Person receives the notice (called "transitional care"). Such continued transitional care would be provided under the same terms and conditions that would have applied and with respect to the items and services as would have been covered under the Plan if the termination or contract change had not occurred, with respect to the course of treatment (up to 90 days) relating to the status as a Continuing Care Patient.

A Covered Person may contact the Plan Administrator if a notice is not received and the Covered Person feels they may be eligible for continued care as explained in this section.

CASE MANAGEMENT

The Plan Sponsor has contracted with OhioHealthy to conduct case management services for the Plan. Case Management is a program designed to assist the Covered Person in receiving medically appropriate and coordinated care, specific to their needs.

If the Covered Person is involved in a difficult or complex medical situation, the Plan may provide them with a case manager to assist in getting the care they need. Case Managers are experienced professional nurses certified and trained to coordinate healthcare services among Providers. They are also available to help the Covered Person and their family to obtain equipment or supplies they may need at home.

Case Managers work with the Covered Person, Physicians, Hospitals, and other medical Providers to review proposed treatment plans and to assist in coordinating care. Case Managers may, from time to time, make recommendations regarding alternative methods of treatment that are medically appropriate but more cost-effective for the Plan. The Plan Administrator may, at their discretion, approve such alternate treatment even if the treatment would not normally be covered by the Plan. In all cases, however, all treatment decisions rest with the Covered Person and their medical Providers and all coverage decisions rest with the Plan Administrator.

DISEASE MANAGEMENT

The Disease Management Program is a free service provided to Covered Associates and their covered adult Dependents. The program assists people with chronic conditions by providing tailored health education material designed to assist the individual to work with their Physician to better manage their health.

Associates are eligible to participate in the program if at least one (1) of the following conditions is present: asthma, chronic obstructive pulmonary disease, diabetes, coronary artery disease, high blood pressure, congestive heart failure, or high cholesterol.

Participation in the program starts in one of two ways. First, if a Covered Associate or his/her adult Dependent has one of the eligible medical conditions, they can call OhioHealthy at 1-614-485-7941 to learn more about this program. The second way is if OhioHealthy identifies an eligible individual with one of these conditions.

MATERNITY MANAGEMENT

The Maternity Management Program is a service provided to Covered Associates and their covered Dependents. This support program includes confidential, prenatal telephone education and support by maternity nurse specialists.

To learn more or enroll in this supportive program, call OhioHealthy at 1-614-485-7941 as soon as the pregnancy has been confirmed by a health care professional. As part of the call, a nurse will ask questions such as the estimated date of delivery, if there have been any problems with previous pregnancies, and any ongoing medical conditions. All answers to questions will help provide personalized counseling and education materials, they are also held by the nurse in confidence and will not be shared beyond what is the minimum necessary.

If the baby of the Covered Associate or covered Dependent needs special care before or after delivery, a nurse will be available to assist. Once consent is received to manage care, a maternity nurse specialist will then monitor the treatment plan and facilitate with the Covered Person’s Provider to ensure the best care is being received while still getting the most out of the benefits available.

OHIOHEALTH WELLNESS DISEASE STATE MANAGEMENT PROGRAMS
(OhioHealth Wellness Diabetes Management and OhioHealth Wellness Asthma Management)

OhioHealth Wellness is an Employer based program focused on help a Covered Person better manage chronic conditions, avoid serious health complications, and improve an overall quality of life. The program provides education, support, and access to clinical pharmacists who work with Covered Persons to set personal therapeutic goals, work on lifestyle modifications, and tailor medication therapy.

This program is available to OhioHealth associates, their spouses, and dependents currently enrolled in the OhioHealthy Medical Plan (HDHP+HSA, PPO, or PPO Assist plan). As a benefit to participating, active participants receive medications and supplies related to their condition FREE through OhioHealth's outpatient pharmacies.

OhioHealth Wellness is open to anyone with a diagnosis of Diabetes or Asthma. Participation is easy with online and telephonic visits. Contact the OhioHealth Wellness office at (614) 788.WELL (9355) or email at OhioHealthWellness@OhioHealth.com.

MEDICAL WEIGHT MANAGEMENT

OhioHealth offers a weight management program to assist Covered Persons on their weight loss journey. Surgical and non-surgical weight loss options are available with personalized plans and one-on-one support. An experienced clinical team will provide support and accountability through-out the program, this same clinical team will provide support after weight loss goals have been met to see that new lifestyle changes become permanent.

For non-surgical weight loss, a team of providers comprised of physicians, psychologist, nurse practitioners, dietitians, and exercise physiologist, will work with the Covered Person to develop a personalized diet and exercise plan.

For surgical weight loss, Covered Persons will get support from experienced team members who have a passion for working with bariatric surgery patients. The program will provide pre-surgical medical review, pre-surgery preparation, emotional and relational support, nutritional counseling, post-surgical follow-up visits, and many other benefits.

To secure an appointment, call 614-566-2700 or visit www.ohiohealth.com/weightmanagement.com to learn more!

24/7 NURSE LINE

Compassionate and knowledgeable nursing staff provide health care counseling and information 24 hours a day, 7 days a week. Through a secure and confidential 24/7 nurse phone line, nurses can guide Covered Persons through care options, help prepare the Covered Person to communicate effectively with their Physician and be a trusted source for providing general healthcare information.

Qualified nurses are available to answer questions and assist with making informed healthcare decisions for both the Associate and their Covered Dependents. Whether it's a question about strains and sprains, finding cold and flu relief, or dealing with skin problems, a Registered Nurses is just a phone call away.

The Nurse Line is available at no additional cost. Call **1-866-363-7477 (option 1)** to speak to a nurse, any time of day.

SPECIALTY DRUG AUTHORIZATIONS

OhioHealth has partnered with Archimedes, a health care solutions provider, to ensure Associates and their Covered Dependents are receiving quality specialty care. As part of this partnership, Archimedes conducts ongoing prior authorization and precertification reviews of specialty medications under the medical Plan to ensure Associates and their Covered Dependents receive the appropriate medications.

Archimedes' outreaches can include peer-to-peer consults with physicians and communications with physicians and members about their specialty medications, as needed.

A full list of drugs available on the OhioHealthy website at www.ohiohealthyplans.com under the Drug Authorization Forms section. Prior authorization forms can be found at www.archimedesrx.com/resources.

The following is a general list of Prescription Drug services, supplies, and medications not covered under this Plan (subject to change):

- Drugs not approved by the U.S. Food and Drug Administration (FDA), which may also include off-label use (meaning drugs that may be prescribed, but are not approved for that condition or age group);
- Drugs labeled "Caution: Limited by federal law to investigational use";
- Any drug being used for cosmetic purposes;
- Medical devices or appliances;
- Prescription drugs not covered by a current prescription order;
- Drugs not listed on the Plan's Formulary;
- Any compounded drugs that contain products excluded by the Plan;
- Drugs of unproven clinical efficacy and/or value;
- Drugs that have less expensive, but clinically equivalent alternatives;
- Products for nutritional support, unless required for coverage by the Affordable Care Act;
- Products recently approved by the FDA may not be covered upon release to the market;
- Coverage may be changes and/or the amount paid may vary based on the condition being treated.

DETERMINATIONS BY THE PLAN ADMINISTRATOR

The Plan Administrator has the sole authority and discretion to determine what constitutes Medically Necessary care and treatment, and Experimental, Investigational, or Unproven procedures. In all cases, the Plan Administrator's determination will be final and binding. However, those determinations are solely for the purpose of establishing what services or courses of treatment are covered by the Plan. All decisions regarding medical treatment are between the Covered Person and their Provider and should be based on all appropriate factors, only one (1) of which is the level of benefits available under the Plan.

ALTERNATE BENEFITS

In addition to the benefits specified, the Plan may elect to offer benefits for services furnished by any Provider pursuant to a Plan-approved alternate treatment plan, in which case those charges Incurred for services provided to a Covered Person under an alternate treatment plan to its end, will be more cost effective than those charges to be Incurred for services to be provided under the current treatment plan to its end.

The Plan shall provide such alternate benefits at its sole discretion and only when and for so long as it determines that alternate treatment plan is Medically Necessary and cost effective. If the Plan elects to provide alternate treatment plan benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for such Covered Person in any other instance or for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the Plan Administrator's rights to administer this Plan thereafter in strict accordance with its express terms.

SECTION VIII: COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one (1) Plan, as defined below. The purpose of coordinating benefits is to help Covered Persons pay for Covered Benefits, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim.

If this Plan is the Secondary Plan, benefits will be based on the Primary Plans allowed amount. Any member responsibility remaining after the Primary Plan has paid their portion will be covered at 100% by this Plan.

Under the High Deductible Health Plan (HDHP), this amount will be subject to the applicable Copayment, Deductible and Coinsurance.

For charges not covered by the Primary Plan, this Plan will calculate and pay as if it were the Primary Plan, subject to applicable Copayment, Deductible, Coinsurance, and coverage limitations.

The Plan will coordinate benefits with the following types of medical and/or dental plans:

- Group and non-group insurance contracts;
- Health maintenance organization (HMO) contracts, closed panel plans or other forms of groups or group-type coverage (whether insured or uninsured);
- Medical care components of group long-term care contracts such as skilled nursing care;
- Medical benefits under group or individual motor vehicle policies. See order of benefit determination rules (below) for details;
- Medicare or other governmental benefits, as permitted by law. See below Medicare section below for details. This does not include Medicaid.

The Plan will not coordinate with: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage is considered a separate plan. If a plan has two (2) parts and COB rules apply to only one of the two (2) parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a Provider of service in which such Provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the Provider's contracted amount and the Provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The order of benefit determination rules determines whether this plan is a Primary Plan or Secondary Plan when the Covered Person has health care coverage under more than one Plan. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

The first of the following rules that apply to a Covered Person's situation is the rule to use:

1. **No Coordination of Benefits Provision.** The plan that has no coordination of benefits provision is considered primary;

2. **Motor Vehicle Insurance.** When medical payments are available under motor vehicle insurance (including no-fault policies), this Plan shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier;

3. **Non-Dependent or Dependent.** The plan that covers the person other than as a dependent, for example as an Associate, member, subscriber, policyholder, or retiree, is the Primary Plan and the plan that covers the person as a dependent is the Secondary Plan.

   However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent (e.g. a retired Associate), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other plan is the Primary Plan. (See the "Medicare" section below for additional information.)

4. **Dependent Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:

   a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      i. The plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
      ii. If both parents have the same birthday, the plan that has covered the parent the longest is the Primary Plan.

      If the Other Plan has a rule based on the parent's sex instead of birthday, the Other Plan's rule will apply.

   b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

      i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with the responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This item shall not apply with respect to any Plan Year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;
      ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of paragraph 4(a) above shall determine the order of benefits;
      iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of paragraph 4(a) above shall determine the order of benefits; or
      iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

         - The plan covering the custodial parent;
         - The plan covering the spouse of the custodial parent;
         - The plan covering the non-custodial parent; and then
         - The plan covering the spouse of the non-custodial parent.

c. For a dependent child who has coverage under either or both parent's plans and also has their own coverage as a dependent under their spouse's plan, the plan that covered the person for the longer period of time is the Primary Plan and the plan that covered the person for the shorter period of time is the Secondary Plan.

d. For an adult dependent child covered under both parent's plans (both non-custodial due to the age of the dependent child) and the parents are divorced or separated or not living together, whether or not they have ever been married:

   i. The plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
   ii. If both parents have the same birthday, the plan that has covered the parent the longest is the Primary Plan.

5. **Active Employee or Retired or Laid-off Employee**. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired or as a dependent of an active employee is the Primary Plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the Secondary Plan.

   If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

   This rule does not apply if the above paragraph 3 rule can determine the order of benefits.

6. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or under a right of continuation pursuant to state or other federal law is the Secondary Plan.

   If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

   This rule does not apply if the above paragraph 3 rule can determine the order of benefits.

7. **Longer or Shorter Length of Coverage**. The plan that covered the person for the longer period of time is the Primary Plan and the plan that covered the person for the shorter period of time is the Secondary Plan.

8. If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

MEDICARE

If a Covered Person is also receiving benefits under Medicare, including Medicare Prescription Drug coverage, federal law may require this Plan to be primary over Medicare.

The order of benefit determination rules determine which plan will be the Primary Plan. The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer (MSP) regulations. Examples of these regulations are as follows:

1. This Plan generally pays first under the following circumstances:

    - The Associate continues to be actively employed by the Employer and a Covered Person becomes eligible for and enrolls in Medicare because of age or disability;

    - The Associate continues to be actively employed by the Employer; the covered spouse becomes eligible for and enrolls in Medicare, and is also covered under a retiree plan through their former employer. In this case, this Plan will be primary, Medicare pays second, and the retiree plan would pay last; or

    - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for thirty (30) months from the date of Medicare eligibility based on ESRD. The thirty (30) month period can also include COBRA continuation coverage or another source of coverage. At the end of the thirty (30) months, Medicare becomes the primary payer.

2. Medicare generally pays first under the following circumstances:

    - The Associate is no longer actively employed by an employer;

    - The Covered Person has Medicare coverage due to age, and also has COBRA continuation coverage through the Plan;

    - The Covered Person has Medicare coverage based on a disability, and the Associate also has COBRA continuation coverage through the Plan. Medicare normally pays first, however an exception is that COBRA may pay first for Covered Persons with ESRD until the end of the thirty (30) month period;

    - The Covered Person has retiree coverage plus Medicare coverage; or

    - Upon completion of thirty (30) months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (If a person with ESRD was eligible for Medicare based on age or other disability ***before*** being diagnosed with ESRD and Medicare was previously paying primary, then the person can continue to receive Medicare benefits on a primary basis).

3. Medicare is the secondary payer when no-fault insurance, worker's compensation, or liability insurance is available as primary payer.

TRICARE

In all instances where an eligible Associate is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

MEDICAID

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

In all cases, benefits available through a state or federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, the Plan may recover the excess from one (1) or more of the persons it paid or for whom the Plan has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

SECTION IX: RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

This Plan is designed to cover an Associate and their Dependent(s) with health benefits. This Plan is not intended to serve as a supplement to, or replacement for, any payments or benefits a Covered Person has or may recover when charges are Incurred as the result of an Accident, Illness, Injury or other medical condition caused by an act or omission of any Other Party. Benefits under this Plan are reduced or excluded subject to the terms and conditions of this Subrogation, Reimbursement and Offset Provision anytime there is an Other Party who is liable or responsible (legally or voluntarily) to make payments in relation to the Accident, Illness, or Injury.

For purposes of this section, **Other Party** is defined to include, but is not limited to, the following:

1. The party or parties that caused the Accident, Illness, Injury, or other medical condition;

2. The insurer or other indemnifier of the party or parties who caused the Accident, Illness, Injury, or other medical condition;

3. The Covered Person's own insurer including, but not limited to, uninsured motorist, underinsured motorist, medical payment, no-fault insurers, or home-owner's insurance;

4. A worker's compensation or school insurer; or

5. Any other person, entity, policy, or plan that is liable or legally responsible to make payments in relation to the Accident, Illness, Injury, or other medical condition.

For purposes of this section, **Recovery** is defined to include, but is not limited to, any amount paid or payable by an Other Party through a settlement, judgment, jury award, mediation, arbitration, or other means in connection with an Accident, Injury, or Illness.

If the Covered Person has the legal right to seek a Recovery from such Other Party, benefits will only be payable if there is an agreement to the following:

1. The Plan is subrogated to all rights the Covered Person may have, and they acknowledge that the Plan will have a first priority lien and right of recovery, on any Recovery received from any Other Party as a result of an Accident, Illness, Injury or other medical condition caused by an act or omission of the Other Party. Any Covered Person accepting benefits from the Plan assigns from any such Recovery an amount equal to the benefits paid by the Plan. A Covered Person further agrees that notice of this assignment presented to the Covered Person's attorney and/or insurance company or Other Party responsible for payment of the damages is binding on the party receiving such notice;

2. The Covered Person, or their legal representative, shall notify the Plan of any claim or potential claim the Covered Person and/or their Dependent(s) have against any Other Party within thirty (30) days of the act which gives rise to such claim. That, if requested, the Covered Person or their legal representative shall supply the Plan with any information that is reasonably necessary to protect the Plan's subrogation interests;

3. If an act or omission of an Other Party causing an Accident, Illness or Injury results in payments being made under the Plan, that neither the Covered Person nor their Dependent(s) do anything that would prejudice the Plan's rights to recover payments;

4. If requested, the Covered Person shall execute documents (including a lien agreement) and deliver instruments and papers and do whatever else is necessary to protect the Plan's rights. Such documents may require the Covered Person to direct their attorney (and other representatives) in writing to retain separately from any Recovery that the attorney or representative receive on the Covered Person's behalf an amount of money sufficient to reimburse the Plan as required by such agreement and to pay such money to the Plan.

Failure or refusal to execute such documents or agreements or to furnish information does not preclude the Plan from exercising its right to Subrogation or obtaining full reimbursement. In the event the Covered Person does not sign or refuses to sign such an agreement, the Plan has no obligation to make any payment for any treatment required as a result of the act or omission of any Other Party, such agreement is expressly incorporated in this Plan and will be provided to the Covered Person at anytime upon request;

5. The Plan is also granted a right of reimbursement from the proceeds of any Recovery obtained or that may be obtained by the Covered Person. This right of reimbursement runs concurrent with and is not necessarily exclusive of the Plan's subrogation and lien rights described above. A Covered Person shall promptly convey to the Plan any amounts received from any Recovery for the reasonable value of the medical benefits advanced by the Plan or provided by the Plan to the Covered Person;

6. In the event that the Covered Person fails to cooperate with the Plan or fails to comply with the terms of this provision, the Plan may offset or otherwise reduce present or future benefits otherwise payable to the Covered Person or their Spouse or Dependent under the terms of the Plan. Moreover, in the event that a Covered Person fails to cooperate with the Plan, the Covered Person shall be responsible for any and all costs Incurred by the Plan in enforcing its rights, including but not limited to attorney's fees;

7. The Plan has a right to recover, through subrogation, reimbursement, offset or through any other available means, the following:

   - Any amount from the first dollar, that the Covered Person or any other person or organization on behalf of the Covered Person is entitled to receive as a result of the Accident, Illness, Injury or other medical condition, to the full extent of benefits paid or provided by the Plan; and

   - Any overpayments made directly to Providers on behalf of the Covered Person for the Accident, Illness, Injury, or other medical condition.

8. The Plan's rights under this section shall be in first priority, to the full extent of any and all benefits paid or payable under the Plan, and will not be reduced due to the Covered Person's own negligence or due to the Covered Person not being made whole. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person is fully compensated by their recovery from all sources;

9. The Covered Person shall be solely responsible for all expenses of recovery from any Other Party, including but not limited to all attorney's fees and costs, which amounts will not reduce the amount of reimbursement payable to the Plan under the operation of any common fund doctrines. Specifically, the Plan does not permit a deduction in any amount to which it is subrogated or to which it is entitled to reimbursement for attorneys' fees, costs or expenses expended by or on behalf of a Covered Person to obtain a settlement, payment or other recovery;

10. The Plan will not pay any fees or costs Associated with any claim or lawsuit without the Plan's express written consent in advance;

11. The Covered Person or their legal representative or Legal Guardian, shall be considered a constructive trustee with respect to any Recovery received or that may be received from any Other Party in consideration of an Accident, Illness, Injury or other medical condition for which they have received benefits. Any such funds will be held in trust until the Plan's lien is satisfied;

12. The Plan's rights apply to the Covered Person, to the spouse and Dependent(s) of a Covered Person, COBRA beneficiaries, and any other person who may recover on behalf of a participant, including the Covered Person's estate;

13. The Plan reserves the right to independently pursue and recover paid benefits; and
14. The Plan's Subrogation, Reimbursement and Offset provisions apply to a Recovery obtained by the Covered Person in connection with an Accident, Injury, or Illness without regard to the description, name or label applied to the Recovery.

MINOR STATUS

1. In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and their estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees Associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full, and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan's subrogation and reimbursement rights.

SEVERABILITY

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

Notwithstanding anything contained herein to the contrary, to the extent this Plan is not governed by ERISA, the Plan's right to subrogation and reimbursement may be subject to applicable state subrogation laws.

SECTION X: GENERAL EXCLUSIONS

Exclusions are not considered Covered Benefits under this Plan and will not be considered for payment as determined by the Plan. Also refer to the "Definition" section which may include additional information.

The Plan does not pay for Expenses Incurred for the following, unless otherwise stated:

1. **Abortions.** Expenses related to an abortion will not be considered eligible if services are received after twelve (12) weeks of pregnancy. After twelve (12) weeks an abortion is covered if the mother's life is at risk, or if there are major fetal abnormalities, or in the case of rape or incest. Covered will also be subject to the state law in which the service is performed

2. **Acupuncture.** Expenses for Acupuncture will not be considered eligible in the following situations:

   - Acupuncture point injection for any other indication, including Infertility and recurrent pregnancy loss;
   - Acupuncture treatments other than for the relief of migraines or back/neck pain;
   - Maintenance Acupuncture services when significant therapeutic improvement is not expected;
   - Treatment intended to improve or maintain general physical condition.

3. **Acts of War.** Expenses for the treatment of Illness or Injury resulting from a war or any act of war or terrorism, whether declared or undeclared, civil war, hostilities, or invasion, or while in the armed forces of any country or international organization will not be considered eligible.

4. **Administrative & Other Services.** Expenses for completion of claim forms, shipping & handling, annual or other charges for to in a Physician's practice, charges to have preferred access to a Physician's services such as boutique or concierge Physician practices will not be considered eligible. This exclusion also includes duplicate services and charges or inappropriate billing including the preparation of medical reports and itemized bills.

5. **Allergy.** Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine auto injections.

6. **Alternative / Complimentary Treatment.** Treatment, services or supplies for, including, but not limited to, holistic/naturopathic services or homeopathic remedies, and herbal supplements.

7. **Before Enrollment and After Termination.** Services, supplies or treatment (including those related to pregnancy) rendered before coverage begins under this Plan, or after coverage ends. Also includes services rendered to individuals not eligible for coverage.

8. **Blood.** Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.

9. **Cardiac Rehabilitation.** Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

10. **Chelation Therapy.** Expenses for chelation therapy will not be considered eligible except in the treatment of conditions considered medically appropriate and not Experimental or Investigational for the medical condition for which the treatment is recognized.

11. **Close Relative.** Expenses for services, care or supplies provided by a person who normally resides in the Covered Person's home or by a Close Relative will not be considered eligible.

12. **Contraception.** Contraception not required to be covered under Preventive Care, includes over-the-counter contraceptive supplies such as condoms, contraceptive foams, jellies, and ointments.

13. **Cosmetic Treatment/Cosmetic Surgery.** Expenses for Cosmetic and reconstructive services including surgeries and/or related services that are considered Cosmetic, unproven, and not Medically Necessary, unless specifically listed as a Covered Benefits. This exclusion includes plastic surgery or any treatment, surgery, service, or supply to alter, improve or enhance the shape or appearance of the body whether for psychological or emotional reasons including:

    - Abdominoplasty;
    - Body contouring, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of nonmalignant moles, blemishes, varicose veins, Cosmetic eyelid surgery and other surgical procedures;
    - Breast augmentation;
    - Brow lifts;
    - Calf implants;
    - Check, chin, and nose implants;
    - Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments, or other treatments or supplies to alter the appearance or texture of the skin;
    - Face lifts, forehead lift, or neck tightening;
    - Facial bone remodeling;
    - Hair removal or hair transplantation;
    - Injection of fillers or neurotoxins;
    - Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when Medically Necessary or required by applicable law;
    - Lip augmentation or lip reduction;
    - Otoplasty;
    - Pectoral implants;
    - Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
    - Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy);
    - Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
    - Rhinoplasty;
    - Skin resurfacing;
    - Surgery to correct Gynecomastia;
    - Thyroid cartilage reduction, reduction thyroid chondroplasty;
    - Trachea shave;
    - Voice modification surgery, voice lessons or voice therapy.

14. **Counseling.** Services and treatment for a marriage (marital and premarital), religious, family, career, social adjustment, pastoral, or financial counselor unless specifically listed as a Covered Benefit.

15. **Court-Ordered.** Any treatment or therapy which is court-ordered, including those required as a condition of parole or release.

16. **Custodial Care.** Expenses for Custodial Care will not be considered eligible, unless specifically listed as a Covered Benefit.

17. **Dental Services.** Any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of Injuries or disease of the teeth, gums, and other structures supporting the teeth unless specifically listed as a Covered Benefit. This exclusion includes but is not limited to:

    - Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
    - Services of Dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth.

18. **Developmental Delays.** Therapies for the treatment of delays in development, unless resulting from acute Illness or Injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered (except as provided for the treatment of Pervasive Developmental Delays/Autism Spectrum Disorders). Examples of non-covered diagnoses include Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature unless specifically listed as a Covered Benefits.
19. **Disposable Outpatient Medical Supplies.** Disposable Outpatient supplies: any Outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

20. **Drugs and Medications**. The following drugs, medications, and charges are not covered:

    - Any expenses for Prescription Drugs, and supplies covered under the separate Prescription Drug Benefit.
    - Any Prescription Drug purchased illegally outside the United States, even if otherwise covered under this Plan within the United States;
    - Any Prescription Drugs, injectables, or medications or supplies provided by the Covered Person or through a third party vendor contract with the customer;
    - Any services related to the dispensing, injection, or application of a drug;
    - Drugs related to the treatment of non-Covered Benefit;
    - Except as specifically listed in the Covered Benefits section over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a Prescription including vitamins;
    - Immunizations related to work and travel;
    - Injectable drugs if an alternative oral drug is available;
    - Needles, syringes, and other injectable aids, except as covered for diabetic supplies not available at a pharmacy;
    - Outpatient Prescription Drugs;
    - Performance enhancing steroids;
    - Self-injectable Prescription Drugs and medications.

21. **Educational Services.** Charges for education services (except as provided for the treatment of Pervasive Developmental Disorders/Autism Spectrum Disorders):

    - Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
    - Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and

- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

22. **Examinations.** Routine physical exams and related services required by a third party, such as for an occupation, employment, labor agreement, professional license, school, camp, travel, sports, purchase of insurance, or premarital tests or examinations.

23. **Excess Charges.** Charges or the portion thereof which are in excess of the Maximum Allowable Amount (Usual, Customary and Reasonable Allowance, the Negotiated Rate or fee schedule), or in excess of benefit limits outlined in this Plan.

24. **Exercise Programs.** Exercise programs, exercise equipment, health club memberships, training, advice, or coaching for treatment of any condition will not be considered eligible, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan. This includes services, devices and supplies to enhance strength, physical condition, endurance, or physical performance.

25. **Experimental, Investigational or Unproven Services.** Expenses for treatment, procedures, devices, drugs, or medicines which are determined to be Experimental, Investigational or an Unproven service will not be considered eligible, unless specifically listed as a Covered Benefit.

26. **Facility Charge.** Facility charges for care, services, or supplies provided in:

    - Assisted living facilities;
    - Health resorts;
    - Rest homes;
    - Similar institutions serving as an individual's primary residence or providing primarily custodial or rest care; or
    - Spas, sanitariums.

27. **Food Items.** Any food item, including infant formulas, nutritional supplements, vitamins, including Prescription vitamins, medical foods, and other nutritional items. This does not apply to enteral feedings to meet nutritional requirements as order by the Covered Person's Physician.

28. **Foot Care/Podiatry.** Any services, supplies, or devices to improve comfort or appearance of toes, feet, or ankles, including but not limited to the following unless specifically listed as a Covered Benefit:

    - Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working, or wearing shoes; and
    - Shoes, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices, and supplies, even if required following a covered treatment of an Illness or Injury.

29. **Growth/Height.** Any treatment, device, drug, service, or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

30. **Hearing.** Expenses for the following:

    - Any hearing service or supply that does not meet professionally accepted standards;
    - Hearing exams given during a stay in a Hospital or other facility (does not include newborn hearing screening); and
    - Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.

31. **Home Births.** Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

32. **Home and Mobility**. Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

    - Equipment installed in the Covered Person's home, workplace, or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity, or temperature;
    - Equipment or supplies to aid sleeping or sitting, including non-Hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
    - Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
    - Other additions or alterations to the Covered Person's home, workplace, or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
    - Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools;
    - Removal from the Covered Person's home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or Illness;
    - Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen the Illness or Injury; and
    - Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

33. **Infertility.** Except as specifically as a Covered Benefit, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

    - Any charges Associated with care required to obtain ART services (e.g., office, Hospital, ultrasounds, laboratory tests); and any charges Associated with obtaining sperm for any ART procedures;
    - Assisted Reproductive Technologies (ART) once the Plan's lifetime limit has been reached;
    - Drugs related to the treatment of non-covered benefits;
    - Home ovulation prediction kits or home pregnancy tests;
    - Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
    - Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
    - Injectable Infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
    - Ovulation induction and intrauterine insemination services if the Covered Person is not Infertile;
    - Procedures, services and supplies to reverse voluntary sterilization;

    This exclusion also includes: the purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests; and charges associated with the use of a gestational carrier or surrogate.

    Nothing in this section is intended to exclude coverage for any Infertility counseling or treatment required to be covered (if any) as a preventive service.

34. **Legal Fees.** Expenses paid relating to any litigation, including, but not limited to, attorneys' fees, extra-contractual damages, compensatory damages, and punitive damages will not be considered eligible.

35. **Maintenance Care.** Such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

36. **Medical Foods.** Medical foods are excluded unless they meet the criteria stated under Nutritional Therapy for Inborne Errors of Metabolism under the Covered Benefit section.

37. **Medicare.** Payment for that portion of the charge for which Medicare or another party is the primary payer.

38. **Missed Appointments.** Expenses for missed appointments will not be considered eligible.

39. **Not Determined to be Medically Necessary.** Services, supplies, treatment, facilities, or equipment which the Plan determines do not meet the definition of Medically Necessary, even if prescribed and/or approved by a Provider.

40. **Not Listed as Covered.** Services that are not specifically listed as a Covered Benefit.

41. **Not Performed Under the Direction of a Physician.** Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.

42. **Not Precertified.** Unauthorized services, including any service obtained by or on behalf of a Covered Person without Precertification required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.

43. **Not Recommended by a Physician.** Expenses by a Hospital or covered residential treatment center if Hospitalization is not recommended or approved by a legally Qualified Physician will not be considered eligible.

44. **Nursing and Home Health Aides.** Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities).

45. **Operated by the Government.** Expenses for treatment at a facility owned or operated by the government will not be considered eligible unless the Covered Person is legally obligated to pay. This does not apply to Covered Expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury. This exclusion also includes care received while in the custody of a governmental authority.

46. **Oral Nutritional Supplements, Oral Vitamins, Oral Electrolytes, Oral Infant Formulas, and dietary supplements** are excluded except for the treatment of inborne errors of metabolism.

47. **Personal Convenience/Comfort.** Services or supplies for personal comfort or convenience, such as but not limited to private room, internet, television, and guest trays, orthopedic mattresses, non-hospital adjustable beds, blood pressure instruments, scales, elastic bandages over the counter stockings, first-aid supplies, barber or beauty services or other guest services, housekeeping, cooking, cleaning, shopping, and security or other home services, or other living expenses.

48. **Performance Enhancing.** Services, devices and supplies to enhance strength, physical condition, endurance, or physical performance, including:

    - Drugs or preparations to enhance strength, performance, or endurance;
    - Treatments, services and supplies to treat Illnesses, Injuries or disabilities related to the use of performance enhancing drugs or preparations.

49. **Private Duty Nursing.** Private duty nursing while a Hospital Inpatient Person or Outpatient, unless specifically listed as a Covered Benefit.

50. **Resident Physician.** Services of a resident Physician or intern rendered in that capacity.

51. **Rest Cures.** Expenses related to rest cures.

52. **Reversal of Sterilization.** Procedures or treatments to reverse prior sterilization.

53. **Routine Care.** Services provided where there is no evidence of pathology, dysfunction, or disease; except as required to be covered under the Preventive Care benefit.

54. **School.** Services that should legally be provided by a school.

55. **Scope of License.** Charge submitted for services by an unlicensed Hospital, Physician, or other Provider; or not within the scope of the Provider's license.

56. **Services at No Charge or Cost.** Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, or which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.

57. **Services Not Rendered.** Charges submitted for services that were not rendered.

58. **Sexual Dysfunction/Impotence.** Any treatment, drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire (unless specifically listed as a Covered Benefit), including:

    - Surgery, drugs, implants, devices, or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
    - Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

59. **Smoking Cessation.** Treatments, services or supplies to stop or reduce smoking or the use of other tobacco products, or to treat or reduce nicotine addiction, dependence, or cravings, unless specifically listed as a Covered Benefit or required by law. The Plan does not cover any of the following: e-cigarettes; gum; and/or hypnosis.

60. **Speech Therapy.** Speech therapy for treatment of delays in speech development, unless specifically listed as a Covered Benefit For example, the Plan does not cover therapy when it is used to improve speech skills that have not fully developed.

61. **Therapies and Tests.** Expenses for or related to:

    - Aromatherapy;
    - Bioenergetic therapy;
    - Carbon dioxide therapy;
    - Computer-aided tomography (CAT) scanning of the entire body;
    - Diversional therapy;
    - Educational therapy (except as provided for the treatment of Pervasive Developmental Delays/Autism Spectrum Disorders);
    - Gastric irrigation;
    - Hair analysis;
    - Hypnosis, and hypnotherapy, except when performed by a Physician as a form of anesthesia in connection with covered surgery;

- Lovaas therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

62. **Transplant.** Transplant coverage does not include charges for:

    - Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise precertified;
    - Harvesting and/or storage of bone marrow, tissue, or stem cells without the expectation of transplantation within 12 months for an existing Illness;
    - Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing Illness;
    - Home infusion therapy after the transplant occurrence;
    - Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an Outpatient transplant occurrence;
    - Services and supplies furnished to a donor when recipient is not a Covered Person.

63. **Transportation.** Transportation services which are solely for the convenience or for routine transportation to receive Outpatient or inpatient services.

64. **Travel.** Expenses for travel will not be considered eligible, unless specifically listed as a Covered Benefits or authorized in advance by the Plan.

65. **Travel Outside the United States.** Any non-Emergency charges Incurred outside of the United States if travel was for the sole purpose of obtaining medical services, Prescription Drugs, or supplies, even if otherwise covered under this Plan. This includes Prescription Drugs or supplies if:

    - Such Prescription Drugs or supplies are unavailable or illegal in the United States; or
    - The purchase of such Prescription Drugs or supplies outside the United States is considered illegal.

66. **Treatment of a Non-Covered Service.** Services and supplies provided in connection with treatment or care that is not covered under the Plan.

67. **Vision Care.** Vision related services and supplies, unless specifically listed as a Covered Benefit. The Plan does not cover:

    - Acuity tests;
    - Eye exams during a stay in a Hospital or other facility for health care;
    - Eye exams for contact lenses or their fitting;
    - Eye surgery for the correction of vision, including radial keratotomy, LASIK, and similar procedures;
    - Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
    - Replacement of lenses or frames that are lost or stolen or broken;
    - Services to treat errors of refraction;
    - Special supplies such as non-Prescription sunglasses and subnormal vision aids;
    - Vision service or supply which does not meet professionally accepted standards.

However, benefits will be provided for the necessary initial placement of a pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye. This exclusion does not apply to an aphakic patient and soft lenses or sclera shells intended for use as corneal bandages and as otherwise covered as a preventive service.

68. **Vitamin D Screening.** Vitamin D screening if not Medically Necessary, as determined by the Plan Administrator, for the diagnosis and treatment of Illness, Injury, restoration of physiological functions, or covered preventive services.

69. **Weight Control.** Any treatment, drug service or supply intended to decrease or increase body weight, control weight, or treat obesity, including Morbid Obesity, regardless of the existence of comorbid conditions. This exclusion includes but is not limited to:

    - Counseling, coaching, training, hypnosis, or other forms of therapy;
    - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
    - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement;
    - Liposuction; and
    - Weight control services including, surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

    This exclusion does not include specific services for Morbid Obesity as listed in the Covered Benefits section of this Plan.

70. **Work Related.** Any Illness or Injury related to employment or self-employment including any Illness or Injury that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to the Covered Person for the services or supplies. Sources of coverage or reimbursement may include the Covered Person's employer, workers' compensation, or an Occupational Illness or similar program under local, state, or federal law. A source of coverage or reimbursement will be considered available even if the Covered Person waived their right to payment from that source. An Illness will be deemed to be non-Occupational regardless of cause if proof is furnished that the person: is covered under any type of workers' compensation law; and is not covered for that Illness under such law.

    If the Covered Person is also covered under a workers' compensation law or similar law and submits proof that there is no coverage for a particular Illness or Injury under such law, that Illness or Injury will be considered non-occupational regardless of cause.

The Plan does not limit a Covered Person's right to choose their own medical care. If a medical expense is not a Covered Benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

SECTION XI: PRESCRIPTION DRUG BENEFITS

Participating Pharmacies have contracted with the Plan, through a Pharmacy Benefit Manager (PBM), to charge Covered Persons reduced fees for Covered Prescription Drugs.

The Pharmacy Benefit Manager of the Prescription Drug Benefit is:

Express Scripts
Customer Service: 1-800-428-0529
www.express-scripts.com

A Covered Person can fill Prescriptions at any Participating Pharmacy including OhioHealth Hospital Ambulatory Pharmacies.

This Plan will provide benefits for Medically Necessary Prescription Drugs that are dispensed for a Covered Person in addition to certain Preventive drugs. All Prescription Drugs and refills must be prescribed by a Physician, or authorized Prescriber, and dispensed by a licensed pharmacist.

Prescriptions will be covered as shown in the Prescription Drug Schedule of Benefits. If accessing a non-Participating Pharmacy, a Covered Person will be required to pay for the Prescription Drug upfront and submit a claim form to receive reimbursement from the Plan. For non-Participating Providers, the Covered Person will be responsible for paying the applicable tier Copayment plus the difference between the Maximum Allowable Amount and the applicable Copayment. Reimbursement forms are available by contacting the Pharmacy Benefit Manager.

This Plan has a closed formulary and covers a specific list of drugs and medications. Drugs not included on the Plan's formulary will not be covered. Contact the Pharmacy Benefit Manager to determine which drugs are covered.

Penalties for not using a Participating Pharmacy or charges for non-covered Prescription Drugs will NOT be counted towards the Covered Person's Out-of-Pocket Maximum.

Retail Pharmacy Benefits: Outpatient Prescription Drugs are covered when dispensed by a retail Pharmacy. Each Prescription is limited to a maximum 90-day supply for maintenance medication when filled at a Participating Pharmacy and 30 days for all other Prescriptions.

Mail Order Pharmacy Benefits: Outpatient Prescription Drugs are covered when dispensed by Express Scripts, RMB or Marion General Hospital Ambulatory Pharmacy. Each Prescription is limited to a maximum 90-day supply when filled at these pharmacies. Prescriptions for more than a 90 day supply are not eligible for coverage.

Mandatory Generic: The Plan requires pharmacies to dispense Generic Drugs when available. When a Generic Drug is available, but the Pharmacy dispenses a brand name Drug per the Covered Person's or prescribing Physician's request, the Covered Person will be charged the generic Copayment plus the difference between the brand name Drug and the Generic Drug. The difference will not be counted towards the Covered Person's Out-of-Pocket Maximum.

Non-Formulary Requests: A Covered Person has the right to request a non-formulary Prescription Drug if they need a drug not on the Plan's list of covered drugs (formulary), or the Covered Person has been receiving a specific non-formulary Prescription Drug for at least six (6) months previous to the development, or revision, of the formulary and the prescribing Physician has determined that the formulary drug is inappropriate, or that changing drug therapy presents a significant health risk. The prescribing Physician must complete a Medical Necessity form and submit it to the PBM for review. After reasonable investigation and consultation with the prescribing Physician, the PBM will make a determination. The Covered Person will be responsible for all applicable Copayments, Coinsurance, or Deductibles depending upon which Tier a drug is placed in by the Plan.

Additional information about the Prescription Drug Benefit can be found by calling the number on the Associate's ID card or by logging into the Express Scripts website at www.express-scripts.com.

The Plan Administrator retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Plan's claim and appeal procedures.

COVERED PRESCRIPTION DRUGS

1. All drugs prescribed by a Physician that require a Prescription either by federal or state law but excludes any drugs stated as not covered under this Plan.

2. All compounded Prescriptions must contain ingredients that are covered drugs.

3. Insulin and other diabetic supplies (i.e. alcohol swabs, needles and syringes, test agents, lancets/lancing devices, and test strips for glucose monitoring and/or visual reading) when prescribed by a Physician.

4. Specialty Drugs. Prior authorization may be required.

5. Female contraceptive drugs and devices.

6. Over-the-counter (OTC) drugs under USPSTF recommended Preventive Care guidelines when prescribed by a health care Provider. Aspirin may be covered for certain men and women when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm.

7. Over-the-counter (OTC) drugs under USPSTF recommended Preventive Care guidelines for women's contraceptive methods may be covered only if the method is both FDA-approved and prescribed for a woman by her health care Provider. This does not include contraception for men.

8. Oral and self-injectable Infertility Prescription Drugs used for the purpose of treating Infertility including, but not limited to: urofollitropin, menotropin, human chorionic gonadotropin and progesterone.

9. Weight loss drugs, when approved by the Plan.

LIMITATIONS

This benefit applies only when a Covered Person incurs a Covered Prescription Drug charge. The covered drug charge for any one Prescription will be limited to:

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

2. Refills up to 1 year from the date of order by a Physician.

Select Prescription Drugs may also require step-therapy or a prior authorization from the Pharmacy Benefit Manager. Contact the Pharmacy Benefit Manager for additional information.

A Participating Pharmacy may refuse to fill a Prescription order or refill when in the professional judgment of the pharmacist the Prescription should not be filled.

Step-Therapy: Step-therapy is another form of prior authorization. With step-therapy, certain medications will be excluded from coverage unless one or more "prerequisite therapy" medications are tried first or unless the Prescriber obtains a medical exception. The Plan will not cover the step-therapy drug if the Prescriber does not

prescribe a prerequisite drug first or fails to obtain a medical exception. The list of step-therapy drugs is subject to change.

Medical Exceptions: The prescribing Provider may seek a medical exception to obtain coverage for drugs for which coverage is denied through step-therapy. The Provider must submit such exception requests to the Pharmacy Benefit Manager. Coverage granted as a result of a medical exception shall be based on an individual, case by case Medical Necessity determination and coverage will not apply or extend to other Covered Persons.

Additional information about any of the above limitations can be found by contacting the PBM at the number on the Associate's ID card or by logging into the Express Scripts website at www.express-scripts.com.

EXCLUSIONS

This benefit will not cover a charge for any of the following (not an all-inclusive list):

1. **Administration.** Any charge for the administration of a Covered Prescription Drug, except for covered immunizations received at a retail Pharmacy.

2. **Allergy.** Any charge for allergy sera and extracts.

3. **Appetite Suppressants.** A charge for appetite suppressants, dietary supplements, or any over-the-counter medication used for weight loss.

4. **Before or After.** Prescription orders filled prior to the Effective Date or after the termination date of coverage.

5. **Blood.** Biological sera, blood, blood plasma, blood products or substitutes or any other blood products.

6. **Compound Drugs.** All compounded Prescriptions require that all ingredients are covered drugs. Compound Prescription medications with ingredients not requiring a Physician's authorization by state or federal law or with ingredients that are excluded are not covered.

7. **Consumed on Premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed, except for covered immunization received at a retail Pharmacy.

8. **Contraceptives.** Intrauterine devices (IUDs), and cervical caps (including their insertion) when covered under the medical Plan.

9. **Cosmetic.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin-A, medications for hair growth or removal, and skin discolorations.

10. **Devices and Supplies.** Devices and supplies (except insulin needles and syringes) of any type, even though such devices may require a Prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

11. **Excess.** Amounts paid for any Prescription Drug after a benefit limit has been reached, or for any Prescription Drug that is excluded from coverage will not count toward any Out-of-Pocket Maximum. This exclusion includes any drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.).

12. **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person. This exclusion will not apply with respect to drugs that:

    a. Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
    b. Have been granted treatment Investigational New Drug (IND); or Group c/treatment IND status; and
    c. The Plan determines, based on available scientific evidence, are effective or show promise of being effective for the Illness.

13. **FDA.** Any drug not approved by the Food and Drug Administration.

14. **Food Items.** Any food item, including infant formulas, nutritional supplements, vitamins, medical foods, and other nutritional items, even if it is the sole source of nutrition.

15. **Genetics.** Any treatment, device, drug, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defect.

16. **Impotence.** A charge for any Prescription Drug dispensed for the treatment of erectile dysfunction, impotence or sexual dysfunction, enhance sexual performance, increase sexual desire, enhance sensitivity, or to change the shape or appearance of a sex organ.

17. **Infertility.** A charge for Drugs used primarily for the treatment of Infertility, or for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, unless specifically listed as covered.

18. **Injectables.** Injectable drugs that are not intended for self-administration or injectable drugs if an alternative oral drug is available unless prior authorization is obtained.

19. **Inpatient Medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

20. **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use". This exclusion will not apply with respect to drugs that:

    a. Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
    b. Have been granted treatment Investigational New Drug (IND); or Group c/treatment IND status; and
    c. The Plan determines, based on available scientific evidence, are effective or show promise of being effective for the Illness.

21. **Medically Necessary.** Prescription Drugs that do not meet the Plan's criteria for Medical Necessity are not covered.

22. **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

23. **Non-Formulary**. Any drug or medication that is not included on the Plan's Prescription Drug formulary list.

24. **Occupational.** Drugs, services, and supplies provided in connection with treatment of an Occupational Injury or Occupational Illness.

25. **Outside of United States.** Any non-Emergency charges Incurred outside of the United States (1) if a Covered Person traveled to such location to obtain Prescription Drugs, or supplies, even if otherwise covered under this Plan, or (2) such drugs or supplies are unavailable or illegal in the United States, or (3) the purchase of such Prescription Drugs or supplies outside the United States is considered illegal;

26. **Over-the-Counter.** Over-the-counter (OTC) medications that do not require a written Prescription by a Physician's unless specifically listed as covered. Medications that have OTC equivalents are also excluded.

27. **Refills.** Any refill that is requested more than one (1) year after the Prescription was written or any refill that is more than the number of refills ordered by the Physician.

28. **Replacement.** Charges Associated with the replacement of lost, stolen, or spilled medication.

29. **Strength and Performance.** Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance, or physical performance, including performance enhancing steroids.

OFF-LABEL USE

FDA approved Prescription Drugs may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least two (2) studies published in nationally recognized peer review journals. Coverage of off label use of these drugs may, in the PBM's sole discretion, be subject to step-therapy or other requirements or limitations.

SECTION XII: MEDICAL CLAIM PROCESSING

All claims for benefits must be **submitted within twelve (12) months from the Incurred date of service**, including any corrected claim or additional requested information needed to make a benefit determination. If this requirement is not met, applicable claims will be denied. If the Provider has a network agreement that specifies a shorter filing period, the network agreement will be applied, and any extenuating circumstances would be reviewed upon appeal.

All Providers of services and/or Covered Persons should submit their expenses as stated on the Covered Person's ID card. The Associate's ID card explains to Providers and Covered Persons how to file a claim.

Note: Cancelled checks, balance-due statements, photocopies, faxes, handwritten claims, and payment receipts do not contain sufficient information to meet claim-filing requirements and cannot be accepted.

If a Covered Person or Provider needs help filing a claim or information on the benefits provided under the Plan, they may contact the telephone number listed on the Associate's ID card and speak with a Member Advocate.

The Plan's claim procedures are intended to reflect the Department of Labor's claims procedures regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those regulations, those regulations will control. In addition, any changes in those regulations shall be deemed to amend this Plan automatically, effective as of the date of those changes.

TYPES OF CLAIMS

How a Covered Person files a claim for benefits depends on the type of claim it is. There are several categories of claims for benefits:

Pre-Service Care Claim - A pre-service claim is a claim for a benefit under the Plan which the terms of the Plan require approval of the benefit in advance of obtaining medical care. There are two (2) special kinds of pre-service claims:

Urgent Care Claim - An Urgent Care Claim is any pre-service claim for medical care or treatment where applying the timeframes for non-Urgent Care could (a) seriously jeopardize the Covered Person's life or health or their ability to regain maximum function or (b) in the opinion of a Physician with knowledge of their medical Condition, would subject them to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies. Determination of ***urgent*** can be made by (a) an individual acting on behalf of the plan and applying the judgment of a Prudent Layperson who possesses an average knowledge of medicine or (b) any Physician with knowledge of their medical Condition can determine that a claim involves Urgent Care.

Concurrent Care Claim - A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously approved pre-service claim. Where possible, this type of claim should be filed at least twenty-four (24) hours before the expiration of any course of treatment for which an extension is being sought.

Additionally, if the Plan or its designee reduces or terminates a course of treatment before the end of the course previously approved (unless it's due to a health plan amendment or health plan termination), then the reduction or termination is considered an Adverse Benefit Determination. The Plan or its designee will notify the Covered Person, in advance, of the reduction or termination so that they may appeal and obtain an answer on the appeal before the benefit is reduced or terminated.

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

WHO MUST FILE

The Covered Person may initiate pre-service claims if they are able, or their treating Physician may file the claim for them. The Covered Person is responsible for filing Post-Service Claims, although the Plan or its designee may accept billings directly from Providers on their behalf, if they contain all of the information necessary to process the claim.

Appointing an Authorized Representative. If the Covered Person wishes to have someone act on their behalf for purposes of filing claims, making inquiries, and filing appeals, they must furnish the Plan, or its designee, with a written designation of their Authorized Representative. The Covered Person can appoint any individual as their Authorized Representative. A Provider with knowledge of the Covered Person's medical condition can act as their Authorized Representative for purposes of an Urgent Care Claim as defined above without a written designation as Authorized Representative. Once the Covered Person appoints an Authorized Representative in writing, all subsequent communications regarding their claim will be provided to their Authorized Representative.

TIMING OF CLAIMS DETERMINATIONS

Urgent Care Claims. If the Covered Person's claim involves Urgent Care, the Covered Person or their Authorized Representative will be notified of the Plan's or its designee's initial decision on the claim, whether adverse or not, as soon as is feasible, but not later than seventy-two (72) hours after receiving the claim. If the claim does not include sufficient information for the Plan or its designee to make an intelligent decision, the Covered Person or their representative will be notified within twenty-four (24) hours after receipt of the claim of the need to provide additional information. The Covered Person or their representative will have at least forty-eight (48) hours to respond to this request; the Plan or its designee then must inform them of its decision within forty-eight (48) hours of receiving the additional information. The Plan or its designee may provide notification its benefit determination decision orally and follow with written or electronic notification not later than three (3) days after the oral notification.

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

Other Pre-Service Claims. If the claim is for any other pre-service authorization, the Plan or its designee will notify the Covered Person of its initial determination, whether adverse or not, as soon as possible, but not more than fifteen (15) days from the date it receives the claim. This fifteen (15) day period may be extended by the Plan or its designee for an additional fifteen (15) days if the extension is required due to matters beyond the Plan's or its designee's control. The Plan or its designee will provide notification of such an extension and date by which it expects to render a decision.

If an extension is needed because all of the necessary information was not provided to process the claim, the Plan or its designee will notify the Covered Person, in writing, within the initial fifteen (15) day response period and will specifically describe the missing information. The Covered Person will have at least forty-five (45) days to provide any additional information requested by the Plan or its designee.

Post-Service Claims. If the claim is for a post-service reimbursement or payment of benefits, the Plan or its designee will notify the Covered Person within thirty (30) days of receipt of the claim that the claim has been approved or denied. The thirty (30) days can be extended to forty-five (45), if the Plan or its designee provides notification within the initial thirty (30) days of the circumstances beyond the Plan's or its designee's control that require an extension of the time period, and the date by which the Plan or its designee expects to render a decision. If more information is necessary to decide a Post-Service Claim, the Plan or its designee will deny the claim and provide notification of the specific information necessary to complete the claim.

No legal action for recovery of benefits allegedly due under any Employer sponsored benefit plan may be commenced by or on behalf of an Associate or former Associate against the Plan, the Plan Administrator, or successor of the same unless it is filed within one (1) year after the date of the final determination noted in the appeals procedure of the relevant benefit plan document.

NO ASSIGNMENT OF BENEFITS

Except as provided in "Payment of Benefits," rights and benefits under the Plan are not assignable, either before or after services or supplies are provided. In the absence of a written agreement with a Provider, the Claims Administrator reserves the right to make benefit payments to the Provider or the Covered Person, as the Claims Administrator elects in its sole discretion. Payment to either party discharges the Plan's responsibility to the Associate or Dependents for benefits available under the Plan. Direct payment to a Provider does not constitute a waiver of this anti-assignment provision. A Covered Person may not interpret or rely upon the direct payment of a Provider by the Claims Administrator as constituting authority to assign any other rights or benefits under the Plan to any party, including, but not limited to, a Provider.

PAYMENT OF BENEFITS

If in the opinion of the Claims Administrator, a party entitled to a benefit payment under this Plan cannot be found, the Claims Administrator may, at its option, make such payment to the individual or individuals as are, in the Claims Administrator's opinion, equitably entitled thereto. In the event of the death of the Covered Person prior to such time as all benefit payments due him/her have been made, the Claims Administrator may, at their sole discretion and option, honor benefit assignments, if any, made prior to the death of such Covered Person. All such benefit payments shall absolve the Plan and the Claims Administrator from any further liability for the payment of said benefits under this Plan.

Benefits payable under the Plan may be assigned to the Provider of service. The Claims Administrator will endeavor to pay assigned benefits directly to the assignee, but to the extent any such benefits are paid directly to the Covered Person, the Plan and the Claims Administrator shall be deemed to have fulfilled their obligations with respect to the payment. To avoid the payment of assigned benefits directly to the assignee, the Claims Administrator must receive a written request signed by both the Covered Person and the assignee no later than the time the claim for benefits is filed.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error;
- Made after the date the person should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person, or any party is greater than the amount payable under the Plan.

INTERNAL COVERAGE GUIDELINES

The Claims Administrator may utilize internal coverage guidelines to determine Maximum Allowable Amounts, to determine whether a particular charge or service is Medically Necessary, or for other purposes in its capacity as Claims Administrator. These internal coverage guidelines are expressly incorporated into this document by this reference and are binding.

MISSTATEMENTS

The Employer's or OhioHealthy's failure to implement or insist upon compliance with any provision of this Plan at any given time or times shall not constitute a waiver of the Employer's or OhioHealthy's right to implement or insist upon compliance with that provision at any other time or times.

ADVERSE BENEFIT DETERMINATIONS

If a benefit is denied, reduced, terminated, or refused payment, including eligibility denials, utilization reviews and coverage rescissions, in whole or in part, it is considered an Adverse Benefit Determination, as defined. When an Adverse Benefit Determination is made, the claimant will receive written or electronic notification of the following:

1. The specific reason(s) for the Adverse Benefit Determination;
2. Information to confirm the identity of the claim at issue, including the date of service, Provider's name and claim amount;
3. Reference to relevant Plan provisions used in making the determination;
4. A description of additional information necessary for the claimant to perfect the claim and an explanation of why the additional information is necessary;
5. A description of the Plan's appeal procedures applicable to the claim, including any applicable time limits;
6. The claimant's right to bring a civil action under ERISA 502(a) following exhaustion of an appeal of an Adverse Benefit Determination; and
7. If the Adverse Benefit Determination reflected was based upon an internal rule, guideline or protocol, a copy of the rule, guideline or protocol will be provided free of charge upon written request. In addition, if the determination was based on a limitation or exclusion that the treatment was experimental or not Medically Necessary, an explanation of the scientific or clinical judgment relied upon will be sent free of charge upon written request.

PHYSICAL EXAMINATIONS

The Plan Administrator will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or review. This will be done at no cost to the Covered Person.

FRAUD

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this document and other Plan materials. Please read them carefully and refer to all Plan materials provided (i.e., COBRA notices). A few examples of events that require Plan notification would be divorce, Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA (please note that the examples listed are not all inclusive).

These actions will result in denial of the Covered Person's claim or termination from the Plan and are subject to prosecution and punishment to the full extent under state and/or federal law.

Covered Persons must:

1. File accurate claims. If someone else files claims on the Covered Person's behalf, the Covered Person should review the form before signing it;
2. Review the Explanation of Benefits (EOB) form. Make certain that benefits have been paid correctly based on the Covered Person's knowledge of the expenses Incurred and the services rendered;
3. Never allow another person to seek medical treatment under the Covered Person's identity. If the Plan identification card is lost, report the loss to the Plan immediately;
4. Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of their knowledge; and
5. Notify the Plan when an event occurs that affects a Covered Person's eligibility.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a Provider:

1. Bills for services or treatment that have never been received;
2. Asks a Covered Person to sign a blank claim form; or
3. Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the Member Advocate telephone number on the ID card. All calls are strictly confidential.

SECTION XIII: APPEAL OF ADVERSE BENEFIT DETERMINATIONS

A Covered Person, or their Authorized Representative, has one hundred eighty (180) calendar days following receipt of an Adverse Benefit Determination notice to submit a **written first level appeal** to the Claims Administrator. If an appeal relates to an Urgent Care Claim, the Covered Person will be notified of the appeal determination as soon as possible, but not later than seventy-two (72) hours after receipt of the appeal request. If an appeal relates to a non-urgent Pre-Service Claim, the Covered Person will be notified of the appeal determination no later than fifteen (15) calendar days after receipt of the appeal request. If the appeal relates to a Post-Service Claim, the Covered Person will be notified of the appeal determination no later than thirty (30) calendar days after receipt of the appeal request.

If a medical professional was consulted for the initial Adverse Benefit Determination, the appeal can be requested either in writing or verbally, and an independent reviewer, with the same specialty as the servicing Provider, will perform the appeal review.

Any individual involved in the initial Adverse Benefit Determination will not participate in the determination of the appeal. The Covered Person may submit comments, documents, and other supporting information in conjunction with the appeal. Upon written request (and free of charge), reasonable access to the Plan's documents and information relevant to the appealed claim will be provided. As part of the appeal process, a full and fair review of all comments and documentation will be provided on an unbiased basis.

Prior to the exhaustion of the internal appeal process, any new or additional evidence considered, relied upon, or generated in connection with the claim or internal appeal of an Adverse Benefit Determination, will be provided to the Covered Person, or their Authorized Representative, free of charge to provide them an opportunity to respond to such new evidence or rationale.

If the appeal determination is to uphold the initial claim processing, the written notification will include all mandated notices required for Adverse Benefit Determinations, and also include a description of the Covered Person's right to further action.

If the Covered Person remains dissatisfied with the appeal determination, they may submit a **second level appeal** in writing within sixty (60) calendar days of receipt of the initial appeal determination notice. The second level appeal will be reviewed by individuals who were not involved in the initial appeal determination. A second level appeal, including all relevant information, may be sent to the address listed below.

All appeal procedures specified must be exhausted before any legal action is filed. No legal action can be filed more than one (1) year after the appeal determination notice.

FILING AN APPEAL OF AN ADVERSE BENEFIT DETERMINATION

The Covered Person or their Authorized Representative may submit appeals to the Claims Administrator. The address for the Claims Administrator is:

OhioHealthy
Attn: Appeals Coordinator
P.O. Box 2582
Hudson, OH 44236-2582

EXTERNAL REVIEW

External Review is available when an adverse benefit determination involves medical judgment, rescission of coverage, or the Plan's alleged failure to recognize a Surprise Medical Bill prohibited by the No Surprises Act, and the internal Appeal process is exhausted or if the Plan fails to adhere to the requirements of claim and appeal processing.

Upon issuance of a final Adverse Benefit Determination on benefits involving medical judgments and coverage rescissions from the internal review and appeal procedures discussed above, the Covered Person (or an Authorized Representative) has four (4) months to file a request for an external review. If the last day for filing a request for an external review falls on a Saturday, Sunday or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or federal holiday. Within five (5) business days following receipt of an external review request, the Plan will complete a preliminary review to determine if:

1. The Covered Person was covered at the time the health care service was provided;
2. The final Adverse Benefit Determination does not relate to the Covered Person's failure to meet eligibility requirements under the Plan;
3. The Covered Person exhausted the Plan's internal review and appeal process; and
4. The Covered Person has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Plan will issue written notice that either:

1. The external review request is complete and confirmed eligible for external review, with information about the external review process;
2. The external review request is complete but ineligible for external review, the reasons for ineligibility and contact information for the Employee Benefits Security Administration (866-444-3272); or
3. The external review request is not complete, the description of information or materials needed to make the external review request complete within the four (4) month filing period or within the forty-eight (48) hour period following receipt of the notice, whichever is later.

Within five (5) days after the complete request for external review has been assigned to an Independent Review Organization ("IRO"), the Plan will provide the IRO the documents and information considered in making the final Adverse Benefit Determination. If the Covered Person submits any information to the IRO, the IRO must forward any such information to the Plan within one (1) business day. The Plan may reconsider its final Adverse Benefit Determination and if it decides to reverse its final Adverse Benefit Determination before the IRO's external review decision, the Plan will notify in writing, within one (1) business day, the Covered Person and IRO of its reversal. The IRO must provide a decision within thirty (30) calendar days from the date of request for the external review. The Plan will comply with the IRO's determination.

Request for expedited external review

A group health plan must allow a Covered Person to make a request for an expedited external review if it involves a medical condition where the time for completion of a standard external review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency Services, but has not been discharged from a facility.

The IRO must provide a notice of the final external review decision as expeditiously as the claimant's medical condition or circumstance require, but ***in no event more than seventy-two (72) hours*** after the IRO receives the request for an expedited external review. If the notice is not in writing, ***within forty-eight (48) hours*** after providing the notice, the IRO must provide written confirmation of the decision to both the claimant and the plan.

FILING AN EXTERNAL REVIEW

The Covered Person, or their Authorized Representative, may file an External Review by submitting a written request, including all supporting documentation to:

OhioHealthy
Attn: Appeals Coordinator
P.O. Box 2582
Hudson, OH 44236-2582

PROVIDER PAYMENT PROCESS AND INDEPENDENT DISPUTE RESOLUTION

The No Surprises Act requires the Plan to follow a specific process for paying Providers and facilities for Out-of-Network claims covered by the No Surprises Act and this Plan complies with that process as required. That payment process may include an independent dispute resolution process between the Plan and an Out-of-Network Provider.

Note: The separate payment process under the No Surprises Act is applicable to the Out-of-Network Provider, not the Covered Person, and is different from the claims review procedures explained above. A Covered Person must follow the claims review procedures explained above to request benefits or address any benefit dispute under the Plan.

SECTION XIV: FEDERAL LAWS IMPACTING BENEFITS

COBRA CONTINUATION COVERAGE

If a Covered Person loses coverage under the Plan, they have the right, in certain situations, to temporarily continue coverage, at their expense, beyond the date it would otherwise end. This right is guaranteed under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).

See Section, "Notice of COBRA Continuation of Coverage and Responsibilities."

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

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

MENTAL HEALTH PARITY ACT

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans that provide mental health or Substance Use Disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

The Mental Health Parity Act of 1996 (MHPA) provided that large group health plans cannot impose annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical/surgical benefits.

MHPAEA preserves the MHPA protections and adds significant new protections, such as extending the parity requirements to Substance Use Disorders. Although the law requires a general equivalence in the way MH/SUD and medical/surgical benefits are treated with respect to annual and lifetime dollar limits, financial requirements, and treatment limitations, MHPAEA does NOT require large group health plans to cover MH/SUD benefits. The law's requirements apply only to large group health plans that choose to include MH/SUD benefits in their plans.

Requirements include the following:

- If a group health plan includes medical/surgical benefits and MH/SUD benefits, the financial requirements (e.g., Deductibles and Copayments) and treatment limitations (e.g., number of visits or days of coverage) that apply to MH/SUD benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits (this is referred to as the "substantially all/predominant test").

  The substantially all/predominant test must be applied separately to six classifications of benefits: Inpatient In-Network; inpatient Out-of-Network; Outpatient In-Network; Outpatient Out-of-Network; emergency; and Prescription Drug. Although the regulation does not require plans to cover MH/SUD benefits, if they do, they must provide MH/SUD benefits in all classifications in which medical/surgical benefits are provided.

- MH/SUD benefits may not be subject to any separate cost-sharing requirements or treatment limitations that only apply to such benefits. All cumulative financial requirements, including Deductibles and out-of-pocket limits, in a classification must combine both medical/surgical and MH/SUD benefits in the classification.

- If a group health plan includes medical/surgical benefits and MH/SUD benefits, and the plan or coverage provides for Out-of-Network medical/surgical benefits, it must provide for Out-of-Network MH/SUD benefits; and

- Standards for Medical Necessity determinations and reasons for any denial of benefits relating to MH/SUD benefits must be disclosed upon request.

- A group health plan cannot impose a non-quantitative treatment limitation with respect to MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

In accordance with The Newborns' and Mother's Health Protection Act, the Plan does not restrict benefits for any Hospitalization stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal birth, or less than ninety-six (96) hours following a caesarean birth, or require that a Provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods, unless agreed to by the mother and her Physician.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A Dependent Child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period of which the order applies.

In accordance with federal law, the Plan has written policies and procedures for the receipt and processing of Qualified Medical Child Support Orders. A copy of these policies and procedures may be obtained by making a written request to the Plan Administrator.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act (WHCRA), passed by Congress in 1998, requires all group health plans and health insurance issuers that already offer benefits for a mastectomy, to also provide coverage for the ensuing breast Reconstructive Surgery. Plans also have to cover surgery on the non-affected breast to ensure a symmetrical appearance. The legislation also mandates coverage for prostheses and for all other services used to treat physical complications during all stages of a Mastectomy, including lymphedemas.

The Plan is required to provide Plan Participants with a notice about these coverage standards upon enrollment and annually thereafter.

Specifically, the WHCRA requires that the Plan provide the following benefits coverage for:

1. Reconstructive Surgery after a mastectomy;
2. Surgery on the non-affected breast to ensure a symmetrical appearance;
3. Breast Prosthesis; and
4. Other physical complications stemming from a mastectomy, including lymphedemas.

In accordance with the WHCRA, the Plan provides the above coverage.

CONTINUATION OF RELIEF FOR EMPLOYEE BENEFIT PLANS AND PLAN PARTICIPANTS AND BENEFICIARIES DUE TO THE COVID-19 OUTBREAK

The Department of Labor (DOL), Department of the Treasury, and the Internal Revenue Service (IRS), (collectively "Agencies"), issued EBSA Disaster Relief Notice 2020-01 ("Notice 2020-01") and the Notice of Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak ("Joint Notice").

The Joint Notice and Notice 2020-01 (collectively "Notices") provide relief for certain actions related to employee benefit plans required under the Employee Retirement Income Security Act of 1974 ("ERISA") section 518 and the Internal Revenue Code ("Code") section 7508A beginning March 1, 2020. The relief is focused on employee benefit plans, Plan Participants and beneficiaries, employers and other Plan Sponsors, plan fiduciaries, and other service Providers impacted by the coronavirus outbreak.

Relief Period. Individuals and plans with timeframes that are subject to the relief will have the applicable periods under the Notices disregarded beginning until the earlier of: 1 year from the date they were first eligible for relief; or 60 days after the announced end of the National Emergency (called the "Outbreak Period"). On the applicable date, the timeframes for individuals and plans with periods that were previously disregarded under the Notices will resume.

Impacted Deadlines. The deadlines and timeframes impacted are:

- The 30-day period (or 60-day period, if applicable) to request HIPAA special enrollment;
- The 60-day election period for COBRA;
- The date for making COBRA premium payments;
- The date for individuals to notify the plan of a qualifying event or determination of disability;
- The date within which individuals may file a benefit claim under the plan's claims procedure;
- The date within which claimants may file an appeal of an Adverse Benefit Determination;
- The date within which claimants may file a request for an external review after receipt of an Adverse Benefit Determination or final internal Adverse Benefit Determination; and
- The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete.

While the National Emergency for the COVID-19 pandemic is still ongoing, the statutory authority the agencies rely on to extend the timelines (ERISA section 518 and Code section 7508A) limits this kind of emergency extension to a one-year timeframe. In no case will a disregarded period exceed 1 year. This one-year time limit applies to an individual event and not to the relief as a whole.

Additional information can be found on the Department of Labor (DOL), EBSA website: https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/disaster-relief/ebsa-disaster-relief-notice-2021-01 or by reaching out to the Plan Administrator.

SECTION XV: HIPAA PRIVACY AND SECURITY

In compliance with the requirements of the HIPAA regulations (45 CFR Part 164 (Subpart E)), herein referred to as the "HIPAA Privacy Rule", and any applicable state laws, the following has been established as the extent to which the Plan Sponsor will receive, use, and/or disclose Protected Health Information (PHI).

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

1. The Plan (and any Business Associate acting on behalf of the Plan), or any health care issuer servicing the Plan will disclose an individuals' PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this section and the HIPAA Privacy Rule.

2. All disclosures of PHI by the Plan's Business Associate or health care issuer, to the Plan Sponsor, will comply with the restrictions and requirements set forth in this document and in the HIPAA Privacy Rule.

3. The Plan (and any Business Associate acting on behalf of the Plan), may not permit a health care issuer, to disclose an individuals' PHI to the Plan Sponsor for employment-related actions and decisions in connection with any other benefit or Associate benefit plan of the Plan Sponsor.

4. The Plan Sponsor will not use or further disclose individuals' PHI other than as described in the Plan Documents and permitted by the HIPAA Privacy Rule.

5. The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides an individuals' PHI received from the Plan (or from the Plan's Business Associate or health care issuer), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.

6. The Plan Sponsor will not use or disclose individuals' PHI for employment-related actions and decisions or in connection with any other benefit or Associate benefit plan of the Plan Sponsor.

The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the HIPAA Privacy Rules, of which the Plan Sponsor becomes aware.

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

1. The Plan Sponsor will make the PHI of the individual, who is the subject of the PHI, available to such individual in accordance with 45 CFR Part 164.524.

2. The Plan Sponsor will make an individuals' PHI available for amendment, and incorporate any amendments to an individuals' PHI, in accordance with 45 CFR Part 164.526.

3. The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of an individuals' PHI that it must account for in accordance with 45 CFR Part 164.528.

4. The Plan Sponsor will make its internal practices, books, and records relating to the use and disclosure of an individuals' PHI received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

5. The Plan Sponsor will, if feasible, return or destroy all PHI received from the Plan (or a Business Associate or health care issuer with respect to the Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such PHI after such information is no longer needed for the

purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

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

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

1. The Plan, or a Business Associate or health care issuer with respect to the Plan, may disclose summary health information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the HIPAA Privacy Rule, if the Plan Sponsor requests the summary health information for the purpose of:

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

2. The Plan, or a Business Associate or health care issuer with respect to the Plan, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the HIPAA Privacy Rule.

Required separation between the Plan and the Plan Sponsor

1. In accordance with the HIPAA Privacy Rule, this section describes the Associates or classes of Associates or workforce members under the control of the Plan Sponsor who may have access to individuals' PHI received from the Plan or from a Business Associate or health care issuer servicing the Plan.

   - Human Resources
   - Benefit Office
   - Accounting
   - I.T.
   - Agent/Broker

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

4. The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

HIPAA SECURITY STANDARDS

Definitions

1. *Electronic Protected Health Information (ePHI)* – The term "Electronic Protected Health Information" or "ePHI" has the meaning set forth in 45 CFR Part 160.103, as amended from time to time, and generally means PHI that is transmitted or maintained in any electronic media.

2. *Plan* - The term "Plan" means OhioHealth Corporation Welfare Benefits Plan.

3. *Plan Documents* - The term "Plan Documents" means the group health plan's governing documents and instructions (*i.e.,* the documents under which the group health plan was established and is maintained), including but not limited to OhioHealth Corporation Welfare Benefits Plan.

4. *Plan Sponsor* - The term "Plan Sponsor" means the entity as defined at section 3(16)(B) of ERISA codified in 29 USC § 1002(16)(B). The Plan's Sponsor is listed in the "General Plan Information" section.

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

Any terms not otherwise defined in this section shall have the meanings set forth in the security standards.

Plan Sponsor Obligations

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

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

2. Plan Sponsor shall ensure that the adequate separation that is required by 45 CFR Part 164.504(f)(2)(iii) of the HIPAA Privacy and Security Rules is supported by reasonable and appropriate security measures;

3. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect such information; and

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

   - Plan Sponsor shall report to the Plan within a reasonable time after becoming aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's ePHI; and
   - Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every month or more frequently upon the Plan's request.

SECTION XVI: RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. OhioHealth Corporation, is the Plan Administrator, also called the Plan Sponsor. The Plan is administered by the Plan Administrator in accordance with ERISA. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Plan Participant is entitled to them.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status, and coverage under the Plan;
3. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions;
5. To make factual findings;
5. To decide disputes which may arise relative to a Plan Participant's rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials; or, alternatively, to appoint a qualified administrator to carry out these functions on the Plan Administrator's behalf;
7. To keep and maintain the plan documents and all other records pertaining to the Plan;
8. To appoint a Claims Administrator to pay claims;
9. To perform all necessary reporting as required by federal or state law;
10. To establish and communicate procedures to determine whether a medical child support order or decree is a QMCSO;
11. To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out their duties and responsibilities for the purpose of providing benefits to the Associates and their Dependent(s) and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

1. With care, skill, prudence, and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

2. By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

3. In accordance with the plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary, or continuing either the appointment or the procedures; or

2. The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Associate and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by Covered Associates.

The level of any Associate contributions will be set by the Plan Administrator. These Associate contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Associate or withheld from the Associate's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

NOT AN EMPLOYMENT CONTRACT

This Plan and any amendments constitute the terms and provisions of coverage under this Plan. The Plan shall not be deemed to constitute a contract of any type between the Employer and any person or to be consideration for or an inducement or condition of, the employment of any Associate. Nothing in this Plan shall be deemed to give any Associate the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Associate at any time.

CLERICAL ERROR

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

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

CONFORMITY WITH APPLICABLE LAWS

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

AMENDING AND TERMINATING THE PLAN

The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend, or terminate the Plan in whole or in part.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of Covered Person*s* are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

MINIMUM ESSENTIAL COVERAGE

Refer to the Employer’s Summary of Benefits and Coverage (SBC) for determination as to whether the Plan provides “minimum essential coverage” within the meaning of Code Section 5000A(f) and any accompanying regulations or guidance and whether it provides “minimum value” within the meaning of Code Section 36B(c)(2)(C)(ii) and any accompanying regulations or guidance (e.g. the Plan provides at least 60% actuarial value).

HOW TO FILE A COMPLAINT

If there is a complaint regarding the Plan or services relating to the Plan’s benefits, please call a Member Advocate at the number listed on the Associate ID card or write to:

OhioHealthy
Attn: Complaint Department
P.O. Box 2582
Hudson, OH 44236

If the complaint is regarding how a claim was processed, then see section “Appeals of Adverse Benefit Determinations” on how to submit an appeal.

SECTION XV: RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When Emergency Services or certain non-Emergency Services are received by an Out-of-Network Provider at an In-Network Health Care Facility, or air ambulance services are received from an Out-of-Network Provider, Covered Persons are protected from Surprise Billing or Balance Billing as required under the No Surprises Act.

Balance Billing (sometimes called "Surprise Billing")

When a Covered Person sees a Provider, they may owe certain out-of-pocket costs, such as a Copayment, Coinsurance, and/or a Deductible. Additionally, other costs may be due, or in some cases the entire bill, if a Covered Person sees a Provider that is Out-of-Network.

Use of the Plan's PPO Network is voluntary; however, Out-of-Network Providers may be permitted to bill for the difference between what the Plan agreed to pay (i.e. the Maximum Allowable Amount) and the full amount charged for a service. This is called Balance Billing. This amount is likely to be more than the cost had the Covered Person seen an In-Network Provider for the same service and will not count toward the annual Out-of-Pocket Maximum under the Plan.

Surprise Billing is an unexpected Balance Bill. This can happen when a Covered Person cannot control who is involved in their care, such as when a Covered Person has an Emergency Medical Condition or when a Covered Person schedules a visit at an In-Network facility but are unexpectedly treated by an Out-of-Network Provider.

Protections from Balance Billing under the No Surprises Act

Emergency Services

If a Covered Person has an Emergency Medical Condition and receives Emergency Services at an Out-of-Network Emergency Facility, the cost-sharing requirement under the Plan will be calculated based on the Maximum Allowable Amount, and such Provider may not bill or hold the Covered Person liable for more than the Plan's cost-sharing requirement for such services. A Covered Person **cannot** be Balance Billed for these Emergency Services. This includes services received after the Covered Person is Stabilized, unless the Covered Person gives written consent and gives up their protections not to be Balanced Billed for these post-stabilization services, to the extent permitted under the No Surprises Act.

Certain Non-Emergency Services at an In-Network Health Care Facility

If a Covered Person receives non-Emergency Services from an Out-of-Network Provider while receiving items or services at an In-Network Health Care Facility, the cost-sharing requirement under the Plan will be calculated based on the Maximum Allowable Amount, and the Provider may not bill or hold the Covered Person liable for more than the Plan's cost-sharing requirement **unless the Covered Person provides consent for Balance Billing** (to the extent permitted by the No Surprises Act). Items or services include equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the Provider furnishing such items or services is at the facility. An Out-of-Network Provider cannot Balance Bill the Covered Person for these items or services unless the Covered Person gives written consent and gives up their protections not to be Balance Billed for these services, to the extent permitted under the No Surprises Act. Before asking for the Covered Persons consent, the Out-of-Network Provider must meet certain written notice requirements under the No Surprises Act.

However, if a Covered Person receives Ancillary Services by an Out-of-Network Provider at an In-Network Health Care Facility, the Out-of-Network Provider **cannot** Balance Bill the Covered Person. The Provider may **NOT** ask a Covered Person to give up their protections not to be Balance Billed with respect to these Ancillary Services.

Additionally, Providers **cannot** Balance Bill for items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished. The Provider may **NOT** ask a Covered Person to give up their protections not to be Balance Billed with respect to these services.

Air Ambulance Services

If a Covered Person receives air ambulance services from an Out-of-Network Provider, the cost-sharing requirement under the Plan will be calculated based on the Maximum Allowable Amount, and the Provider may not bill or hold the Covered Person liable for more than the Plan's cost-sharing requirement for such services. A Covered Person **cannot** be Balance Billed for these air ambulance services. This includes Emergency Services or non-Emergency Services, to the extent such services would be covered if provided by an In-Network air ambulance Provider.

A Covered Person is never required to give up their protections from Balance Billing. A Covered Person is also not required to get care Out-of-Network. Covered Persons have the ability to choose a Provider in the Plan's In-Network.

When Balance Billing is not allowed under the No Surprises Act (as explained above), a Covered Person also has the following protections:

The Plan generally must:

- Cover Emergency Services without requiring approval for services in advance (precertification).
- Cover Emergency Services by Out-of-Network Providers without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply under the Plan to Emergency Services received from an In-Network Provider or In-Network Emergency Facility.
- Cover Emergency Services without regard to any other term or condition of coverage other than the exclusion or coordination of benefits (to the extent not inconsistent with benefits for an Emergency Medical Condition), an affiliation or waiting period (if any), and applicable cost sharing.
- Base what is owed to the Provider (i.e. the Covered Person's cost-sharing) generally on what it would pay an In-Network Provider for the same or similar service or item in the same geographic region.
- Count any amount a Covered Person would pay for Emergency Services or certain Out-of-Network services (received at an In-Network facility) toward the In-Network Deductible and Out-of-Pocket Maximum.

A Covered Person is only responsible for paying their portion of the cost-sharing requirement under the Plan (such as Copayments, Coinsurance, and Deductibles), which will generally not be greater than the amount that the Covered Person would pay if the Provider was In-Network.

A Covered Person who believes they have been wrongly billed may contact the Plan Administrator or the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272. Visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about rights under federal law.

SECTION XVII: STATEMENT OF ERISA RIGHTS

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office, all plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
2. Obtain copies of all plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies;
3. Continue health care coverage for a Plan Participant, Spouse, or other Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Associates or Dependents may have to pay for such coverage;
4. Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights; and

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, they may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until they receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, they may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising their rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order them to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, they should contact the Plan Administrator. If the Plan Participant has any questions about this statement or their rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

SECTION XVIII: GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded health and welfare Plan providing group health benefits and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by Covered Associates. The Plan is not insured and is a portion of the OhioHealth Corporation Welfare Benefits Plan that provides group medical and Prescription Drug benefits.

The Plan Sponsor believes this Plan is a non-grandfathered health plan under the Affordable Care Act. Questions regarding the protections that apply to a non-grandfathered health plan can be directed to the Plan Administrator or the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or visit their website at www.dol.gov/ebsa/healthreform.

PLAN NAME: This Plan is a component of the OhioHealth Corporation Welfare Benefits Plan

PLAN NUMBER: 503

TAX ID NUMBER: 31-4394942

BENEFIT PLAN YEAR: Benefits begin on January 1 and end on the following December 31. For new Associates and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same benefit Plan Year.

PLAN YEAR ENDS: December 31

EMPLOYER INFORMATION:
OhioHealth Corporation
David P. Blom Administrative Campus
3430 OhioHealth Parkway
Columbus, OH 43202
1-614-533-8888

PLAN ADMINISTRATOR:
OhioHealth Corporation
David P. Blom Administrative Campus
3430 OhioHealth Parkway
Columbus, OH 43202
1-614-533-8888

PLAN SPONSOR:
OhioHealth Corporation
David P. Blom Administrative Campus
3430 OhioHealth Parkway
Columbus, OH 43202
1-614-533-8888

NAMED FIDUCIARY:
OhioHealth Corporation
David P. Blom Administrative Campus
3430 OhioHealth Parkway
Columbus, OH 43202
1-614-533-8888

AGENT FOR SERVICE OF LEGAL PROCESS:
OhioHealth Corporation
David P. Blom Administrative Campus
3430 OhioHealth Parkway
Columbus, OH 43202
1-614-533-8888

CLAIMS ADMINISTRATOR:
OhioHealthy
P.O. Box 2582
Hudson, Ohio 33236

SECTION XIX: DEFINITIONS

Accident (Accidental) means an unexpected, unforeseen, and unintended event that causes bodily harm or damage to the body.

Activities of Daily Living (ADL) means the following, with or without assistance: bathing, dressing, toileting and Associated personal hygiene; transferring (which is to move in and out of a bed, chair, wheelchair, tub or shower); mobility; eating (which is getting nourishment into the body by any means other than intravenous); and continence (which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

Acupuncture means a technique used to deliver anesthesia or analgesia, or for treating condition of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Adverse Benefit Determination means a denial, reduction or termination of a benefit or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Ambulance means a vehicle that is staffed with medical personnel and equipped to transport an Ill or Injured person.

Ambulance Transportation means professional ground or air Ambulance Transportation in an Emergency situation or when deemed to be Medically Necessary, which is both: to the closest facility most able to provide the specialized treatment required and the most appropriate mode of transportation consistent with the wellbeing of the Covered Person.

Ambulatory Surgical Center means a free-standing Surgery Center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures; (3) has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located; and (5) does not provide for overnight accommodations.

Ancillary Services means, with respect to an In-Network facility, (i) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a physician or non-physician practitioner, (ii) items and services provided by assistant surgeons, hospitalists, and intensivists; (iii) diagnostic services (including radiology and laboratory services); and (iv) items and services provided by an Out-of-Network Provider if there is no In-Network Provider who can furnish such item or service at such facility.

Associate is an employee as outlined in the Eligibility and Enrollment Procedures section of this Plan.

Authorized Representative means an individual (including a Provider) whom the Covered Person designates in writing to act on their behalf.

Balance Bill (Balance Billing) means the difference between what the Plan agrees to pay (i.e. Maximum Allowable Amount) to an Out-of-Network Provider versus the actual Provider's billed charge. An Out-of-Network Provider may be permitted to bill the Covered Person for this amount.

Behavioral Health Provider means a licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Birthing Center means a freestanding facility that meets all of the following requirements:

- Accepts only patients with low-risk pregnancies.
- Charges for its services.
- Extends staff privileges to Physicians who practice obstetrics and gynecology in an area Hospital.
- Has a Physician or certified nurse midwife present at all births and during the immediate postpartum period.
- Has a written agreement with a Hospital in the area for emergency transfer of a patient or a child; written procedures for such a transfer must be displayed and the staff must be aware of them.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is directed by at least one Physician who is a Specialist in obstetrics and gynecology.
- Is equipped and has trained staff to handle Emergency Medical Conditions and provide immediate support measures to sustain life if:
    - A child is born with an abnormality which impairs function or threatens life.
    - Complications arise during labor.
- Is set up, equipped, and run to provide prenatal care, delivery, and immediate postpartum care.
- Keeps a medical record on each patient and child.
- Meets licensing standards.
- Provides an ongoing quality assurance program. This includes reviews by Physicians who do not own or direct the facility.
- Provides, during labor, delivery and the immediate postpartum period, full-time Skilled Nursing Services directed by an R.N. or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.

Child (Children) means a Child as outlined in the Eligibility and Enrollment Procedures section of this Plan.

Close Relative means a spouse, domestic partner, parent, child, step-child, brother, sister, in-law, or any household member.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to a qualifying event.

Coinsurance is the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Continuing Care Patient means an individual who, with respect to a specific Provider, is: (i) undergoing a course of treatment for a Serious and Complex Condition from that Provider, (ii) undergoing a course of institutional or Inpatient care from that Provider, (iii) scheduled to undergo nonelective surgery from the Provider, including the receipt of postoperative care from such Provider with respect to such a surgery, (iv) pregnant and undergoing a course of treatment for the pregnancy from that Provider, or (v) terminally ill (or was terminally ill) as determined under Section 1861(dd)(3)(A) of the Social Security Act, and is receiving treatment for such illness from that Provider.

Copayment is the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits.

Cosmetic / Cosmetic Treatment means medical or surgical procedures which are primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons.

Covered Associate means an employee of the Employer that is covered under this Plan.

Covered Benefit means treatment, services, supplies, medicines, or facilities necessary and appropriate for the diagnosis, care or treatment of an Illness or Injury and that meet Medical Necessity for coverage as determined by the Plan. Covered Benefits do not include those listed under the General Exclusions section but include services, supplies, medicines, or facilities that are:

- Generally provided in accordance with accepted medical practice and professionally recognized standards;
- Provided safely at the appropriate level of care or services;
- Not provided solely for the convenience of the Covered Person, their family, or any Provider;
- Known to be effective in improving health outcomes. For new interventions, effectiveness is determined by scientific evidence, then by professional standards, and finally by expert opinions; and
- Cost-effective for the condition, compared to alternative interventions, including no intervention. Cost-effective does not necessarily mean the lowest price.

In determining Covered Benefits, consideration is given to the customary practice of Providers in the community or field of specialty. However, the fact that a Provider may prescribe, order, recommend or approve a service, supply, medicine, or facility does not, of itself, make the service a Covered Benefit.

Covered Expense means any expense, or portion thereof, which is Incurred as a result of receiving a Covered Benefit under this Plan.

Covered Person / Covered Associate means an Associate or Dependent who is enrolled under this Plan.

Custodial Care means non-medical care given to a Covered Person to administer medication and to assist with personal hygiene or other Activities of Daily Living rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered healthcare Provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce the disability or condition.

Day Care Treatment means a Partial Confinement Treatment program to provide treatment for a Covered Person during the day. The Hospital, Psychiatric Hospital or Residential Treatment Facility does not make a room charge for day care treatment. Such treatment must be available for at least 4 hours, but not more than 12 hours in any 24-hour period.

Deductible is the amount of Covered Expenses which must be paid by the Covered Person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent is a Child and/or spouse as outlined in the Eligibility and Enrollment Procedures section of this Plan.

Detoxification means the process, by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Alcohol in combination with drugs;
- Alcohol or drug-dependent factors; or
- Intoxicating alcohol or drug;

as determined by a Physician. The process must keep the physiological risk to the patient at a minimum and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Developmental Delays are characterized by impairment in various areas of development such as social interaction skills, adaptive behavior, and communication skills. Developmental Delays may not always have a history of birth trauma or other Illness that could be causing the impairment such as a hearing problem, mental Illness or other neurological symptoms or Illness.

Durable Medical Equipment means equipment which meets all of the following criteria:

- Is primarily used to serve a medical purpose with respect to an Illness or Injury;
- Can withstand repeated use;
- Not for exercise or training;
- Not for use in altering air quality or temperature;
- Generally, is not useful to a person in the absence of an Illness or Injury; and
- Is appropriate for use in the Covered Person's home.

Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

Effective Date means the first day of coverage under this Plan as defined in this Plan. The Covered Person's Effective Date may or may not be the same as their Enrollment Date (as defined by this Plan).

Emergency Department of a Hospital includes a Hospital Outpatient department that provides Emergency Services.

Emergency Facility means an Emergency Department of a Hospital or an Independent Freestanding Emergency Department.

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of Section 1867(e)(1)(A) of the Social Security Act. In that section, such clauses refer to (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in the serious jeopardy, (ii) serious impairment to body functions, or (iii) serious dysfunction of any body organ or part. Final determination as to whether services were rendered in connection with an emergency will rest solely with the Plan. The Plan will not limit what constitutes an Emergency Medical Condition solely on the basis of diagnosis codes, as required by the No Surprises Act.

Emergency Services, with respect to an Emergency Medical Condition, means (i) an appropriate medical screening examination (as required under Section 1867 of the Social Security Act or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of an Emergency Facility as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition, and (ii) within the capabilities of the staff and facilities available, such further medical examination and treatment as are required under section 1867 of the Social Security Act, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to Stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

In addition, Emergency Services include certain additional items and services (known as "post-stabilization services") (i) for which benefits are provided or covered under the Plan, and (ii) that are furnished by an Out-of-Network Provider or Emergency Facility (regardless of the department of the Hospital in which such items or services are furnished) after the Covered Person is Stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services described in the preceding sentence

are furnished; provided, however, that such items and services are **not** included as Emergency Services if all of the conditions in 45 CFR 149.410(b) are met.

Employer means OhioHealth Corporation, including its related entities, as applicable.

Enrollment Date means for:

- Anyone who applies for coverage when first eligible, the first day of the Waiting Period (if applicable); or
- Anyone who enrolls under the Special Enrollment Provision, the Enrollment Date is the first day coverage begins.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time and the applicable regulations.

Experimental, Investigational or Unproven means any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);

- Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one (1) or more large controlled national multi-center population-based studies;

- Items based on anecdotal and Unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established; or

- Items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered Experimental, Investigational or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility includes, but is not limited to a skilled nursing, rehabilitation, convalescent or subacute facility. It is an institution or a designated part of one (1) that is operating pursuant to the law for such an institution and is under the full time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: provide 24 hour-a-day service to include skilled nursing care and therapies deemed to be Medically Necessary for the recovery of health or physical strength; is not a place primarily for Custodial Care; requires compensation from its patients; admits patients only upon Physician orders; has an agreement to have a Physician's services available when needed; maintains adequate medical records for all patients; has a written

transfer agreement with at least one (1) Hospital and is licensed by the state in which it operates and provides the services under which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Gender Dysphoria is defined as a condition characterized by the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender also known as "natal gender", which is the individuals' sex determined at birth.

Generic Drug means a Prescription Drug, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by Pharmacy Benefit Manager.

Health Care Facility means (i) a Hospital (as defined in section 1861(e) of the Social Security Act); (ii) a hospital Outpatient department; (iii) a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); or (iv) an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information among other things.

Home Health Care Agency is an agency that meets all of the following requirements.

- Has an administrator.
- Has full-time supervision by a Physician or an R.N.
- Is Associated with a professional group (of at least one Physician and one R.N.) which makes policy.
- Keeps complete medical records on each person.
- Mainly provides Skilled Nursing Services and other therapeutic services.
- Meets licensing standards.

Home Health Care means a formal program of care and intermittent treatment that is: performed in the home; and prescribed by a Physician; and intermittent care and treatment for the recovery of health or physical strength under an established Home Health Care Plan; and prescribed in place of a Hospital or an Extended Care Facility or results in a shorter Hospital or Extended Care Facility stay; and organized, administered, and supervised by a Hospital or Qualified licensed Providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person's attending Physician which is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings by a Hospice Care Agency for Covered Persons suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Agency is an agency or organization that meets all of the following requirements:

- Assesses the patient's medical and social needs.
- Develops a Hospice Care Program to meet those needs.
- Establishes policies about how Hospice Care is provided.
- Has a full-time administrator.
- Has at least the following personnel one Physician, one R.N. and one licensed or certified social worker employed by the agency.
- Has Hospice Care available 24 hours a day.
- Keeps a medical record on each patient.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Permits all area medical personnel to utilize its services for their patients.
- Provides an ongoing quality assurance program. This includes reviews by Physicians, other than those who own or direct the agency.
- Provides Skilled Nursing Services, medical social services; and psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - Physician services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for Terminally Ill people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Uses volunteers trained in providing services for non-medical needs.

Hospice Facility means a facility or distinct part of one that meets all of the following requirements:

- Charges for its services.
- Has a full-time administrator.
- Is run by a staff of Physicians. At least one staff Physician must be on call at all times.
- Keeps a medical record on each patient.
- Mainly provides inpatient Hospice Care to Terminally Ill persons.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides 24-hour-a-day nursing services under the direction of an R.N.
- Provides an ongoing quality assurance program including reviews by Physicians other than those who own or direct the facility.

Hospice Care Program is a written plan of Hospice Care, which:

- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs;
- Is designed to provide palliative and supportive care to Terminally Ill persons, and supportive care to their families; and
- Is established by and reviewed from time to time by a Physician attending the person, and appropriate personnel of a Hospice Care Agency.

Hospital means:

- A facility that is licensed as an acute Hospital;
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons as Inpatients at the patient’s expense;
- Has a staff of licensed Physicians available at all times;
- It is accredited by The Joint Commission (formerly known as JCAHO), or is recognized by the American Hospital Association (AHA), or other recognized accrediting body or licensed by the state as an acute care

psychiatric, substance abuse or dual diagnosis facility for the treatment of Mental Health Disorders and is Qualified to receive payments under the Medicare program, or, if outside of the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country;
- Always provides 24 hour nursing services by registered graduate nurses; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, Hospital also includes Surgery Centers and Birthing Centers licensed by the state in which they operate and the following:

- A facility operating legally as a Psychiatric Hospital or Residential Treatment Facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least fifteen (15) resident patients; has a Physician in regular attendance; continuously provides twenty-four (24) hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Hospitalization means a continuous confinement as an inpatient in a Hospital for which a room and board charge is made.

Illness means a bodily disorder, disease, physical or mental Illness, functional nervous disorder, pregnancy, or complication of pregnancy. The term “Illness” when used in connection with a newborn Child includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Incurred means the date the service or treatment is given, the supply is received, or the facility is used, without regard to when the service, treatment, supply, or facility is billed, charged, or paid.

Independent Contractor means someone who signs an agreement with the employer as an Independent Contractor or an entity or individual who performs services to or on behalf of the employer who is not an Associate or an officer of the employer and who retains control over how the work gets done. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor shall be made consistent with Section § 530 of the Internal Revenue Code.

Independent Freestanding Emergency Department means a Health Care Facility that is geographically separate and distinct and licensed separately from a hospital under applicable state law and provides Emergency Services.

Infertility Treatment means services, tests, supplies, devices, or drugs which are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an Infertility condition when such treatment is done in an attempt to bring about a pregnancy.

Infertile / Infertility means the condition of a presumably healthy Covered Person who is unable to conceive or produce conception after:

- For a woman who is under 35 years of age: 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- For a woman who is 35 years of age or older: 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

Injury means a physical harm or disability to the body which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at the Hospital. A person is not an Inpatient on any day on which they are on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

Jaw Joint Disorder means:

- A Temporomandibular Joint (TMJ) dysfunction or any alike disorder of the jaw joint; or
- A Myofascial Pain Dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

Legal Guardianship/Guardian means the individual is recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

L.P.N. means a licensed practical or vocational nurse.

Maintenance Care means care made up of services and supplies that:

- Are given mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Give a surrounding free from exposures that can worsen the person's physical or mental condition.

Maximum Allowable Amount shall mean the maximum amount owed for services covered by the Plan. For purposes of Providers who have entered into agreements with the Preferred Provider Organization or have entered into agreements with the Plan for providing Specialized Services to Covered Persons, the Maximum Allowable Amount shall be the amount specified in such agreements. For services provided by Out-of-Network Providers required to be covered at the In-Network benefit level under the No Surprises Act, the Maximum Allowable Amount shall be the Recognized Amount. For all other purposes, the Maximum Allowable Amount shall be the Usual, Reasonable, and Customary Charge or a negotiated rate.

Note: The bill a Covered Person receives for services from Out-of-Network Providers may be significantly higher than the Maximum Allowable Amount. In addition to Deductible, Copayments and Coinsurance, the Covered Person may be responsible for the difference between the Maximum Allowable Amount and the amount the Provider bills for the services (if not prohibited by law). Any amount paid to the Provider in excess of the Maximum Allowable Amount will not apply to the Annual Out-of-Pocket Maximum or Deductible.

The Plan Administrator has the sole authority and discretion to determine the level of the Maximum Allowable Amount the Plan will use, and in all cases the Plan Administrator's determination will be final and binding.

Medically Necessary/Medical Necessity means Health care services, supplies or treatment that are required to identify or treat the Illness or Injury which a Physician has diagnosed or reasonably suspects. To be Medically Necessary the service, supplies or treatment must be:

1. Consistent with the diagnosis and treatment of the patient's condition;
2. Consistent with professionally recognized standards of health care;
3. Not solely for the convenience of the patient, Physician, or supplier; and
4. Performed in the least costly setting required by the patient's medical condition.

The fact that a Physician may have prescribed, ordered, recommended, or approved the services, supplies or treatment does not necessarily mean that they satisfy the above criteria.

To the extent any guidance, policies, or standards are used to determine Medical Necessity, such guidance, policies, or standards are incorporated into the Plan by reference herein and constitute binding Plan terms and conditions.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

If a service or supply is more expensive than an equivalent service or supply that is medically appropriate and is likely to produce the equivalent therapeutic or diagnostic result for the patient, the more expensive service or supply shall not be Medically Necessary, unless the Plan Administrator deems an exception is warranted in its sole and absolute discretion.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act as amended.

Mental Disorder means an Illness commonly understood to be a Mental Disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a Behavioral Health Provider such as a Psychiatric Physician, a psychologist or a psychiatric social worker.

Any one of the following conditions is a Mental Disorder under this Plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive Developmental Disorder (including Autism).
- Psychotic disorders/Delusional disorder.
- Schizo-affective disorder.
- Schizophrenia.

Morbid Obesity is defined as (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, or musculoskeletal dysfunction.

Negotiated Rate means the amount that Providers have contracted to accept a payment in full for Covered Expenses of the Plan, subject to the Covered Person's applicable Copayment, Deductible and Coinsurance.

Network describes Providers (acting within the scope of practice of their license or certification under applicable state law) and facilities that have signed a contract with the Plan (are in the Plan's "Network") and have a direct or indirect contractual relationship with the Plan for furnishing a specific item or service. In-Network Providers and facilities are also known as "participating" Providers and facilities. This type of In-Network is also called a Preferred Provider Organization (PPO) Network.

Night Care Treatment means a Partial Confinement Treatment program provided when a Covered Person needs to be confined during the night. A room charge is made by the Hospital, Psychiatric Hospital or Residential Treatment Facility. Such treatment must be available at least eight (8) hours in a row a night and five (5) nights a week.

No Surprises Act means The No Surprises Act enacted on December 27, 2020 as Title I of Division BB of the Consolidated Appropriations Act, 2021, including the implementing regulations and other binding guidance issued thereunder.

Occupational Injury or Occupational Illness means an Injury or Illness that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an Injury or Illness that does.

Occurrence means a period of Illness or Injury. An occurrence ends when 60 consecutive days have passed during which the Covered Person:

- Receives no medical treatment; services; or supplies; for a disease or Injury; and
- Neither takes any medication, nor has any medication prescribed, for a disease or Injury.

Orthodontic Treatment means any medical or dental service or supply furnished to prevent, diagnose or to correct a misalignment of the teeth, the bite, the jaws, or the jaw joint relationship whether or not for the purpose of relieving pain. The following are not considered Orthodontic Treatment:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.

Orthotic Appliances means braces, splints, casts and other appliances used to support or restrain a weak or deformed part of the body and is designed for repeated use, intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally is not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services or supplies in a facility in which a patient is not registered as a bed patient and room and board charges are not Incurred.

Out-of-Network describes Providers (acting within the scope of practice of their license or certification under applicable state law) and facilities that have not signed a contract with the Plan, and do not have a direct or indirect contractual relationship with the Plan for furnishing a specific item or service. Out-of-Network Providers and facilities are also known as "non-participating" Providers and facilities.

Out-of-Pocket Maximum is the total dollar amount listed on the Schedule of Benefits that a Covered Person will pay out-of-pocket for a majority of Covered Benefits during a Calendar Year any applicable Deductible has been met.

Partial Confinement Treatment means a plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat Substance Abuse or Mental Disorders. The plan must meet the following tests:

- Day Care Treatment and Night Care Treatment are considered Partial Confinement Treatment.
- It does not require full-time confinement.
- It is carried out in a Hospital; Psychiatric Hospital or Residential Treatment Facility; on less than a full-time inpatient basis.
- It is in accord with accepted medical practice for the condition of the person.
- It is supervised by a Psychiatric Physician who weekly reviews and evaluates its effect.

Pharmacy means an establishment where Prescription Drugs are legally dispensed. Pharmacy includes a retail Pharmacy, Mail Order Pharmacy and Specialty Pharmacy. Participating Pharmacy is a Pharmacy that has entered into a contractual agreement with the Pharmacy Benefit Manager (PBM), an affiliate, or a third party vendor, for the provision of Covered Services. A non-Participating Pharmacy is a Pharmacy that is not contracted and does not participate in the Pharmacy network.

Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who perform services payable under this Plan: a doctor of medicine (MD), doctor of dental medicine including oral surgeons (DMD), osteopathy (DO), podiatry (DPM), dentistry (DDS), chiropractic (DC),

optometry (OPT), a Physician's assistant (PA), a nurse practitioner (NP), a certified nurse midwife (CNM) when performed in a facility, or a certified registered nurse anesthetist (CRNA). The term Physician also may include, at the Plan Sponsor's discretion, other licensed practitioners who are regulated by a state or federal agency, who perform services payable under this Plan, and who are acting within the scope of their license, unless specifically excluded by this Plan.

Placed or Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan Participant has the same meaning as Covered Person.

Plan Administrator means the individual or organization responsible for administering the Plan, as set forth in Section XVI (General Plan Information).

Plan Sponsor means an employer who sponsors a group health plan, as set forth in Section XVI (General Plan Information).

Plan Year is the twelve (12) month period specified in Section XVI (General Plan Information).

Post-Service Claim is any claim for a benefit that is not a Pre-Service Claim. An example would be a claim for payment for a diagnostic test or other services that a Covered Person already had done.

Prescriber is any Physician or Dentist, acting within the scope of their license, who has the legal authority to write an order for a Prescription Drug.

Prescription is an order for the dispensing of a Prescription Drug by a Prescriber. If it is an oral order, it must be promptly put in writing by the Pharmacy.

Prescription Drug means a drug, biological, or compounded Prescription which, by State and Federal Law, may be dispensed only by Prescription and which is required to be labeled "Caution: Federal Law prohibits dispensing without Prescription." This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within their capacity as a paid healthcare professional.

Precertification means the process where OhioHealthy is contacted before certain services are provided, such as Hospitalization or Outpatient surgery. It is not a guarantee that benefits will be payable.

Pre-Service Claim means a claim for a benefit or service that requires Precertification prior to care being received. An example would be obtaining Precertification for a diagnostic test or medical procedure.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and wellbeing, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy.

Primary Care Physician (PCP) means a family practitioner, general practitioner, non-specializing internist (i.e., those that work out of a family practice clinic), pediatrician, nurse practitioner, or Physician's assistant. Generally, these Physicians provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners give routine medical care; internist treat routine and complex conditions in adults; and pediatricians treat Children.

Provider means a Physician or a Health Care Facility, Skilled Nursing Facility, urgent care center, laboratory, or any other duly licensed institution or health professional under contract to provide professional and hospital services to Covered Persons.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

Psychiatric Hospital is an institution that meets all of the following requirements:

- Has a Psychiatric Physician present during the whole treatment day;
- Is not mainly a school or a custodial, recreational, or training institution;
- Is staffed by Psychiatric Physicians involved in care and treatment;
- Is supervised full-time by a Psychiatric Physician who is responsible for patient care and is there regularly;
- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, Substance Abuse or Mental Disorders;
- Makes charges;
- Meets licensing standards;
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological, and social needs. The plan must be supervised by a Psychiatric Physician;
- Provides infirmary-level medical services. Also, it provides, or arranges with a Hospital in the area for, any other medical service that may be required;
- Provides, at all times, psychiatric social work, and nursing services;
- Provides, at all times, Skilled Nursing Services by licensed nurses who are supervised by a full-time R.N.

Psychiatric Physician is a Physician who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, Substance Abuse or Mental Disorders.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law - a court order requiring a parent to provide health care coverage to one or more children.

Qualified means licensed, registered, or certified by the state in which the Provider practices.

Qualifying Payment Amount (QPA) under the No Surprises Act is generally the Plan's median In-Network contracted rate for the same or similar service provided within the same medical specialty and same geographic area, adjusted for cost-of-living increases.

Recognized Amount under the No Surprises Act means one of the following: (1) an All-Payer Model Agreement; (2) existing state law or regulation; or if no All-Payer Model Agreement or state law is in place (3) the lesser of the billed amount or the Qualifying Payment Amount.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic when a physical impairment exists, and the surgery restores or improves function.

Rehabilitation Services means the combined and coordinated use of medical, social, educational, and vocational measures for training or retraining of a patient disabled by Illness or Injury.

Residential Treatment Facility (for Mental Health Disorders) is an institution that meets all of the following requirements:

- Has access to necessary medical services 24 hours per day/7 days a week;
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission;

- Has peer-oriented activities;
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults);
- Is admitted by a Physician;
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located;
- Offers group therapy sessions with at least an RN or Masters-level health professional;
- On-site licensed Behavioral Health Provider 24 hours per day/7 days a week;
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission);
- Provides a level of skilled intervention consistent with patient risk;
- Provides access to at least weekly sessions with a Psychiatrist or psychologist for individual psychotherapy;
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs; and
- Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the OhioHealthy credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).

Residential Treatment Facility (for Substance Use Disorders) is an institution that meets all of the following requirements:

- 24-hours per day/7 days a week supervision by a Physician with evidence of close and frequent observation; and
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on-site or externally;
- Has access to necessary medical services 24 hours per day/7 days a week;
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission;
- Has peer-oriented activities;
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults);
- If the Covered Person requires Detoxification services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending Physician;
- Is admitted by a Physician;
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located;
- Offers group therapy sessions with at least an RN or Masters-level health professional;
- On-site, licensed Behavioral Health Provider, medical or Substance Abuse professionals 24 hours per day/7 days a week;
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission);
- Provides a level of skilled intervention consistent with patient risk;
- Provides access to at least weekly sessions with a Psychiatrist or psychologist for individual psychotherapy;
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs; and
- Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the OhioHealthy credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).

Semi-Private Room Rate means the room and board charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, OhioHealthy will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Serious and Complex Condition is: (i) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm, or (ii) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, and that requires specialized medical care over a prolonged period of time.

Service Area is the geographic area, as determined by OhioHealthy, in which Network Providers for this Plan are located.

Skilled Nursing Facility is an institution that meets all of the following requirements:

- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law;
  - Is primarily engaged in providing Skilled Nursing Services and related services for residents who require medical or nursing care, or Rehabilitation Services for the rehabilitation of injured, disabled, or sick persons;
- Charges patients for its services;
- Has a utilization review plan;
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of Mental Disorders;
- Is supervised full-time by a Physician or an R.N.;
- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from Illness or Injury:
  - Professional nursing care by an R.N., or by an L.P.N. directed by a full-time R.N.; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities;
- Keeps a complete medical record on each patient;
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.;
- Qualifies as a Skilled Nursing Facility under Medicare or as an institution accredited by:
  - The Bureau of Hospitals of the American Osteopathic Association;
  - The Commission on the Accreditation of Rehabilitative Facilities; or
  - The Joint Commission on Accreditation of Health Care Organizations

Skilled Nursing Facilities also include rehabilitation Hospitals (all levels of care, e.g. acute) and portions of a Hospital designated for skilled or Rehabilitation Services.

Skilled Nursing Facilities does not include:

- Institutions which provide only minimal care, Custodial Care services, ambulatory; or part-time care services; or
- Institutions which primarily provide for the care and treatment of alcoholism, Substance Abuse or Mental Disorders.

Skilled Nursing Services are services that meet all of the following requirements:
- The services require medical or paramedical training;
- The services are rendered by an R.N. or L.P.N. within the scope of their license; and
- The services are not custodial.

Specialist means a Provider who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Providers that are not considered a Specialist include, but are not limited to, family practitioners, non-specializing internists, or pediatricians. An OB/GYN is considered a specialist.

Stabilize (Stabilization) has the meaning given in section 1867(e)(3) of the Social Security Act.

Substance Use Disorder / Substance Abuse means a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to the Covered Person.) This term does not include conditions not attributable to a Mental Disorder that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food, or caffeine intoxication.

Surgery Center means a freestanding Ambulatory Surgical Center that meets all of the following requirements:

- Charges for its services;
- Does not have a place for patients to stay overnight;
- Extends surgical staff privileges to Physicians who practice surgery in an area Hospital; and Dentists who perform oral surgery;
- Has at least 2 operating rooms and one recovery room;
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period;
- Is directed by a staff of Physicians. At least one of them must be on the premises when surgery is performed and during the recovery period;
- Is equipped and has trained staff to handle Emergency Medical Conditions;
- Is set up, equipped, and run to provide general surgery;
- Meets licensing standards;
- Provides, in the operating and recovery rooms, full-time Skilled Nursing Services directed by an R.N.; and
- Provides, or arranges with a medical facility in the area for, diagnostic X-ray and lab services needed in connection with surgery.
- Must have all of the following:
- A blood volume expander;
- A defibrillator;
- A Physician trained in cardiopulmonary resuscitation;
- A tracheotomy set;
- Has a written agreement with a Hospital in the area for immediate emergency transfer of patients;
- Keeps a medical record on each patient; own or direct the facility;
- Provides an ongoing quality assurance program. The program must include reviews by Physicians who do not; and
- Written procedures for such a transfer must be displayed and the staff must be aware of them.

Surprise Medical Bill (Surprise Billing) means an unexpected Balance Bill. This can happen when a Covered Person cannot control who is involved in their care, such as when a Covered Person has an Emergency Medical Condition or when a Covered Person schedules a visit at an In-Network facility but are unexpectedly treated by an Out-of-Network Provider.

Terminal Illness or Terminally Ill means a life expectancy of 6 months or less to live.

Third Party Administrator (TPA) is a service Provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled means the following:

- The Associate is unable to perform any job or any occupation or business for which they are qualified by education, training or experience and are not engaged in any occupation for wage or profit; or

- A covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.

Urgent Care Provider means a freestanding medical facility that meets all of the following requirements:

- Has a full-time administrator who is a licensed Physician;
- Is licensed and certified as required by any state or federal law or regulation;
- Is run by a staff of Physicians with at least one Physician on call at all times;
- Keeps a medical record on each patient;
- Makes charges;
- Provides an ongoing quality assurance program. This includes reviews by Physicians other than those who own or direct the facility;
- Provides unscheduled medical services to treat an Urgent Condition if the person's Physician is not reasonably available; and
- Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.

An Urgent Care Provider also means a Physician's office that has contracted with OhioHealthy to provide Urgent Care and classified as a Network Urgent Care Provider.

Urgent Care Claims means a request for medical care or treatment where using the normal Precertification requirements would:

- Seriously jeopardize the Covered Person's life or health; or
- Seriously jeopardize the ability of the Covered Person to regain maximum function; or
- In the opinion of a Physician with knowledge of the Covered Person's medical condition, subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment.

Urgent Care is the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have an Injury or Illness that requires immediate care but is not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Urgent Condition means a sudden Illness or Injury that:

- Does not require the level of care provided in the emergency room of a Hospital;
- Includes a condition which would subject Covered Person to severe pain that could not be adequately managed without Urgent Care or treatment.
- Is severe enough to require prompt medical attention to avoid serious deterioration of the Covered Persons health; and
- Requires immediate Outpatient medical care that cannot be postponed until the Covered Person's Physician becomes reasonably available.

Usual, Customary and Reasonable (UCR) Allowance is the prevailing fee or fees most frequently accepted by Providers of the same services with similar training and experience for comparable services, or services of comparable gravity, severity, and magnitude, in the locality where the services were performed. The UCR allowance is established using historical data within a specific geographical area, supplemented by data provided by independent research firms that specialize in collecting this data. For Network charges, the UCR is the fee set forth in the negotiated fee schedule. All charges shall be deemed to be Incurred as of the date of the treatment that gives rise to the charge or as of the date of purchase of the supply or service covered by the charge.

The Plan Administrator has the sole authority and discretion to determine the UCR Allowance for each service, and in all cases the Plan Administrator's determination will be final and binding. The Plan Administrator, in its sole discretion, shall determine which data shall be relied upon for making the UCR Allowance determination. Any data not relied upon by the Plan Administrator has no relevance to the UCR Allowance determination and is expressly excluded from consideration in reaching the UCR Allowance amount. Such excluded data shall not be taken into account if any dispute arises over the amount of the UCR Allowance.

Virtual Consult means a medical consult using a secure platform (as determined by OhioHealthy in its sole discretion) with email, interactive video, and telephone to connect a Provider and a patient.

Waiting Period means the period of time that must pass before coverage can become effective for an Associate or Dependent who is otherwise eligible to enroll under the terms of this Plan. (See Eligibility and Enrollment Procedures section of this Plan to determine what, if any, Waiting Period applies.)

Walk-in Clinics are freestanding health care facilities. They are an alternative to a Physician's office visit for:

- Injuries;
- Non-Emergency Illnesses;
- The administration of certain immunizations; and
- Treatment is unscheduled.

It is not an alternative for emergency room services, or the ongoing care provided by a Physician. Neither an emergency room, nor the Outpatient department of a Hospital, shall be considered a Walk-in Clinic.