CITY OF STOW
EMPLOYEE GROUP
HEALTH BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

EFFECTIVE DATE
January 1, 2011

REVISED DATE
August 1, 2020

FOR COVERAGE INQUIRIES OR TO CONTACT THE CLAIMS ADMINISTRATOR:

MUTUAL HEALTH SERVICES
P.O. Box 5700
Cleveland, Ohio 44101
Phone: (330) 666-0337 or
1-800-367-3762 National Toll Free

PLAN AMENDMENT AND SUMMARY OF MATERIAL MODIFICATIONS

This Amendment amends your Employee Benefit Plan Document (Plan) and becomes a part of your Plan as of the effective date stated for each Part below. Please place this Amendment with your Plan Document/Summary Plan Description for future reference.

PART I: EFFECTIVE MARCH 22, 2022:

1. **Any current reference in the Medical Schedule of Benefits to "Telemedicine Services" coverage is changed to "Telehealth Services". The benefit(s) will remain payable as currently shown.**

2. **The language for "Telemedicine Services" under the Medical-Surgical Benefits entitled, "Outpatient Medical Care" is deleted in its entirety and replaced with the following:**

   Telehealth Services

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

3. **The following definition is added and replaces any existing definition for "Telemedicine Services":**

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

PART II: PLAN CLARIFICATION:

The "Plan Amendment and Summary of Material Modifications" ("Amendment") issued in the fourth quarter of 2021 concerning the No Surprises Act is clarified as follows:

a. **The effective date of the Amendment is January 1, 2022 (not on the first day of the Plan's next Plan Year occurring on or after January 1, 2022).**

b. **The bullet point in the provision entitled, "No Surprise Billing" that states, "Air ambulance Covered Services received from a Non-Contracting Provider" is clarified to state, "Ambulance services received from a Non-Contracting Provider. Please refer to the Ambulance Services benefit for additional information."**

Please note: This is not a benefit change but a clerical correction.

The Plan Administrator adopts the terms and conditions set forth in this Amendment as of the effective date stated for each Part above, regardless of the date signed below. This Amendment terminates concurrently with the Plan to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Plan except as stated.

CITY OF STOW
Plan Administrator

Signature on behalf of the Plan

JOHN D. PRIBONIC
Printed Name and Title

Group Name, if the Plan is not administered by the Group

ALL PLANS
Plan Name

3/22/2022
Date

CITY OF STOW
EMPLOYEE GROUP
HEALTH BENEFIT PLAN

PLAN AMENDMENT AND SUMMARY OF MATERIAL MODIFICATIONS

This Amendment amends your Employee Benefit Plan Document (Plan) and becomes a part of your Plan effective on January 1, 2022, unless stated otherwise. Please place this Amendment with your Plan Document/Summary Plan Description for future reference.

1. **Any reference to the term, "Gender Dysphoria Treatment" is replaced with the term, "Gender Affirming Services".**

2. **The provision entitled "Exclusions Applicable to Comprehensive Major Medical Expense Coverage" is clarified only as follows:**

   (20) Charges for cosmetic products, **wigs**, hair replacement, transplant, removal or hair growth stimulants.

The City of Stow adopts the terms and conditions set forth in this Amendment as of the effective date, regardless of the date signed below. This Amendment terminates concurrently with the Plan to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Plan except as stated.

Signature on behalf of the Plan

JOHN D. PRIBONIC, MAYOR

Printed Name and Title

1/15/2022

Date

GRANDFATHERED HEALTH PLAN DISCLOSURE

The City of Stow believes this Plan is a "grandfathered health plan" under the PPACA. As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your human resources department. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

PLAN AMENDMENT AND SUMMARY OF MATERIAL MODIFICATIONS

This Amendment amends your Employee Benefit Plan Document (Plan) and becomes a part of your Plan effective on the first day of the Plan's next Plan Year occurring on or after January 1, 2022. Please place this Amendment with your Plan Document/Summary Plan Description for future reference.

1. **The following is added to the Medical Schedule of Benefits and to the "General Information" provision:**

   No Surprises Act

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

2. **Any reference in the Plan to precertification for Emergency Services or Emergency Medical Conditions being required is deleted.**

3. **The following are added to the provisions entitled, "Preferred Provider Organization (PPO)," "Exclusive Provider Organization (EPO)" or "Network Provider," as applicable:**

   a. No Surprise Billing

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

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

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

   For PPO Plans, the following is added:

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

For EPO or Network only Plans, the following is added:

Remember that, outside of the services described herein, this Plan does not cover services received from Non-Contracting Providers. Should you elect to knowingly and purposefully seek care from a Non-Contracting Provider and voluntarily give consent for services for which you can be balance billed, you will be responsible for ALL charges related to services received from that Non-Contracting Provider. Before you can consent to be balance billed, your Non-Contracting Provider must give you, or your authorized representative, a written notice, in advance of performing the service, that includes detailed information designed to ensure that you knowingly accept all of the out-of-pocket charges. The notice must also include an estimate of the Health Care Provider's charge for the services.

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

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

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

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

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

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

Serious and Complex Condition means:

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

4. The following benefit is added to the section entitled, "Medical-Surgical Benefits" or, if already included in the Plan, replaces any existing benefit for Emergency Services:

EMERGENCY SERVICES

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

In the event of an emergency:

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

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

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

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

For Plans subject to ERISA, the following is added:

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

For Non-ERISA Plans, the following is added:

Your Plan will calculate the amount to be paid for Non-Contracting Emergency Services in three different ways and pay the greatest of the three amounts: 1) the amount your Plan pays to PPO/EPO Network Providers for the Emergency Services furnished (this calculation is not required if your Plan does not have negotiated per service amounts with PPO/EPO Network Providers for the services furnished); 2) the amount that would be paid using the same method your Plan generally uses to determine payment for Non-Contracting Provider services but substituting PPO/EPO network Copayments and Coinsurance amounts; and (3) the amount that would be paid under Medicare for the services provided. All three of these amounts are calculated before application of any PPO/EPO network Copayments or Coinsurance.

5. The following definitions are added, if not already included in the Plan Document/Summary Plan Description:

Contracting - the status of a Health Care Provider:

- that has an agreement with Mutual Health Services about payment for Covered Services; or
- that is designated by Mutual Health Services as Contracting.

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

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

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

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

Independent Freestanding Emergency Department – a health care facility that:

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

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

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

The Plan Administrator adopts the terms and conditions set forth in this Amendment as of the effective date, regardless of the date signed below. This Amendment terminates concurrently with the Plan to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Plan except as stated.

City of Stow
Plan Administrator

Signature on behalf of the Plan

JOHN D. PRIBONIC, MAYOR
Printed Name and Title

Group Name, if the Plan is not administered by the Group

ALL
Plan Name

1/15/2022
Date

PLAN AMENDMENT AND SUMMARY OF MATERIAL MODIFICATIONS

This Amendment amends your Employee Benefit Plan Document (Plan) and becomes a part of your Plan, effective January 1, 2021. Please place this Amendment with your Plan Document/summary of benefits for future reference.

1. **The Medical Schedule of Benefits is amended for Telemedicine Services as shown below. Telemedicine Services may be scheduled in advance or be "on-demand."**

   a. **If not currently a Covered Service in the Plan, coverage for On-Demand, Virtual Telemedicine Services is added at the Plan's applicable in-network or out-of-network Physician Office Visit/Consultation benefit.**

   b. **Any current coverage for On-Demand, Virtual Telemedicine Services will remain payable as shown for the in-network benefit. Out-of-network coverage is added at the Plan's current Physician Office Visit/Consultation out-of-network benefit.**

   c. **Scheduled Telemedicine Services will remain payable at the Plan's applicable in-network or out-of-network Physician/Specialist Office Visit/Consultation benefit.**

2. **The language for Telemedicine Services under the Medical-Surgical Benefits entitled, "Outpatient Medical Care" is deleted in its entirety and replaced with the following:**

   Telemedicine Services

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

3. **Any exclusion referencing services delivered through telecommunication or other electronic technology (e.g., electronic mail, audio, video, etc.) is deleted.**

4. **The following definition is added and replaces any existing definition for "Telemedicine Services":**

   Telemedicine Services – a mode of providing health care services through synchronous or asynchronous information and communication technology by a health care professional, within the professional's scope of practice, who is located at a site other than the site where the recipient is located.

The Plan Administrator adopts the terms and conditions set forth in this Amendment as of the effective date, regardless of the date signed below. This Amendment terminates concurrently with the Plan to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Plan except as stated.

CITY OF STOW
Plan Administrator

Signature on behalf of the Plan

JOHN PRIBNIC, MAYOR
Printed Name and Title

Group Name, if the Plan is not administered by the Group

Plan Name

11/24/2020
Date

PLAN AMENDMENT AND SUMMARY OF MATERIAL MODIFICATIONS

This Amendment amends your Employee Benefit Plan Document (Plan) and becomes a part of your Plan, effective January 27, 2020. Please place this Amendment with your Plan Document/summary of benefits for future reference.

1. **Any current reference in the Medical Schedule of Benefits to "Telehealth" coverage is changed to "On-Demand, Virtual Telemedicine/Telehealth Services". The benefit will remain payable as currently shown.**

2. **The following is added to the Medical Schedule of Benefits and the "General Information" provision:**

   To the extent state or federal law requires different benefits than described herein, this section will be deemed to include those benefits.

3. **COVID-19 treatment does not include testing and the items and services related to the provider's associated visit, which may include a telehealth (also known as "telemedicine") visit, urgent care or emergency room visit, to determine whether the COVID-19 testing is required and to administer the test, which are required by law to be covered without member cost sharing, as described in Item 5 below. Therefore, the following is added to the Medical Schedule of Benefits:**

   COVID-19 treatment will be paid at the in-network level of benefits, whether the services are rendered in network or out of network; all member cost sharing, as applicable, will apply.

4. **The "Employee Eligibility" provision is amended as follows:**

   During the term of the national public health emergency declared by HHS on January 31, 2020 (effective January 27, 2020), otherwise eligible Employees who are impacted by COVID-19, including but not limited to, layoffs, furloughs, reduced hours or reduced pay, will continue to be covered under the Plan, regardless of any "actively at work" or similar eligibility requirements, provided the Plan remains in effect.

5. **The following benefit is added for COVID-19 services:**

   Coverage is provided for COVID-19 testing, as well as any items and services related to the provider's associated visit, which may include a telehealth (also known as "telemedicine") visit, urgent care or emergency room visit, to determine whether the COVID-19 testing is required and to administer the test. This coverage is not subject to member cost sharing, prior authorization or medical management requirements. This requirement is only in effect during the national public health emergency declared by HHS on January 31, 2020 (effective January 27, 2020), or as required by law, if any provisions of this section are extended beyond the emergency period.

6. **The following is added to the Medical-Surgical Benefits entitled, "Outpatient Medical Care" and replaces any existing benefit that addresses services not performed in-person (telehealth):**

   This Plan provides coverage for Telemedicine/Telehealth Services no less favorably than its coverage for the provision of in-person health care services. Coverage for Telemedicine/Telehealth Services includes the use of an interactive two-way telecommunications system, which includes both an audio and video component.

   During the term of the national public health emergency declared by HHS on January 31, 2020 (effective on January 27, 2020) , certain additional services, such as physical therapy, occupational therapy and speech therapy are also covered under the Plan but may require both an audio and visual component through a portal, in order to be covered.

7. **The following exclusion is added and replaces any existing exclusion for telephone or internet consultations or similar telehealth consultations:**

   Telephone consultations or consultations by electronic mail or facsimile, except as required by law, authorized by the Plan or as otherwise described herein.

8. **The following definition is added:**

Telemedicine/Telehealth Services – certain services that are provided by a provider who is not at the same location as the patient, using an interactive two-way telecommunications system, which includes both an audio and video component.

The Plan Administrator adopts the terms and conditions set forth in this Amendment as of the effective date, regardless of the date signed below. This Amendment terminates concurrently with the Plan to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the Plan except as stated.

JOHN. D. PRIBONIC
Plan Administrator

Signature on behalf of the Plan

CITY OF STOW
Group Name, if the Plan is not administered by the Group

JOHN D. PRIBONIC, MAYOR
Printed Name and Title

Plan Name

5-5-2020
Date

Welcome to the City of Stow Employee Group Health Benefit Plan.

The purpose of this Health Benefit Plan is to help protect you and your family from the financial burden which may arise as a result of an unexpected accident or illness.

This Plan is as comprehensive as possible and offers you the flexibility of choosing your health care provider while encouraging you to use the plan wisely. We have selected a medical-review organization to provide Hospital Pre-Admission Certification services. Please be sure to review the Hospital Pre-Admission Certification requirement included in this Summary Plan Description. All Covered Persons must comply with this requirement to obtain full benefits under the Plan.

This Plan is a self-funded benefit plan. City of Stow has retained the services of a professional Claims Administrator to perform the day-to-day claims administration of the Plan, but the ultimate risk of loss belongs to the City of Stow. City of Stow, as Plan Administrator, has the final, sole discretion to interpret the Plan, decide any questions of eligibility, and determine any benefits which are payable under the Plan.

While City of Stow expects in good faith to continue this Plan indefinitely, it reserves the right to amend, suspend, or terminate the Plan in whole or in part, at any time, with or without advance notice. Any amendment or modification to the Plan must be made in writing, properly adopted, and signed by an authorized representative of City of Stow.

We encourage you to become familiar with the contents of this Summary Plan Description to help you understand the benefits available to you. If, after reviewing the Summary Plan Description, you have any questions, please contact the Finance department health care plan coordinator, your Human Resource Representative or Mutual Health Services.

Sincerely,

City of Stow

CITY OF STOW
HEALTH BENEFIT PLAN

As required under the Employee Retirement Income Security Act of 1974, this booklet provides you with a “Summary Plan Description” of your new Health Benefit Plan. You will notice that a brief description of your benefits is provided for your convenience.

While this booklet describes the principal provisions in your Plan in simplified terms, it is not a contract, and will not be binding over a Plan provision. The administration of your Plan is subject to the actual terms and provisions of the Plan as set forth in the formal Summary Plan Document. This description is intended only to help you understand the Plan and can in no way be considered to modify the actual terms and provisions as specified in the Summary Plan Document if adopted by the City.

The following important information is provided to help you understand your legal rights under the Plan.

The Plan has specific conditions that you must meet to be eligible to receive benefits. Please see the “Employee Eligibility” and “Dependent Eligibility” sections of this booklet. This booklet, called a Summary Plan Description, describes the benefits that are available under the Plan. Please see the “Schedule of Benefits” and the “Description of Coverage” sections.

Circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of any benefits are described in the “Schedule of Benefits”, “Exclusions”, “Termination of Employee Coverage” and “Termination of Dependent Coverage” sections of this booklet. You may also lose benefits if you defraud the Plan, or if the Employer is unable to pay benefits.

The Plan can be amended, discontinued or terminated at any time without prior notice to you. Any such change in coverage takes effect immediately for you and your Dependents whether or not you are actively at work.

I
PLAN INFORMATION

Name and Type of Plan

The name of the Plan is the City of Stow Employee Group Health Benefit Plan. The Plan provides medical and dental benefits.

Name and Address of the Employer

City of Stow
3760 Darrow Road Stow, Ohio 44224 (330)
689-2890

Plan Sponsor

The Employer named above is the Plan Sponsor.

Plan Administrator

The Plan Sponsor named above is the Plan Administrator. The Plan Administrator has the discretionary authority to interpret the Plan, including those provisions relating to eligibility and benefit determination. The Plan Administrator's interpretations and determinations are final and binding.

Agent for Service of Legal Process

Service of legal process may be made upon the Plan Administrator.

Plan Trustees

None

Type of Administration of the Plan

The Plan is partially a self-funded plan and is administered directly by the Plan Administrator with claims being paid on behalf of the Plan by the Claims Administrator, Mutual Health Services, P.O. Box 5700, Cleveland, Ohio, 44101, in accordance with the provisions of the Plan Document. The Employer is solely responsible for funding and payment of Benefits under the Plan. Mutual Health Services is the designated claims paying agent only and does not insure or underwrite the Employer's liability under the Plan.

Funding and Source of Contributions

The Plan is a partially self-funded Plan. The Employer has established and maintains a separate account to accumulate assets in an amount necessary to pay benefits.

Plan Year

The fiscal records of the Plan are kept on a Plan Year basis ending on each December 31st.

Internal Revenue Service Identification Numbers

Plan Sponsor Identification Number (EIN): 34-6002740
Plan Number (PN): 502

Authority of City Council and Collective Bargaining Agreement

The Plan is maintained pursuant to authorization of Stow City Council and collective bargaining agreements. An employee may obtain a copy of the applicable agreement by sending a written request to the Plan Administrator. He may examine such agreement during normal working hours at the office of the Plan Administrator.

Preferred Provider Organization (PPO)

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

In the following situations, services rendered by a Non-PPO Network Provider will be considered at the PPO level:

- Certain PPO Network Provider Hospital-affiliated Physicians who are Non-PPO Network Providers. This is limited to charges for anesthesiologists and emergency room Physicians and the professional component charges for pathology and radiology;
- Covered Persons residing outside the PPO Network Provider service area who are treated by providers outside the service area;
- Student Dependents living outside the PPO Network Provider service area who are treated by Non-PPO Network Providers while attending school or Covered Persons visiting outside the PPO Network Provider service area who require Medically Necessary care;
- Treatment of an Acute Medical Condition;
- Charges made by Non-PPO Network Providers for services that are not available within the scope of PPO Network Providers;
- Referrals by PPO Network Providers.

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

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

Medical Mutual SuperMed PPO

Aetna Open Choice PPO/NAP

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

II
SCHEDULE OF BENEFITS

This Plan includes a mandatory Hospital Pre-Admission Certification requirement. This medical review requirement must be followed to prevent a reduction in benefits payable by the Plan.

COMPREHENSIVE MAJOR MEDICAL EXPENSE COVERAGE

The Plan will pay, after satisfaction of the specified Deductible Amount, the Benefit Percentage and any applicable co-insurance indicated in the Schedule of Benefits, subject to the specified maximums.

The level of benefits payable under this Plan depends upon whether a Covered Person chooses to obtain medical care from a PPO Network Provider or Non-PPO Network Provider. The Plan encourages the selection of a PPO Network Provider by paying higher benefits when a Covered Person obtains medical care from a PPO Network Provider.

Certain facilities, medical centers, and medical providers have been designated as PPO Network Providers under this Plan. Treatment obtained from any PPO Network Provider is payable as specified in the Schedule of Benefits under Network benefits. A separate listing or directory of Network medical providers designed to assist the Covered Person in the selection of PPO Network Providers will be provided automatically as a separate document by the Employer at no charge. Outpatient Prescription Drugs are payable under Network benefits.

All other medical providers and facilities are considered Non-PPO Network Providers. Treatment obtained from any Non-PPO Network Provider is payable as specified in the Schedule of Benefits under Non-Network benefits.

PPO Network Provider benefits will be paid for Non-PPO Network Providers under certain circumstances as shown on page 7 in the section entitled **"**Preferred Provider Organization (PPO)".

Charges made by a Non-PPO Network Provider may exceed the Allowed Amount for such procedures and a Covered Person may be balance billed for the difference. A Covered Person will not be balance billed for procedures performed by a PPO Network Provider in excess of the PPO Network Provider fee schedule.

Any amount applied toward the PPO Network Provider Calendar Year Deductible Amount will be applied toward the Non-PPO Network Provider Calendar Year Deductible Amount, and vice versa.

Any amount applied toward the PPO Network Provider Out-of-Pocket Maximum will be applied toward the Non-PPO Network Provider Out-of-Pocket Maximum, and vice versa.

Any overall maximums as shown in the Schedule of Benefits are Plan maximums that apply to PPO Network Providers and Non-PPO Network Providers benefits combined.

SCHEDULE OF BENEFITS
COMPREHENSIVE MAJOR MEDICAL BENEFITS

Precertification Review: Precertification review is required for all inpatient Hospital Confinements. For elective stays, certification is required at least 24 hours prior to admission. For emergency admissions, certification is required within 48 hours following admission.

If preadmission Hospital certification is not utilized, your benefits under the Plan may be reduced by 50% up to $500.00.

All benefits will be based upon Allowed Amount

Annual Maximum Amount Payable per Individual is…….. Unlimited
(The Lifetime Maximum of $20,000 on Morbid Obesity Treatment including any related surgeries continues to apply)

Network (PPO Network Providers)

Calendar Year Deductible:
Per Individual……$450.00
Per Family……$900.00

Then: all eligible charges will be paid at 80% until the maximum out-of-pocket amount has been satisfied.

With: 100% payment on eligible charges thereafter for that individual for the remainder of that Calendar Year.

Maximum Out-of-Pocket Expense per Calendar Year (including the Deductible)
Per Individual……$800.00
Per Family……$1,600.00

Non-Network (Non-PPO Network Providers)

Calendar Year Deductible:
Per Individual……$950.00
Per Family……$1,900.00

Then: all eligible charges will be paid at 60% until the maximum out-of-pocket amount has been satisfied.

With: 100% payment on eligible charges thereafter for that individual for the remainder of that Calendar Year.

Maximum Out-of-Pocket Expense per Calendar Year (including the Deductible):
Per Individual……$1,300.00
Per Family……$2,600.00

Deductible and Out of Pocket Expenses Do Cross Apply

The Out-of-Pocket Maximum does not include expenses incurred because of failure to comply with the Hospital Pre-Admission Certification requirement.

COVERED SERVICES

Subject to Deductible unless otherwise stated:	**Percentage Payable Network**	**Non-Network**
Inpatient Maximum Daily Semi-Private Room Charge	80%	60%
Private Room Rate (The Hospital's average semi-private room rate)	80%	60%
Special Care Unit (ICU & CCU)	80%	60%
Inpatient Miscellaneous Charges	80%	60%
Inpatient Physicians Visits	80%	60%
Preadmission Testing	100% no Deductible	60%
Diagnostic X-ray and Lab	100% no Deductible for the first $200.00 per Calendar Year then 80%	60%
Consultation Expenses	80%	60%
Surgical Expense Benefits	80%	60%
Second Surgical Opinion	80%	60%
Outpatient Surgery (Includes Office Surgery)	100% no Deductible	60%
Outpatient Surgical Facility	100% no Deductible	60%
Outpatient Hospital	100% no Deductible	60%
Durable Medical Equipment	80%	60%
Anesthesia (Inpatient)	80%	60%
Anesthesia (Outpatient)	100% no Deductible	60%
Ambulance Services	80%	60%
Emergency Room Treatment	80%	80%
Non-Life Threatening Emergency Room	80%	60%
Physician/Specialist Office Visits Including Scheduled Telemedicine Services.	80%	60%
Office Related Charges (X-Ray, Lab and Injections)	80%	60%
Allergy Testing/Treatments/Injections	80%	60%

COVERED SERVICES

Subject to Deductible unless otherwise stated:	**Percentage Payable Network**	**Non-Network**
Routine Colonoscopy- Employees and Dependents age 50 and over One every 10 years maximum	100% no Deductible	60%
Routine Colonoscopy- Employees only age 40 and over One every 5 years maximum	$750 Deductible* then 100%	Not Covered

*$750 Deductible is separate from any Deductible as shown in the Medical Schedule of Benefits and does not apply to the Maximum Out-of-Pocket Expense per Calendar Year.

Wellness Benefits (Age 9+) (Includes (one exam per Calendar Year of each) -routine physical examinations, mammogram, gynecological exam, pap test, prostate exams and unlimited immunizations) (Also includes: 12-lead electrocardiogram, imaging cardiac stress test at age 40 and over with no more than 1 per 3 years maximum, resting echocardiogram (one per Lifetime Maximum), spirometry ((FEV1, FVC, FEV1/FVC), chest x-ray with no more than one per 5 years maximum, and routine lab tests normally associated with annual physical examinations)	100% no Deductible	60%
Well Child Benefit (Birth to age 9) (unlimited visits from birth to age 9)	100% no Deductible	60%
Vitamins/Supplements (Birth to age 3)	100% no Deductible	60%
Therapy Services (Includes Medically Necessary, chemotherapy, dialysis, hyperbaric and pulmonary therapy, occupational therapy, radiation therapy, respiratory therapy, speech therapy and physical therapy)	80%	60%
Cardiac Rehabilitation	80%	60%
Chiropractic Care (12 visits maximum per Calendar Year)	80%	60%
Skilled Nursing Care (100 days maximum per Calendar Year)	80%	60%
Home Health Care (40 visits maximum per Calendar Year)	80%	60%
Hospice Care (180 days maximum per Calendar Year)	80%	60%
Transplants	80%	60%
Gender Dysphoria Treatment	Benefits are paid based on the services rendered	

COVERED SERVICES

Subject to Deductible unless otherwise stated:	**Percentage Payable Network**	**Non-Network**

Mental Illness, Alcoholism and Drug Abuse
In accordance with Federal Mental Health Parity requirements, this Plan will not apply any financial requirement or treatment limitation to Mental Illness, Alcoholism or Drug Abuse benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits in the same classification.

Prescription Drug Benefit	80%	Not Covered
Morbid Obesity Treatment ($20,000 Lifetime Maximum, including any related surgeries)	80%	60%
Supplemental Accident .....100% no Deductible for the first $300 per accident	then 80%	60%
Sterilization	80%	60%
Temporomandibular Joint Disorder - Therapeutic Must be ordered by a Physician (therapeutic- Medically Necessary only)	80%	60%
Contraceptive Drugs and Devices Must be prescribed by a Physician	80%	60%
Genetic Testing Coverage is for the testing only of inherited (genetic) disorders as required by PPACA. Genetic counseling is not covered.	80%	60%
Sleep Disorder	Benefits are paid based on the services rendered	
Infertility testing only Treatment is not covered	80%	60%

DENTAL BENEFITS

Note: Dental Benefits are stand-alone, HIPAA-excepted benefits.

All benefits will be based upon Dental Allowed Amount

Calendar Year Maximum (per individual, Class I, II and III)..... $1,200.00

Orthodontic Lifetime Maximum..... $1,500.00 per Participant
(Not subject to Deductible)

Calendar Year Deductible (Class II and III only) (does not apply to Orthodontic Services):
Per individual..... $50.00
Per family $150.00

Percentages Payable:
Class I - Preventive Services……..100%, not subject to Deductible
Bitewings- 2 per Calendar Year, full mouth x-ray: 1 per 36 months
Class II - Basic Restorative Services..... 80%, subject to Deductible
Class III - Major Restorative Services/Periodontics..... 50%, subject to Deductible
Class IV - Orthodontic Services..... 50%, not subject to Deductible
Maximum lifetime benefit of $1,500

Dental Expense Coverage benefits are payable after satisfaction of the Deductible Amount (if applicable to the service), at the Benefit Percentage indicated of the Dental Allowed Amount, subject to any specific Maximum.

PRESCRIPTION DRUG BENEFITS

Outpatient Prescription Drug benefit coverage for certain City of Stow personnel begins under this Plan for a Covered Person when the maximum benefit payable under the A.F.S.C.M.E. Care Plan drug program has been reached. When the A.F.S.C.M.E. Care Plan maximum is met, charges for Outpatient drugs which are considered Eligible Expenses under this Plan will be payable the same as any other Comprehensive Major Medical Expense Coverage Benefit, subject to the Calendar Year Deductible Amount, Benefit Percentage and Out-of-Pocket Maximum.

MEDTRAX 1-800-771-4648

COVERED PRESCRIPTION DRUGS

Benefits include up to a 34-day supply of most Prescription Drugs. Benefits include coverage for oral contraceptives.

The amount of drugs, including insulin, which is to be dispensed per prescription or refill, will be in quantities prescribed up to a 34-day supply.

When a Physician writes a prescription for both disposable syringes and needles and a one-month supply of insulin, the Covered Person must present the prescription to a pharmacist. If the Physician prescribes a three-month supply of insulin, coverage is provided for up to 100 disposable syringes and needles.

Prescriptions or refills can be prescribed over the telephone. Prescriptions can be refilled for the number specified by the Physician and are good for one year from the date of the prescription order.

HOW THE PLAN WORKS

When the Physician writes a prescription for a covered drug item for you or for a Dependent, present the prescription and your identification card to a participating Pharmacy.

When you have a prescription filled at a Pharmacy, payment is made to the Pharmacy. You will need to complete a medical expense reimbursement form and send that to Mutual Health Services with the itemized Pharmacy receipt. Reimbursement forms are available by contacting the claims office.

If you have any questions regarding your prescription coverage, you may call Mutual Health Services at 1-800-367-3762 or MedTrax at 1-800-771-4648.

MAIL ORDER DRUG PROGRAM

You will be able to save time and money by ordering your maintenance drugs through the Mail-Order Drug Program. Maintenance drugs can be purchased through your Mail-Order Drug Program.

To order your prescriptions, send the initial order form and attach the original prescription from your Physician. The prescription will come directly to your home.

In order to take advantage of this program, you must order at least a 30-day supply but can receive up to a 90-day supply of your maintenance drugs.

EXCLUSIONS AND LIMITATIONS

This Prescription Drug program does not provide benefits for the following:

1. Covered drugs for which benefits are paid elsewhere under the Plan; including but not limited to: (1) insulin; and (2) drugs used in connection with covered transplants under the transplant section;

2. Drugs not requiring a prescription under federal law;

3. Fertility drugs/agents;

4. Charges for growth hormones, unless prior approval is obtained by the Plan;

5. Charges for Retin-A or similar products for those over age 21;

6. Smoking cessation products;

7. Drugs which sole purpose are to promote or stimulate hair growth, refer to medical covered services;

8. Any charge for therapeutic devices or appliances, regardless of their intended use (except for disposable insulin syringes); support garments; medical supplies and equipment; other non-medical items regardless of their intended use, refer to medical covered services;

9. Any charge for administration of drugs or insulin;

10. The charge for more than a 34-day supply of retail Prescription Drugs;

11. The charge for any prescription order refill in excess of the number specified by a doctor or any refill dispensed after one year from the date of the original prescription order;

12. Immunizing agents, biological sera, blood or plasma, laterite, injectable drugs, except insulin;

13. Dietary supplements and vitamins except prenatal vitamins used while receiving maternity benefits;

14. Health and beauty aids;

15. Drugs labeled “Caution: limited by Federal law to investigational use” or experimental drugs, even though a charge is made;

16. Drugs taken or given while at a Hospital, convalescent care facility, or similar institution;

17. Fluoride preparations;

18. Weight control/Anti-Obesity Drugs;

19. The charge for any medication for which you or your eligible Dependent is entitled to receive reimbursement under any Worker's Compensation law, or for which entitlement to benefits is available without charge from any municipal, state or federal program of any sort, whether contributory or not;

20. Drugs which do not have the required governmental approval when you receive them or are considered Experimental, investigative, or of a research nature; and

21. Drugs and medicines not covered under the Plan. Please see the General Limitations and Exclusions section.

PLEASE NOTE: If your Medical coverage terminates or if your eligible Dependent's Medical coverage terminates, coverage under this program also terminates. If you continue to use your Prescription Drug benefit, you will be held responsible for payment of any charges Incurred on or after such termination date.

III
ELIGIBILITY FOR COVERAGE

Eligibility Requirements: To become eligible for coverage, an employee must be a member of the following Employee Class and complete the specified Waiting Period:

Employee Class:	All Active Full-Time Employees. (See Definitions Section)
Waiting Period:	Eligibility will begin on the first day of the month following (or coinciding with) date of hire.

Employees may be required to contribute to the cost of coverage for themselves or their Dependents as specified in the Source of Contribution provision of this booklet.

Employee Eligibility

If you are a member of an eligible Employee Class, you will become eligible for coverage under this Plan on the later of: (1) the effective date of this Plan; or (2) the first day of the month following (or coinciding with) date of hire.

The Waiting Period will not apply to Employees covered on the effective date of the Plan.

If both legal Spouses are employed by the Employer, either legal Spouse, but not both, may choose to be covered as an Employee and include his or her Spouse as a Dependent along with any eligible Dependent children.

No one can be covered under this Plan as both an employee and Dependent.

Dependent Eligibility

Your Dependent will become eligible for coverage under this Plan on the later of: (1) the date the employee becomes an Eligible Person; or (2) the date your Dependent meets this Plan's definition of Dependent.

Illegal Alien

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

Source of Contribution

The Comprehensive Major Medical Expense Coverage and Dental Expense Coverage for Employees and Dependents are Non-Contributory coverages.

The Comprehensive Major Medical Expense Coverage and Dental Expense Coverage for City Council members and Dependents are Contributory coverages.

Employee Coverage

When Employee coverage is Non-Contributory, your coverage will automatically begin on the date you become an Eligible Person. An enrollment form must be completed for

administrative purposes.

When employee coverage is Contributory, your coverage will become effective on the date you become an Eligible Person provided you have elected coverage by completing an enrollment form within 30 days of your date of eligibility.

Dependent Coverage

When Dependent coverage is Non-Contributory, coverage for your Dependent will automatically begin on the date your Dependent becomes an Eligible Person. An enrollment form must be completed for administrative purposes.

When Dependent coverage is Contributory, coverage for your Dependent will become effective on the date your Dependent becomes an Eligible Person provided Dependent coverage has been elected by completing an enrollment form within 30 days of his date of eligibility.

When you are already enrolled for Dependent coverage, any additional Dependents will automatically become covered. An enrollment form must be completed for administrative purposes.

In no event will coverage for your Dependent begin before your coverage begins. Dependents ages 26 will be required to pay full premium as allowed by the Plan.

Open Enrollment

The open enrollment period shall be yearly during such period as may be established under the Plan.

Late Enrollees

If you or your eligible Dependents do not enroll for Contributory coverage within 30 days of becoming eligible, you and/or your Dependents will be considered a Late Enrollee.

Special Enrollment Rights

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

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

2. If coverage was non-COBRA, loss of eligibility or the Group's contributions must end. A loss of eligibility for special enrollment includes:

    a. Loss of eligibility for coverage as a result of legal separation or divorce

b. Cessation of Dependent status (such as attaining the maximum age to be eligible as a dependent child under the Plan)

c. Death of an Eligible Employee

d. Termination of employment

e. Reduction in the number of hours of employment that results in a loss of eligibility for plan participation (including a strike, layoff or lock-out)

f. Loss of coverage that was one of multiple health insurance plans offered by an employer, and the Eligible Employee elects a different plan during an open enrollment period

g. An individual no longer resides, lives, or works in an HMO Service Area (whether or not within the choice of the individual), and no other benefit package is available to the individual through the other employer

h. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual

i. Termination of an Employee's or Dependent's coverage under Medicaid or under a state child health insurance plan (CHIP)

j. The Employee or Dependent is determined to be eligible for premium assistance in the Group's plan under a Medicaid or CHIP plan

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

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

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

Termination of Employee Coverage

Your coverage will terminate on the earliest of: (1) the date the Plan terminates; or (2) the date on which you cease to be in an eligible Employee Class; or (3) the date all coverage or certain benefits are terminated for your class by modification of the Plan; or (4) the date you become a full-time member of the armed forces of any country; or (5) the date you fail to make any required contribution.

Termination of Dependent Coverage

Coverage for your Dependents will terminate on the earliest of: (1) the date your coverage terminates; or (2) the date Dependent Coverage under the Plan terminates; or (3) the date your Dependent Spouse becomes a full-time member of the armed forces of any country; or (4) the date you fail to make any required contribution on behalf of his Dependent(s); or (5) the date your Dependent no longer meets the Plan's definition of Dependent.

Continuation of Coverage in the Event of Temporary Layoff

In the event of a layoff, your coverage will continue for a maximum of three months following the date the layoff begins, subject to the payment of any required contribution. Coverage continued under this provision is preliminary to coverage continued under the Plan's Right to Continue Benefits Under Federal Law provision.

Continuation of Coverage in the Event of Leave of Absence

In the event of Employer approved leave of absence, your coverage will continue for a maximum of six months following the date such leave of absence begins, subject to the payment of any required contribution. Coverage continued under this provision is preliminary to coverage continued under the Plan's Right to Continue Benefits Under Federal Law provision.

Continuation of Coverage in the Event of Total Disability

Coverage will continue for a maximum of twenty-four months following the date on which Total Disability commences, subject to the payment of any required contribution. Coverage continued under this provision is preliminary to coverage continued under the Plan's Right to Continue Benefits Under Federal Law provision.

Right to Continue Benefits Under the Family and Medical Leave Act of 1993 (P.L. 103-3)

Your Health Benefit Plan intends to comply with the Family and Medical Leave Act of 1993 (FMLA) regarding the maintenance of Health Benefits during any period that an eligible employee takes a reasonable leave of absence as specified under the FMLA for medical reasons, for the birth or adoption of a child, or for the care of a child, Spouse or parent who has a serious health condition. In such situations, the FMLA allows an eligible employee to maintain "group health plan" coverage at the level and under the conditions coverage would have been provided if the employee had continued in employment continuously for the duration of such leave. Employee eligibility requirements, the obligations of the employer and employee concerning conditions of leave, and notification and reporting requirements are specified in the FMLA. Any Plan provision(s) which conflicts with the FMLA are superseded by the FMLA to the extent such provision(s) conflict with the FMLA. An employee with questions concerning any rights and/or obligations under the FMLA should review the posted notice on the FMLA at his place of employment or contact his employer or Plan Administrator.

Right to Continue Benefits Under Federal Law

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The following is a summary of the federal law.

Cobra continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description *or* get a copy of the Plan Document from the Plan Administrator. The name, address and telephone number of the Plan Administrator is listed in the Plan Information section of your Plan's Summary Plan Description booklet.

If you have questions concerning the information in this notice or your rights to continuation coverage, you may contact your Employer, the Plan Administrator, or the Claims Administrator, Mutual Health Services at (800) 367-3762 or at the address listed below:

Mutual Health Services
PO Box 5700
Cleveland, Ohio 44101

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, Spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or
(2) Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any one of the following qualifying events happens:

(1) Your Spouse dies;
(2) Your Spouse's hours of employment are reduced;
(3) Your Spouse's employment ends for any reason other than his or her gross misconduct;
(4) Your Spouse becomes enrolled in Medicare (Part A, Part B, or both); or
(5) You become divorced or legally separated from your Spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the

Plan because any one of the following qualifying events happens:

(1) The parent-employee dies;
(2) The parent-employee's hours of employment are reduced;
(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
(5) The parents become divorced or legally separated;
(6) The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

For the other qualifying events (divorce or legal separation of the employee and Spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs in order to be eligible to elect continuation coverage. The name, address and telephone number of the Plan Administrator are listed in the Plan Information section of your Plan's Summary Plan Description booklet.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. A qualified beneficiary will have 60 days from the later of the date such person would lose coverage or the date the Election Notice is provided by the Plan Administrator to elect continuation coverage. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of an employee, enrollment of the employee in Medicare (Part A, Part B, or both only if the entitlement is the initial qualifying event), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage in order to be eligible for the extension of continuation coverage. The name, address and telephone number of the Plan Administrator are listed in the Plan Information section of your Plan's

Summary Plan Description booklet. If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must give notice of the fact within 30 days of the Social Security Administration's determination.

Second qualifying event extension for 18-month period of continuation coverage

If your family experiences another qualifying event that would have triggered a loss of coverage under the Plan while receiving COBRA continuation coverage, the Spouse and dependent children in your family can get additional months of COBRA continuation coverage up to a maximum of 36 months. This extension is available to the Spouse and dependent children if the former employee dies or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event in order to be eligible for the extension of continuation coverage. The name, address and telephone number of the Plan Administrator are listed in the Plan Information section of your Plan's Summary Plan Description booklet.

How can you elect continuation coverage?

Individuals eligible for continuation coverage will be notified of their rights and will be given an Election Form which must be completed and returned in order to purchase coverage. Each qualified beneficiary has an independent right to elect continuation coverage. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you avoid such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of the continuation coverage if you get continuation coverage for the maximum time available to you.

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment for continuation coverage within the 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of the continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period.

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the first day of each month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

Although periodic payments are due on specified dates, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

If You Have Questions

For additional information you may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Extension of Benefits

If an Employee is disabled on the date his coverage terminates, he may elect either Extension of Benefits or coverage under the Plan's Right to Continue Benefits Under Federal Law provision. If Extension of Benefits is elected, he cannot elect continuation coverage under Federal Law. If Continuation Law coverage is elected, this provision may apply upon termination of such coverage.

Under this Extension of benefits provision, Comprehensive Major Medical Expense Coverage benefits will be extended during the continuance of the Disability with respect to the Illness or Injury causing Total Disability for a maximum of three (3) months from the date

of termination of coverage. This Extension of Benefits provision will apply only to Comprehensive Major Medical Expense Coverage.

In no event will benefits be payable for charges incurred on or after the date the person becomes covered under any other plan, or any other arrangement for members in a group, whether insured or self-insured.

The Plan may require certification from a Physician that the Employee is Totally Disabled as defined in this Plan.

Rights Under The Uniformed Services Employment And Reemployment Rights Act (P.L. 103-353)

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

Continuation of Coverage Due to Military Leave

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

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

Reinstatement of Coverage Following Military Leave

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

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

1. You have given advance written or verbal notice of the military leave to City of Stow (advance notice to your Employer is not required in situations of military necessity or if giving notice is otherwise impossible or unreasonable under the circumstances);
2. The cumulative length of the leave and all previous absences from employment do not exceed five (5) years;
3. Reemployment follows a release from military service under honorable conditions; and
4. You report to, or submit an application to City of Stow as follows:
    a. On the first business day following completion of military service for a leave of thirty (30) days or less; or
    b. Within fourteen (14) days of completion of military service for a leave of thirty-one (31) days to one hundred-eighty (180) days; or
    c. Within ninety (90) days of completion of military service for a leave of more than one hundred-eighty days.

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

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

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

Employee Benefits Provisions of the Omnibus Budget Reconciliation Act of 1993 P.L. 103-66 (OBRA)

This Plan intends to comply with the Employee Benefits Related Provisions of OBRA 1993, as amended from time to time, as described below:

(1) Group health plans must honor qualified medical child support orders.

OBRA 1993 requires employer-sponsored group health plans to recognize "qualified medical child support orders" by providing benefits for participants' children in accordance with such orders.

A "medical child support order" (MCSO) is any court judgment decree or order (including a court's approval of a domestic relations settlement agreement) that (1) provides for child support related to health benefits with respect to the child of a group health plan participant, or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law, or (2) enforces a state medical child support law enacted under the Social Security Act with respect to a group health plan.

A "qualified medical child support order" (QMCSO) is one that (1) either creates or recognizes the right of an alternate recipient - a participant's child who is recognized under the order as having a right to be enrolled under the plan - or assigns to the alternate recipient the right to receive benefits for which a participant or other beneficiary is entitled under the group health plan, and (2) includes the name and last known address of the participant and of each alternate recipient, a description of the type of coverage to be provided or the manner in which such coverage is to be determined, the period for which coverage must be provided, and each plan to which the order applies.

Notification and determination requirements

To facilitate determination, your group health plan has established reasonable written procedures (available upon request) for determining whether MCSOs are QMCSOs and for administering the provision of benefits under QMCSOs.

When a plan administrator receives an MCSO, it will promptly notify the participant and each alternate recipient that it has received the order and must inform them of the plan’s procedures for determining if the order is a QMCSO. The administrator will then – within a reasonable time – determine whether the MCSO is qualified and notify the participant and any alternate recipients of the determination. The Plan will pay benefits in line with the administrator’s determination.

Direct medical expense reimbursement to alternate payees

A group health plan must permit an alternate recipient to designate a representative to receive any required communications. Any payment for benefits made by a group health plan under a QMCSO to reimburse an alternate recipient's out-of-pocket medical expenses paid by the recipient, or by his custodial parent or legal guardian, must be made to the recipient, custodial parent, or guardian.

(2) States to enact laws requiring issuance of medical child support orders.

As a condition of receiving federal assistance for state Medicaid programs, OBRA 1993 requires states to enact a series of laws "relating to medical child support.

States must have laws that prohibit a group health plan from denying enrollment of a child under the health coverage of the child's parent on the ground that (1) the child was born out of wedlock, (2) the child is not claimed as a dependent on the parent's federal income tax return, or (3) the child does not reside with parent or in the insurer's service area.

Whenever a court or administrative order requires a parent to provide health care coverage for a child and the parent is eligible for family coverage through an employer doing business in the state, states must have laws requiring the employer to enroll the child under the family coverage and withhold from the employee’s compensation any employee share of health coverage contributions or premiums.

In any case in which a child has health coverage through the insurer of a noncustodial parent, states must have laws requiring insurers to provide all information to the custodial parent that is needed in order for the child to obtain benefits through such coverage, to permit the custodial parent (or the provider, with the custodial parent's approval) to submit claims for covered services without the approval of the noncustodial parent, and to make payments on such claims directly to the custodial parent, provider, or state Medicaid agency.

(3) States recovery of Medicaid payments from private health plans.

OBRA 1993 both amends the Social Security Act to require states to enact laws to ensure that Medicaid will be only the secondary payer of claims and amends ERISA to alter the preemption provision accordingly and to require plans to adopt parallel coordination provisions.

Substantive plan requirements

OBRA 1993 requires that benefit payments on behalf of a participant who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the participant.

A group health plan may not take into account with respect to plan enrollment or benefits that an individual qualifies for medical assistance under a state Medicaid plan. Also, group health plans must honor any subrogation rights that a state may have gained by virtue of the state's having paid Medicare benefits for which the private plan has a legal liability for covering.

(4) Health plan coverage of adopted children.

OBRA 1993 amends ERISA to require health plan coverage for adopted children who are under age 18 as of the date of adoption or placement for adoption.

If a group health plan provides coverage for dependent children of participants or beneficiaries, it must extend participation and benefits under the same terms and conditions for the adopted children of participants or beneficiaries as for natural children, regardless of whether the adoption has become final.

(5) Child immunization anti-cutback provision.

A group health plan may not reduce benefits provided as of May 1, 1993, for pediatric vaccines.

Continuation of Coverage for Reservists on Active Duty (Ohio revised Code 3923.382)

This Plan intends to comply with the Ohio revised code 3923.382, as applicable, regarding continuation of coverage for military reservists who are called to active duty. If you have any questions, do not hesitate to contact your Employer or Plan Administrator.

IV
DESCRIPTION OF COMPREHENSIVE MAJOR MEDICAL EXPENSE COVERAGE

The Plan will pay, after satisfaction of the specified Deductible Amount, the Benefit Percentage indicated in the Schedule of Benefits, subject to the specified maximums.

Benefit Limits and Maximums

Benefits payable under Comprehensive Major Medical Expense Coverage are subject to the Benefit Limits and Maximums specified in the Schedule of Benefits and to all exclusions and limitations of this Plan.

Precertification

The precertification program is administered by the Managed Care division of Medical Mutual. This program is designed to ensure medical necessity, to reduce unnecessary hospital admissions, and to ensure that health care services are delivered in the most cost-efficient manner, while keeping quality, as well as cost, in mind. This program also provides a means of getting answers to your health care questions and considering alternatives to a hospital stay.

Inpatient admissions and certain outpatient tests, procedures and equipment require precertification, also known as prior approval. Contracting hospitals and providers in Ohio will assure that any required prior approval is obtained for you. For Non-contracting hospitals and providers, as well as for hospitals and providers outside Ohio, you are responsible for obtaining prior approval. Failure to pre-certify may subject you to significant monetary penalties, up to and including all billed charges.

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

- All hospital admissions
- Reconstructive surgeries
- Durable medical equipment and devices
- MRI's and PET scans
- Home health care

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

Emergency Admissions

An emergency or urgent admission refers to a situation that requires immediate Hospitalization. In such cases, the patient or his or her authorized representative must call Medical Mutual within 48 business hours of admission and provide them with the pertinent information concerning the admission, to avoid the patient being responsible for all billed charges for that emergency admission.

Pre-Admission Certification Toll-Free Number:
Medical-Surgical: 1-800-338-4114
Behavioral Health: 1-800-258-3186

Failure to contact the medical review organization as specified in this Pre-Admission Certification Requirement will result in a maximum 50% up to $500 penalty reduction in benefits payable for all expenses related to a non-certified Hospital Confinement.

Obtaining Pre-Admission Certification does not mean a promise of benefits on behalf of the Plan as all Plan exclusions and limitations will continue to apply to the Covered person's medical expense.

The following information will be requested by the medical review organization in order to evaluate a planned Hospital admission:

(1) the name, address, social security number and age of patient.
(2) the employee's name, social security number and employer.
(3) the scheduled date of admission, admission diagnosis, planned procedure and proposed length of stay.
(4) the name of the Claims Administrator – Mutual Health Services
(5) the name, address and phone number of the admitting Physician and Hospital.

Medical Case Management

If a Covered Person experiences a serious Illness or Injury, he may be contacted by a member of the medical review organization who will discuss with him the advantages of Medical Case Management. The medical review organization will request the consent of the Covered Person to review his medical records in order to prepare a Medical Case Management Plan consisting of quality medical care options. Upon the advice of the medical review organization, the Plan Administrator shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result without a sacrifice to the quality of patient care. If the Covered Person consents to the preparation of a Medical Case Management Plan, it does not mean that the Covered Person is required to follow the recommended Plan.

Calendar Year Deductible Amount

The Individual Calendar Year Deductible Amount is the amount of Eligible Expenses as shown in the Schedule of Benefits which must be incurred by a Covered Person during each Calendar Year, for which no benefits are payable under the Plan.

When two or more Covered Persons in a family incur Eligible Expenses during the same Calendar Year, and the total combined expenses used toward satisfying their Individual Deductibles are at least equal to the Family Deductible shown in the Schedule of Benefits, no further Deductible Amounts are required for that family for the remainder of the Calendar Year.

If, during the last three months of the Calendar Year, a Covered person Incurs Major Medical expenses which are applied toward the Deductible Amount, these expenses will also be applied to the Deductible Amount for the next Calendar Year.

Common Accident Deductible Limit

If two or more Covered Persons in the same family are injured in a common accident, the Deductible Amount applicable in the Calendar Year of the common accident will be limited to a single Deductible Amount for the Calendar Year for Eligible Expenses related to that accident which are incurred by all family members.

Deductible Carryover

If, during the last 3 months of the Calendar Year, a Covered Person incurs expenses which are applied toward the Deductible amount, these expenses will also be applied to the Deductible amount for the succeeding Calendar Year.

Benefit Percentage

The Plan will pay the Benefit Percentage indicated in the Schedule of Benefits for Eligible Expenses incurred by a Covered Person after the satisfaction of any required Deductible Amount.

Out-of-Pocket Maximum

Out-of-Pocket Expenses means those Eligible Expenses, which are incurred by a Covered Person in a Calendar Year, for which no payment is made by the Plan because of the Deductible Amount and Benefit Percentage rate at which benefits are payable by the Plan.

When, during the Calendar Year, Out-of-Pocket Expenses of a Covered Person equal the Individual Out-of-Pocket Maximum shown in the Schedule of Benefits, Eligible Expenses incurred by that Covered Person during the rest of that Calendar Year will be payable at 100% of the Allowed Amount, except as noted below.

When, during the Calendar Year, Out-of-Pocket Expenses of covered members of a family combined equal the Family Out-of-Pocket Maximum shown in the Schedule of Benefits, Eligible Expenses incurred by covered members of that family during the rest of that Calendar Year will be payable at 100% of the Allowed Amount, except as noted below.

Eligible Expenses incurred for any amount not paid by the Plan due to failure to comply with the Hospital Pre-Admission Certification requirement, will not be applied toward satisfaction of the Out-of-Pocket Maximum.

Eligible Expenses for which a Benefit Percentage amount is specifically listed under the Benefit Limits and Maximums section in the Schedule of Benefits, will not be payable at 100% of the Allowed Amount unless specifically noted otherwise.

Eligible Comprehensive Major Medical Expenses

(1) Charges made by a Hospital for Room and Board, payable at the "most common" Semi-Private Charge billed by the Hospital in which the patient is confined. The Plan will also pay charges for Special Care Units and Hospital Miscellaneous Services and a private room if certified as medically necessary by the attending Physician.

(2) Charges made by a Physician for medical care or treatment.

(3) Charges made by a Physician for surgical procedures performed on an Inpatient or Outpatient basis at the Allowed Amount as determined and administered by the Plan.

(4) Charges made by a Physician for a second surgical opinion, limited to the examination, consultation, and any additional diagnostic tests required to properly evaluate the Medical Necessity of surgery. The second opinion must be secured from a board certified specialist in the field for which the patient is contemplating surgery

and must not be part of the same medical or surgical group as the first opinion surgeon. If the second surgical opinion does not confirm the need for surgery, a third opinion may be obtained and will be paid the same as the second surgical opinion. Benefits are payable as specified in the Schedule of Benefits.

(5) Charges made for Pre-Admission Testing (diagnostic laboratory tests and x-rays) performed on an Outpatient basis, which is required in connection with a scheduled surgery or Hospital Confinement. Eligible Expenses will include only those tests performed within 14 days prior to the scheduled surgery or Hospital Confinement. Benefits are payable as specified in the Schedule of Benefits.

(6) Charges incurred for diagnostic x-ray and laboratory examinations performed on an Inpatient or Outpatient basis, if recommended by a Physician to diagnose an Illness or Injury received while covered under this Plan, are payable as specified in the Schedule of Benefits.

(7) Charges made by a Registered Nurse (R.N.), or a Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.) for private duty nursing in the patient's home, Hospital or elsewhere, provided such services are certified as Medically Necessary by the attending Physician.

(8) Charges for the following medical services or supplies that are ordered by a Physician:
   (a) Anesthesia, including the charge for administration.
   (b) Oxygen, including the rental of equipment required for its administration.
   (c) X-ray examination, microscopic and laboratory tests and other diagnostic services.
   (d) Radiation therapy, chemotherapy, radium and radioactive isotope treatments.
   (e) Blood and blood plasma (if not replaced) and other fluids to be injected into the circulatory system.
   (f) Medical supplies including but not limited to braces, orthotics for the feet, crutches, casts, splints, trusses, surgical dressings, and ostomy supplies.
   (g) The initial artificial limb or eyes, or a replacement if occasioned by the natural growth and development of a Covered Person.
   (h) The rental, up to the purchase price, durable medical equipment, including wheelchairs, hospital beds, and other hospital type medical equipment used exclusively for therapeutic treatment.
   (i) Drugs and medicines lawfully obtainable in the United States only upon the written prescription of a Physician. Outpatient Prescription Drug benefit coverage for certain City of Stow personnel begins under this Plan for a Covered Person when the maximum benefit payable under the A.F.S.C.M.E. Care Plan drug program has been reached. When the A.F.S.C.M.E. Care Plan maximum is met, charges for Outpatient drugs which are considered Eligible Expenses under this Plan will be payable as shown in the Medical Schedule of Benefits.
   (j) Speech therapy provided by a qualified speech therapist for the purpose of correcting speech loss or damage which follows surgery to correct a birth defect or which is due to an Injury or Illness (other than a functional nerve disorder), or surgery due to such Injury or Illness.
   (k) Physical Therapy.
   (l) Occupational therapy provided by a licensed occupational therapist, when

rendered as part of a physical medicine and rehabilitative program to improve functional impairments. Benefits are not payable for diversional, recreational or vocational therapies (such as hobbies, arts and crafts.)

(9) Charges for emergency transportation to the nearest Hospital or other covered medical facility (including transfer between Hospitals) where necessary care and treatment can be provided. Such transportation must be certified as Medically Necessary by a Physician and must be furnished by a professional ambulance service.

(10) Maternity expenses incurred by an Employee or a Covered Dependent.

(11) Charges for therapeutic (Medically Necessary) and elective abortions.

(12) Charges for routine newborn nursery care (limited to not more than seven (7) days), and the initial in-Hospital physical examination and circumcision of newborn Dependent child. Such routine Eligible Expense on behalf of a newborn child will apply on the same claim as the mother. Only one Calendar Year Deductible Amount will apply to the mother and newborn child.

(13) Charges for elective sterilization procedures.

(14) Charges for Wellness Benefits for an employee and Dependents for <u>any</u> routine x-ray and laboratory tests (including routine gynecological, mammogram and prostate screening, and related exam) not to exceed the maximum benefit payable in the Schedule of Benefits. Wellness Benefits will also include unlimited Adult Routine Immunization.

(15) Charges for Well Child Care (routine physical exams, inoculations, x-ray and lab tests), including review of the child’s emotional status, for a Dependent child up to age nine, payable as specified in the Schedule of Benefits.

(16) Charges made by a Skilled Nursing Facility, provided the Covered Person's attending Physician certifies that twenty-four hour nursing care is Medically Necessary. Benefits are payable as specified in the Schedule of Benefits. Eligible Expenses will include:

(a) the daily Room and Board charge, not to exceed the facility's Semi-Private Room Charge; and
(b) the facility's other charges for medical care;

A Period of Skilled Nursing Facility Confinement means Inpatient Confinement of a Covered Person in a Skilled Nursing Facility provided:

(a) the Confinement starts within 14 days after discharge from the Hospital;
(b) the Hospital Confinement lasts at least 3 days in a row; and
(c) the Skilled Nursing Facility Confinement is due to the same or related Illness or Injury that caused the Hospital Confinement.

(17) Charges made by a Home Health Care Agency for the following medical services and supplies provided immediately after a period of Hospital or Skilled Nursing Facility Confinement under the terms of a Home Health Care Plan for the Covered

Person named in that plan:

(a) part-time or intermittent nursing care by or under the supervision of a Registered Nurse (R.N.);
(b) part-time or intermittent services of a Home Health Aide;
(c) physical, occupational or speech therapy (if not excluded under the Plan); and
(d) medical supplies; drugs and medicines prescribed by a Physician; and laboratory services; but only to the extent that such charges would have been considered Eligible Expenses if the Covered Person had been confined in a Hospital.

Benefits are not payable for charges made by a Home Health Care Agency for:

(a) home health care visits which exceed the Home Health Care maximum, if any, specified in the Schedule of Benefits. (Each visit by an employee of a Home Health Care Agency will be considered one home health care visit and each 4 hours of Home Health Aide services will be considered one home health care visit);
(b) more than two hours of nursing care in any twenty-four hour period;
(c) care or treatment which is not stated in the Home Health Care Plan;
(d) the services of a person who is a member of your family or your Dependent's family or who normally resides in your home or your Dependent's home;
(e) a period when a Covered Person is not under the continuing care of a Physician; or
(f) Custodial Care.

(18) Charges for Hospice Care provided to a Covered Person who is a patient with a reduced life expectancy due to advanced Illness whose life expectancy is 6 months or less as certified in writing by the attending Physician before the date the initial Hospice Care begins.

Hospice Care includes the following services which are provided by an Inpatient Hospice Facility or through a Hospice Care Agency as part of a Hospice Care Plan:

(a) Room and Board for Confinement in a Hospice Facility;
(b) services and supplies furnished by the Hospice Facility while the patient is confined therein;
(c) part-time nursing care by or under the supervision of a registered nurse (R.N.);
(d) Home Health Aide services;
(e) dietary services; and
(f) counseling services by a licensed social worker or a licensed pastoral counselor.

Hospice Care does not include charges:

(a) for Hospice Care provided in excess of the Hospice Care maximum, if any, specified in the Schedule of Benefits;
(b) for services provided by volunteers or persons who regularly do not charge for their services;
(c) for pre-death counseling which is not provided by or through the Hospice program of care for the sole purpose of adjustment to the terminally ill Covered Person's death;

(d) for services provided by homemakers, caretakers and the like;
(e) for funeral services and arrangements;
(f) for legal or financial services or counseling;
(g) for curative treatment or services; or
(h) for Hospice Care services not made or recommended by the Covered Person's attending Physician or a Hospice program Physician.

If the patient lives beyond his life expectancy and exceeds the Hospice Care maximum, if any, specified in the Schedule of Benefits, he may be eligible for additional benefits, provided the attending Physician submits, in writing, recertification of the Covered Person's prognosis of six months or less to live.

(19) Charges for services and supplies received in connection with human tissue and organ transplant procedures (kidney, bone marrow, heart, heart/lung, lung, liver, pancreas and cornea) subject to the following conditions:

A second surgical opinion must be obtained prior to undergoing any transplant procedure. The mandatory second opinion must occur with the attending Physician's findings regarding the Medical Necessity of such procedure.

The second opinion must be rendered by a board-certified surgeon who is not affiliated in any way with the Physician or the surgeon who rendered the first surgical opinion. The surgeon who gives the second surgical opinion may not perform the surgery.

(a) If the donor is a Covered Person under this Plan, his Eligible Expenses will be covered if donor benefits are not provided under the recipient's plan.

(b) If the recipient is covered under this Plan, his Eligible Expenses will be covered.

(c) If the recipient is a Covered Person but the donor is not, the donor's Eligible Expenses are covered under this Plan if his expenses are not payable under any other plan.

(d) If both the donor and the recipient are covered under this Plan, Eligible Expenses incurred by each person will be considered separately.

(e) The Allowed Amount of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and Hospital's charge for storage or transportation of the organ will be considered an Eligible Expense, payable as specified in the Schedule of Benefits.

All other human organ/tissue transplants or replacement procedures will be covered the same as any other illness.

(20) Charges are payable for expenses incurred for treatment as a direct result of, and within 90 days following, an Injury up to the maximum amount indicated in the Schedule of Benefits under the Supplemental Accident Expense Benefit.

(21) Injury to or care of mouth, teeth and gums. Charges for injury to or care of mouth, teeth, gums and alveolar processes will be covered charges under Medical Benefits only if that care is for the following oral surgical procedures:

a. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

b. Emergency repair due to Injury to sound natural teeth.

c. Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

d. Excision of benign bony growths of the jaw and hard palate.

e. External excision and drainage of cellulitis.

f. Incision of sensory sinuses, salivary glands or ducts.

g. Removal of impacted teeth.

h. Reduction of dislocations and excision of temporomandibular joints (TMJs).

No charge will be covered under Medical Benefits 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.

(22) Charges for therapeutic (medically necessary) treatment of Temporomandibular Joint (TMJ) disorder when ordered by a physician.

(23) Charges for contraceptive drugs and devices when prescribed by a Physician.

(24) Charges for Gender Dysphoria Treatment. The Plan will cover Medically Necessary services for the treatment of gender dysphoria, subject to accepted medical clinical guidelines and the relevant corporate medical policy of Claims Administrator or, if applicable, the Plan's utilization review organization.

(25) Charges for Telemedicine Services payable as shown in the Schedule of Benefits. Coverage for Telemedicine Services includes the use of an interactive two-way telecommunications system, which includes both an audio and video component.

Exclusions Applicable to Comprehensive Major Medical Expense Coverage

(1) Charges incurred after the date of individual termination of coverage under this Plan except as specified in the "Extension of Benefits" provision.

(2) Charges not Medically Necessary for the diagnosis or treatment of an Illness or Injury except as specifically included as Eligible Expenses.

(3) Charges in excess of the Allowed Amount.

(4) Charges not prescribed or recommended by a Physician.

(5) Charges for services or supplies that cannot reasonably be expected to lessen the patient's disability or to enable him to live outside of an institution.

(6) Charges for Custodial Care.

(7) Charges for personal convenience items including, but not limited to, TV and telephone, guest trays, guest beds and reading material.

(8) Charges directly or indirectly related to infertility treatment, including invitro fertilization or embryo transplant procedures, surrogate parenting procedures, artificial insemination, fertility drugs or other infertility treatment.

(9) Charges for vaccinations, inoculations and preventive shots, unless specifically included as Eligible Expenses.

(10) Charges for hearing aids, eyeglasses, contact lenses, and the fitting thereof, or eye examinations, unless specifically included as Eligible Expenses.

(11) Charges for cosmetic surgery except to correct a congenital defect, to repair the effects of an Injury or to perform reconstructive breast surgery on an individual due to mastectomy.

(12) Charges for the treatment of corns, calluses or toenails, unless the charges are for the removal of nail roots or in conjunction with the treatment of a metabolic or peripheral vascular disease.

(13) Charges for orthopedic shoes or other supportive appliances for the feet, unless specifically included as Eligible Expenses.

(14) Charges for any care or treatment of teeth, gums, alveolar process, gingival tissues or Temporomandibular Joint (TMJ) Disturbances (including the prevention or correction of teeth irregularities and malocclusion of the jaw by wire appliances, braces or other mechanical aids) unless such charges are for the professional services of a Physician or qualified oral surgeon in rendering any of the following treatments:
   (a) treatment to repair the effects of an Injury to sound natural teeth;
   (b) treatment for the excision of bony impacted, unerupted teeth, or for the excision of a tumor or cyst, or the incision and drainage of an abscess or cyst; or
   (c) treatment of Temporomandibular Joint (TMJ) Disturbances, not to exceed the maximums specified in the Schedule of Benefits.

(15) Charges for transportation except as specifically included as Eligible Expenses.

(16) Charges for telephone consultations or consultations by electronic mail or facsimile, except as required by law, authorized by the Plan or as otherwise described herein;

(17) Charges for sterilization reversal, or any complications thereof, unless specifically included as Eligible Expenses.

(18) Charges for education materials or training including bio-feedback training.

(19) Charges for marital counseling.

(20) Charges for cosmetic products, hair replacement, transplant, removal or hair growth stimulants.

(21) Charges for treatment of obesity, except when a diagnosis of morbid obesity is determined. Benefits payable for treatment of such obesity will not exceed the maximum specified in the Schedule of Benefits.

(22) Charges for services and supplies provided on a Friday, Saturday or Sunday for a non-emergency Hospital admission occurring on a Friday, Saturday or Sunday, unless surgery is scheduled the following day.

(23) Charges for diagnostic x-ray exams and laboratory tests, ECG's, EKG's, and other diagnostic tests not related to a specific Injury or Illness or a definite set of symptoms, unless specifically included as an Eligible Expense.

(24) Charges for a Hospital admission when the primary reason for admission is to perform diagnostic x-ray exams and other diagnostic tests which could have been performed on an Outpatient basis unless certified as Medically Necessary by the attending Physician.

(25) Charges for speech therapy, except as specifically included as Eligible Expenses.

(26) Charges incurred in connection with any treatment, therapy, teaching technique or program for remedial education or habilitative or rehabilitative training which is principally intended to overcome, ameliorate or compensate for any learning impairment whatsoever, regardless of whether such impairment is diagnosed as functional or organic, unless specifically included as Eligible Expenses.

(27) Charges for treatment of conditions related to autism and intellectual disability.

(28) Charges for any surgical procedure for the correction of a visual refractive problem, including radial keratotomy.

(29) Charges for hearing or vision therapy and any related diagnostic testing, unless specifically included as Eligible Expenses.

(30) Charges for vitamins, minerals or food supplements, unless specifically included as Eligible Expenses.

(31) Charges for the treatment of nicotine dependency, unless specifically included as Eligible Expenses.

(32) Charges for Outpatient occupational therapy, unless specifically included as Eligible Expense.

(33) Charges which exceed a specified maximum.

(34) Charges for supplies or services intended to be covered, all or in part, by supplemental insurance plans to which the City contributes on behalf of the Employee and/or his Dependent(s). Such plans include union health and welfare.

(35) Charges for which benefits are not payable according to the "General Exclusions" section.

(36) Charges related to the treatment of intentionally self-inflicted injuries, unless any such results from a medical condition (such as depression) as required by the Health Insurance Portability and Accountability Act of 1996.

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

(38) Charges for genetic counseling.

V
DESCRIPTION OF
DENTAL EXPENSE COVERAGE

Dental Expense Coverage benefits are payable after satisfaction of the Deductible Amount (if applicable to the service), at the Benefit Percentage indicated of the Allowed Amount, subject to any specified Maximum as shown in the Schedule of Benefits.

Dental coverage includes services provided through Teledentistry, if those services would be covered under the Plan when delivered other than through Teledentistry. All other terms and conditions of the Plan apply.

Calendar Year Maximum

The total amount of Dental Expense Coverage benefits payable per Calendar Year for expenses incurred for Preventive, Basic Restorative and Major Restorative Services will not exceed the Calendar Year Maximum shown in the Schedule of Benefits.

Orthodontic Lifetime Maximum

The total amount of Dental Expense Coverage benefits payable for all expenses incurred during a Covered Person's lifetime for Orthodontic Services will not exceed the Orthodontic Lifetime Maximum shown in the Schedule of Benefits.

Calendar Year Deductible Amount

The Individual Calendar Year Deductible Amount is the amount of Eligible Expenses as shown in the Schedule of Benefits which must be incurred by a Covered Person during each Calendar Year, for which no benefits are payable under the Plan.

When three or more Covered Persons in a family incur Eligible Expenses during the same Calendar Year, and the total combined expenses used toward satisfying their Individual Deductible are at least equal to the Family Deductible shown in the Schedule of Benefits, no further Deductible Amounts are required for the remainder of the Calendar Year.

If during the last three months of a Calendar Year, a Covered Person incurs Dental expenses which are applied toward the Deductible Amount; these expenses will also be applied toward the Deductible Amount for the next Calendar Year.

Common Accident Deductible Limit

If two or more Covered Persons in the same family are injured in a common accident, the Deductible Amount applicable in the Calendar Year of the common accident will be limited to a single Deductible Amount for the Calendar Year for the Eligible Expenses related to that accident which are incurred by all family members.

Benefit Percentage

The Plan will pay the Benefit Percentage indicated in the Schedule of Benefits for Eligible Expenses incurred by a Covered Person after the satisfaction of any required Deductible Amount.

Eligible Dental Expenses Preventive & Diagnostic Services

(1) Routine oral examinations including diagnosis) twice per Calendar Year.

(2) Prophylaxis twice per Calendar Year.
(3) Dental X-rays:
    (a) Supplementary bitewing x-rays- 2 per Calendar Year.
    (b) Full mouth x-rays once in any period of 36 consecutive months.
    (c) Other x-rays as required in connection with the diagnosis of a specific condition requiring treatment.
(4) Topical application of fluoride twice per Calendar Year.
(5) Emergency treatment to relieve pain.
(6) Space maintainers (including installation and the fitting thereof for a Covered Person under age nineteen.
(7) Tests and laboratory examinations including bacteriologic cultures, pulp vitality tests and diagnostic casts (study models).

Basic Restorative Services & Supplies

(1) Oral surgery, including necessary pre-operative treatment during Hospital Confinement and customary post-operative treatment furnished in connection with oral surgery.
    (a) Extraction of one or more teeth, except when done in connection with or in preparation for orthodontic services; and
    (b) Alveoplasty (surgical preparation of ridge for dentures) and tooth replantation.
    (c) Treatment of fracture and reduction of dislocation of the jaw, and other cutting procedures in the oral cavity, except periodontic and endodontic surgery.
(2) Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or fractured teeth.
(3) General anesthesia, nitrous oxide and the administration thereof when Medically Necessary and administered in connection with oral or dental surgery.
(4) Endodontic treatment including root canal therapy.
(5) The injection of antibiotic drugs and application of desensitizing medication by the attending Dentist or Physician.
(6) The repair or recementing of crowns, inlays, onlays, bridgework or dentures, or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, not to exceed one relining or rebasing in any period of 36 consecutive months.
(7) Sealants, subject to a maximum of one time for dependents under the age of 26.

Major Restorative Services & Supplies

(1) Inlays, onlays, gold fillings or crown restorations to restore diseased or fractured teeth, but only when the tooth, as a result of extensive caries or fracture cannot be restored to proper function with an amalgam, silicate, acrylic, synthetic porcelain or composite restoration.
(2) Initial installation of removable partial or complete denture.
(3) Initial installation of fixed partial denture (bridgework -- including inlays and crowns as abutments).
(4) Replacement of an existing removable partial or complete denture or fixed partial denture by a new removable or fixed partial denture, or the addition of teeth to an existing removable partial denture or to a fixed partial denture, but only if: (1) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing removable partial denture or fixed partial denture was installed (2) the existing removable denture or fixed partial denture cannot be made serviceable and, if such a denture was installed at least five years prior to its replacement, or (3) the existing denture is an immediate temporary denture which cannot be made permanent,

and replacement by a permanent removable denture takes place within twelve months from the date of initial installation of the immediate temporary denture.

(5) Implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants.

(6) Gingivectomy and osseous surgery and treatment of periodontal and other diseases of the gums and tissues of the mouth.

Orthodontic Services & Supplies

(1) Orthodontic procedures required for the correction of malposed teeth; an i.e. procedure performed that involve the use of an active Orthodontic appliance and post-treatment retentive appliance for the treatment of malalignment of teeth and/or jaws which significantly interferes with their function. Related oral examinations, surgery and extractions are included.

Exclusions Applicable To Dental Expense Coverage

(1) Procedures, services rendered or supplies not furnished by a dentist, unless they are performed by a licensed dental hygienist, or an expanded function dental auxiliary, under the direction of a dentist or another Physician and that meet the specifications set forth in the appropriate section of the Ohio Revised Code;

(2) Facings on pontics or crowns posterior to the second bicuspid.

(3) Education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene or dental plaque control.

(4) Procedures, services or supplies which are not necessary, according to accepted standards of dental practice.

(5) Procedures, services or supplies which do not meet accepted standards of dental practice, including charges for procedures, services or supplies which are experimental in nature.

(6) Any spare, duplicate or replacement prosthetic device or any other duplicate dental appliance within five years of the insertion or placement of the original prosthetic device or dental appliance.

(7) Any adjustment or repair to a denture which is performed within six months of the installation of the denture.

(8) The replacement of lost, missing or stolen prosthetic device, or any other dental appliance.

(9) Periodontal splinting of teeth except for treatment of trauma.

(10) Procedures, appliances or restorations to increase the vertical dimensions or restore or maintain occlusion or stabilize periodontally involved teeth except as specifically included as Eligible Expenses. Such procedures include but are not limited to, equilibration, periodontal splinting, restoration of tooth structure lost from wear, rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion.

(11) Drugs or medication, including prescriptions, other than antibiotics and application of desensitizing medication by attending Dentist.

(12) Any dental service or supply which is payable under a separate benefit in this Plan, except to the extent that dental benefits payable under this section exceed those benefits payable under the other section of the Plan.

(13) Any dental services or supplies which are furnished prior to the effective date of coverage. In the case of prosthetic devices and crowns charges will not be covered if the impressions were taken before the date coverage commenced, even though the prosthetic device or crown is not installed until after the date coverage commenced.

(14) Charges incurred after the termination date of coverage under this Plan.
(15) Procedures, services or supplies primarily for beautification, including charges for personalized or characterization of dentures.

VII
GENERAL EXCLUSIONS APPLICABLE TO ALL COVERAGES UNDER THIS PLAN

(1) Charges incurred prior to the effective date of coverage under the Plan.

(2) Charges for care or treatment of an Injury or Illness arising out of or in the course of any employment or occupation for wage or profit, or for which the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease Law, whether or not any coverage for such benefits is actually in force.

(3) Charges for treatment provided or furnished by the United States Government or the government of any other country. If this is inconsistent with any Federal Law this exclusion is inoperative.

(4) Charges for care or treatment arising out of war, an act of war, declared or undeclared, or participation in a riot.

(5) Charges for the care or treatment as a result of being engaged in an illegal occupation or commission of or attempted commission of a felony or assault.

(6) Charges for care or treatment while a member of the armed forces of any state or country.

(7) Charges for which the Covered Person is not legally required to pay or which would not have been made if no coverage had existed.

(8) Charges for the completion of claim forms, medical reports or certifications required by the Plan.

(9) Charges which are not specifically included as Eligible Expenses.

(10) Charges for services rendered by a close relative of the Covered Person, including the immediate family or a person related by blood or marriage, or by a person who normally resides in the same household as the Covered Person.

(11) Charges for experimental treatment, procedures, drugs or research studies, or for any such service or supplies not considered legal in the United States.

(12) Charges for services or supplies which were provided more than 12 months prior to the date the charges are submitted to the Plan for payment.

VIII
MISCELLANEOUS PROVISIONS

Coordination of Benefits (COB) Provision

This COB provision applies to This Plan when a Covered Person has health care coverage under more than one Plan. All of the benefits provided by This Plan are subject to this provision.

Definitions

For the purpose of this COB provision, the following definitions will apply:

Plan

Any arrangement of coverage which provides health benefits or services by means of:

(a) group, blanket or franchise coverage, whether insured or uninsured, including coverage provided through:
  (i) HMO's and other prepayment group or individual plans;
  (ii) automobile "no fault" and "fault" insurance, including uninsured/underinsured motorist coverage and medical payment coverage;
  (iii) hospital indemnity benefits of more than $100 per day;

(b) governmental programs, except:

  (i) coverage provided under Title XVIII (Medicare) and Title XIX (Medicaid) of The Social Security Act of 1965, as amended; and
  (ii) any plan when by law its benefits are excess to those of any private insurance plan or non-governmental plan;

(c) any coverage under:

  (i) labor-management trusteed plans;
  (ii) union welfare plans;
  (iii) employer organization plans or employee benefit organization plans.

Plan does not mean:

(a) any type of school accident coverage, including college plans; or
(b) individual or family plans or contracts.

This Plan

The health expense benefits provided by the Employer.

Primary

A Plan which pays Allowable Expenses without regard to the existence of any other Plans.

Secondary

Any Plan which is not considered the Primary Plan. When there are more than two Plans covering the same Covered Person, This Plan may be Primary as to one or more Plans and Secondary as to a different Plan or Plans.

Order of Benefit Determination

A Plan will always be Primary and will pay its benefits first if the Plan has no COB provision or non-duplication provision with the same intent.

If, however, both Plans have a COB provision, the Primary and Secondary Plan will be determined according to the following rules:

(a) The benefits of a Plan which covers a person as an employee are determined before those of a Plan which covers a person as a Dependent.

(b) Covered Dependent Child/Parents **not** Separated or Divorced The benefits of a Plan which covers a child as a Covered Dependent of a parent whose birthday falls earlier in the year are determined before those of a Plan of the parent whose birthday falls later in the year. A person's year of birth is not relevant in applying this rule.

(c) Covered Dependent Child/Parents Separated or Divorced The benefits of a Plan which covers a child as a Covered Dependent of divorced or separated parents are determined in the following order:

(i) the benefits of the Plan of the parent who is the residential parent with legal custody of the child, or the equivalent as defined by the statute in the State in which the employee resides, are determined first;
(ii) the benefits of the Plan of the Spouse of the parent who is the residential parent with legal custody of the child or the equivalent as defined by the statute in the State, in which the employee resides, are determined next;
(iii) the benefits of the Plan of the parent who is not the residential parent with legal custody, or the equivalent as defined by the statute in the State in which the employee resides, are determined last.

If, however, there is a court decree which would otherwise establish financial responsibility for the health care expenses of a child, then the benefits of the Plan which covers the parent with financial responsibility are determined before any other Plan.

(d) The benefits of a Plan which covers a person as an active employee (or a Dependent of such employee) are determined before the benefits of a Plan which covers such person as:
(i) a laid-off or retired employee;
(ii) the Dependent of a laid-off, retired or deceased employee; or
(iii) a COBRA beneficiary continuing coverage in accordance with Federal Law.

(e) If none of the above rules determine an order of benefits, then the benefits of a Plan which has covered the person for the longer period of time are determined before those of the Plan which has covered the person for the shorter period of time.

(f) The Covered Person's benefits under automobile "no fault" and "fault" insurance, including uninsured/underinsured motorist coverage, and medical payment coverage are determined before the benefits of this Plan

How Your Benefits Are Paid

(a) This Plan will determine which Plan is Primary and which Plan is Secondary. In order to obtain all benefits available, a Covered Person should file a claim under each Plan.

(b) This Plan will pay its benefits without regard to the existence of any other Plan when it is Primary.

(c) When This Plan is Secondary it will pay a reduced benefit which, when added to the benefits paid by all other Plans, will not exceed 100% of the total Allowable Expense. Any benefits reduced during any Claim Determination Period because of this provision will be reduced proportionately. Only the reduced amount may be charged against any benefit limit of This Plan. No Plan will pay more than it would have paid in the absence of this COB provision.

Effect of Medicare on the Plan

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

Coverage for a Covered Person will always be Primary if:

1. The Covered Person is entitled to benefits under Medicare based off his/her age, and is an active Employee or the Spouse of an active Employee of an employer with 20 or more Employees; or

2. The Covered Person is entitled to benefits under Medicare because of renal dialysis or kidney transplant. In this case, starting on the date the Covered Person becomes eligible for Medicare, coverage under this plan will be Primary only during the first 30 months of the coordination period such person is so entitled; or

3. The Covered Person is entitled to Medicare on the basis of disability, and his/her employer has 100 or more Employees.

Coverage for a Covered Person will be Secondary if:

1. The Covered Person is entitled to Medicare on the basis of age and is an active Employee or the Spouse of an active Employee of an employer with less than 20 Employees.

2. The Covered Person has been entitled to benefits under Medicare because of renal dialysis or kidney transplant for more than 30 months (coordination period). In this case, coverage under this Plan will be Secondary only after the first 30 months of the coordination period such person is so entitled; or

3. The Covered Person is entitled to Medicare on the basis of disability, and his/her employer has less than 100 Employees.

4. The Covered Person is a retired Employee or the covered Dependent of a retired Employee.

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

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

Subrogation and Right of Recovery

The provisions of this section apply to all current or former Plan Participants and also to the parent(s), guardian, or other representative of a Dependent child who Incurs claims and is or has been covered by the Plan. The Plan's right to Recover (whether by Subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the Plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to Recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult Covered Person without the prior express written consent of the Plan.

The Plan's right of Subrogation or reimbursement, as set forth below, extends to all insurance coverage available to you due to an Injury, Illness, or Condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile coverage, or any first party insurance coverage).

Your health Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other Recovery funds from any insurance coverage or other source will be made until the health Plan’s Subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of Subrogation means the Plan is entitled to pursue any claims that you may have in order to Recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be Subrogated to (stand in the place of) all of your rights of Recovery with respect to any claim or potential claim against any party, due to an Injury, Illness, or Condition to the full extent of benefits provided, or to be provided, by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its Subrogation claim, with or without your consent. The Plan is not required to pay you part of any Recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an Injury, Illness, or Condition, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that

Injury, Illness, or Condition, up to and including the full amount of your Recovery. Benefit payments made under the Plan are conditioned upon your obligation to reimburse the Plan in full from any Recovery you receive for your Injury, Illness or Condition.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider); you agree that if you receive any payment as a result of an Injury, Illness, or Condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other Recovery funds from any insurance coverage or other source will be made until the health Plan's Subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the Illness, Injury, or Condition upon any Recovery whether by settlement, judgment or otherwise, related to treatment for any Illness, Injury, or Condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Assignment

In order to secure the Plan's Recovery rights, you agree to assign to the Plan any benefits, or claims, or rights of Recovery you have under any automobile policy or other coverage, to the full extent of the Plan's Subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the Plan, you acknowledge that the Plan's Recovery rights are a first priority claim and are to be repaid to the Plan before you receive any Recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a Recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire Subrogation and right of Recovery provision shall apply and the Plan is entitled to full Recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to Recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the Plan's efforts to Recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to Recover damages or obtain compensation due to your Injury, Illness or Condition. You and your agents agree to provide the Plan or its representatives notice of any Recovery you or your agents obtain prior to receipt of such Recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other Recovery funds obtained. You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal Injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its Subrogation rights or failure to reimburse the Plan from any settlement or Recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the Plan's Subrogation or Recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or Recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other Recovery prior to fully satisfying the health Plan's Subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the Injury, Illness or Condition to identify potential sources of Recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its Subrogation and reimbursement rights.

Future Benefits

If you fail to cooperate with and reimburse the Plan, the health Plan reserves the right to deny any future benefit payments on any other claim made by you until the Plan is reimbursed in full. However, the amount of any Covered Services excluded under this section will not exceed the amount of your Recovery.

Interpretation

In the event that any claim is made that any part of this Subrogation and right of Recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By

accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the Plan incurs in successful attempts to Recover amounts the Plan is entitled to under this section.

Discretionary Authority

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

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

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your Plan Administrator.

Women's Health and Cancer Rights Act of 1998

This Plan intends to comply with the Women's Health and cancer Rights Act of 1998, as amended from time to time, as described below. A Covered Person who elects breast reconstruction in connection with a mastectomy also will be covered for:

(1) Reconstruction of the breast on which the mastectomy was performed;
(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
(3) Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Deductible and coinsurance for other benefits under the Plan may also apply to these reconstructive surgery benefits.

IX
DEFINITIONS

Active Full-Time Employee

An employee who meets the definition of a full-time employee according to the City Payroll Ordinance or any employee meeting the requirements set forth in the negotiated collective bargaining agreement or as specified under PPACA for health insurance purposes only as determined by the City in its measurement period. This does not include Leased Employees, independent contractors or temporary or seasonal workers.

Acute Medical Condition

A condition or symptom which becomes so acute in nature and which is of such severity that it does in fact constitute an extremely hazardous medical condition which would result in jeopardy to the Covered Person's life or cause serious harm to his health if not treated immediately by a Physician.

Alcoholism

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

Alcoholism or Drug Addiction Treatment Facility

A facility which: (1) operates within the scope of its license; (2) is engaged mainly in providing Inpatient services for the treatment of alcoholism or drug addiction in return for compensation; (3) provides 24 hour nursing services by or under the supervision of registered graduate nurses; and (4) maintains daily clinical records on each patient and has available at all times the services of a Physician under an established agreement.

In no event will this definition include an institution or any part of one which is a Skilled Nursing Facility, or any institution which is used primarily as: (1) a rest facility; (2) a nursing facility; (3) a facility for the aged; or (4) a place for custodial care.

Allowed Amount

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

Ambulatory Surgical Facility

A facility which: (1) operates within the scope of its license; (2) is engaged mainly in performing elective surgery; (3) admits and discharges each patient within a working day; (4) has a medical staff including Physicians and registered graduate nurses; (5) has permanent operating rooms, recovery rooms and equipment for emergency care; and (6) has transfer arrangements with a Hospital for patients requiring Hospital care following treatment in the Ambulatory Surgical Facility.

Benefit Percentage

That figure shown as a percentage in the Schedule of Benefits used to compute the amount of benefits payable for Eligible Expenses incurred by a Covered Person.

Calendar Year

A period of one year, beginning with January 1 and ending December 31.

Community Mental Health Facility

A facility which is approved by a regional planning agency or which provides services under a community mental health and retardation board. Such Board must be established in accordance with state law and where such board provides direct mental health services, the specific program of such services must be approved by the state's Mental Health Commissioner.

Confinement

The period of time during which a Covered Person is an Inpatient incurring a charge for Room and Board in a Hospital or other covered facility.

Contributory Coverage

Coverage, for which the employee bears all or part of the cost.

Copayment

The portion of Eligible Expenses specified in the Schedule of Benefits which is payable by the Covered Person directly to a provider at the time of service or purchase.

Covered Person

An Eligible Person, who enrolls, becomes covered and remains covered under this Plan, meeting the requirements as set forth in the "Eligibility for Coverage" section of this Plan.

Custodial Care

Care comprised of services and supplies, including room and board and other institutional services, which is provided to an individual, whether Disabled or not, primarily to assist him in the activities of daily living.

Day Treatment Programs

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

Day/Night Psychiatric Facility

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

Deductible Amount

The amount of Eligible Expenses as shown in the Schedule of Benefits, which must be incurred by a Covered Person during each Calendar Year or any other period specified before benefits become payable under the Plan.

Dental Allowed Amount

The maximum amount determined and allowed by the Plan for a Covered Service.

Dentist

A person who is licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his license. For the purpose of this definition, a Physician will be considered to be a dentist when he performs any covered dental service and is operating within the scope of his license.

Dependent

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

- Your lawful Spouse provided you are not legally separated;

- Your natural children, adopted children, children placed for adoption with you, stepchildren or legal wards from birth to the end of the calendar month in which the child attains age 26. (Grandchildren are not covered under the Plan unless you have assumed legal guardianship for them);

Coverage may be continued beyond age 26 for your unmarried Dependent children who reside* with you if they are Totally Disabled by reason of a mental or physical handicap which commenced prior to reaching the limiting age, continue to be Totally Disabled and are principally dependent upon you or your Spouse for support. However, notification of the child's condition must be given within 31 days of the child's normal termination date. A non-permanent Total Disability where medical improvement is possible is not considered to be a "handicap" for the purpose of this provision. This includes Alcoholism and Drug Abuse and non-permanent mental impairments.

You may be required to supply proof, upon request by the City of Stow or the Claims Administrator, that a child satisfies these eligibility criteria.

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

Disability/Period Of Disability

Any period of Illness or Injury or multiple Illnesses or Injuries, arising from the same cause, including any and all complications there from, which are not separated by 90 consecutive

days during which the Covered Person is free of Confinement.

Drug Abuse

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

Eligible Expense

Allowed Amount incurred by a Covered Person for services and supplies which are (1) recommended by a Physician; (2) Medically Necessary for the treatment of an Illness or Injury; and (3) provided after the effective date of coverage under this Plan.

Eligible Person

An employee and/or his Dependents are considered an Eligible Person when meeting the eligibility requirements as set forth in the "Eligibility for Coverage" section of this Plan.

Emergency Care Center

A public or private establishment with an organized staff of Physicians and with permanent facilities equipped mainly to provide immediate emergency accident care and non-acute medical care.

Emergency Medical Condition

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

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

Employer

City of Stow

Enrollment Date

The term "Enrollment Date" means the first day of coverage under this Plan or, if earlier, the beginning of any applicable Waiting Period under this Plan.

Essential Health Benefits

Defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Expense Incurred

An expense is incurred when the service or the supply is actually provided.

Experimental/Investigative

Any treatment, procedure, facility, equipment, drug, device or supply which the Plan does not recognize as accepted medical practice or which did not have required governmental approval when received. Determination will be made by the Plan in its sole discretion and will be conclusive.

Freestanding Birth Center

An Outpatient facility which: (1) operates within the scope of its license; (2) maintains daily clinical records; (3) provides 24 hour nursing service by or under the supervision of registered graduate nurses or certified nurse midwives; (4) is staffed, equipped and operated to provide: (a) care for patients during uncomplicated pregnancy, delivery, and the immediate postpartum period; (b) care for infants born in the center who are normal or have abnormalities which do not impair function or threaten life; and (c) care for obstetrical patients and infants born in the center who require emergency and immediate life support measures to sustain life pending transfer to a Hospital.

He, Him, His

Whenever the masculine pronoun is used in this booklet, it will include the feminine gender unless the context clearly indicates otherwise.

Home Health Aide

A person, who provides care of a medical or therapeutic nature, reports to and is under the direct supervision of a Home Health Care Agency.

Home Health Care Agency

A public or private agency or organization, or part of one, that mainly provides skilled nursing and other therapeutic services. It must be legally qualified in the state or locality in which it operates. It must keep critical records on all patients. The services must be supervised by a Physician or registered nurse, and they must be based on policies set by associated professionals, which include at least one Physician and one registered nurse.

Home Health Care Plan

A plan for continued care and treatment of a Covered Person in his home. To qualify, the plan must be established in writing by a Physician who certifies that the Covered Person would require Confinement in a Hospital if he did not have the care and treatment stated in the plan. The Home Health Care Plan is subject to review and approval by an approved medical review organization.

Hospice Care Agency

An agency or organization that is licensed in the state, in which it operates, has Hospice Care available 24 hours a day, 7 days a week and provides or arranges for Hospice Care services or supplies.

Hospice Care Plan

A plan that is supervised by a Physician and has a team consisting of: (1) a Physician who provides Hospice Care; (2) licensed nurses; (3) a licensed mental health specialist; and (4) a licensed social worker.

The Hospice Care Plan must be responsible for: (1) the patient's plan of care; (2) regular reviews of the patient's care; (3) informing the proper persons of any change in the patient's condition; and (4) complying with governmental regulations.

Hospice Facility

A facility which: (1) operates within the scope of its license; (2) is engaged mainly in providing palliative care for the terminally ill; (3) provides 24 hour nursing care by or under the supervision of a registered graduate nurse; (4) provides pre-death and bereavement counseling; (5) maintains daily clinical records on each patient; and (6) has available at all times the services of a Physician under an established agreement.

This definition does not include an institution or any part of one which is a Skilled Nursing Facility, or any institution which is used primarily as a nursing facility or facility for the aged.

Hospital

An accredited institution that meets all applicable regional, state and federal licensing requirements and that meets all of the criteria described below:

1. It is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense;

2. It is accredited by the Joint Commission on Accreditation of Hospitals;

3. It is a Hospital, a Psychiatric Hospital, or a tuberculosis Hospital as those terms are defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare;

4. It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified Physicians;

5. It continuously provides on the premises 24 hour-a-day nursing service by or under the supervision of registered graduate nurses; and

6. It is operated continuously with organized facilities for operative surgery on the premises.

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

Hospital Miscellaneous Charges

Charges made by a Hospital for other than Room and Board and general nursing care including, but not limited to, amounts charged for necessary services, medicines, supplies or services for diagnosis or treatment of an Illness or Injury (except services of a Physician and drugs or supplies not consumed or used in the Hospital) while the Covered Person is confined as an Inpatient.

Illness

Any physical or mental sickness or disease which manifests treatable symptoms and which requires treatment of a Physician. This definition also includes pregnancy.

Injury

Trauma to the body requiring treatment by a Physician caused by a sudden, unforeseen, unexpected external event.

Inpatient

A Covered Person who is a registered bed patient in a Hospital upon the recommendation of a Physician.

Late Enrollee

The term "Late Enrollee" means an individual who is enrolled for coverage after the initial eligibility date. Note, however, a Special Enrollee shall not be considered a Late Enrollee.

Lifetime Maximum

“Lifetime Maximum” refers to a maximum amount measured by the total period of an individual’s participation in the Plan. It does not mean that an individual is entitled to coverage by the Plan for the individual’s entire lifetime.

Medically Necessary

A service or supply which is necessary and appropriate for the diagnosis and treatment of an Illness or Injury based on generally accepted current medical practice.

The fact that any particular Physician may prescribe order, recommend or approve a service or supply does not, of itself, make that service Medically Necessary.

This definition does not include a service or supply if: (1) it is provided only as a convenience to the Covered Person; (2) it is not appropriate treatment for the Covered Person's diagnosis or symptoms; or (3) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

Medicare

Title XVIII (Health Insurance for the Aged) of the United States Social Security Act as amended by Social Security Amendment of 1965 or as later amended.

Mental Illness

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

Non-Contributory Coverage

Coverage for which the employee does not pay any of the cost.

Outpatient

A Covered Person treated on a basis other than as a registered bed patient in a Hospital.

Physician

A legally qualified person acting within the scope of his license and holding the degree of: (1) Doctor of Medicine (M.D.); (2) Doctor of Osteopathy (D.O.); (3) Doctor of Dental Surgery (D.D.S.); (4) Doctor of Podiatry (D.P.M.); (5) Doctor of Chiropractic (D.C.); or (6) a Licensed Clinical Psychologist (Ph.D.).

The definition of Physician may be extended to include a: (1) Certified Nurse Midwife acting within the scope of his license, under the direction and supervision of a licensed Physician; (2) Licensed Physical Therapist (L.P.T.) or Licensed Speech Therapist (L.S.T.) when acting within the scope of their license and performing services ordered by a Doctor of Medicine or Doctor of Osteopathy; (3) Licensed Social Worker/Licensed Professional Clinical Counselor performing services under the direct supervision of a Licensed Clinical Psychologist (Ph.D.) or Doctor of Medicine (M.D.); (4) Licensed Professional Clinical Counselor; and (5) Doctor of Optometry (O.D.).

Plan

City of Stow Employee Group Health Benefit Plan.

Podiatric Treatment

The actual services provided or recommended by a Podiatrist, including examinations, laboratory and x-rays, and treatment.

PPACA

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

Prescription Drug (Federal Legend Drug)

Any medication that by federal or state law may not be dispensed without a prescription order.

Recovered / Recovery

Monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injuries or Illness whether or not said losses reflect medical or dental charges covered by this Plan.

Rehabilitation Facility

A legally operating institution or distinct part of an institution which has a transfer agreement with one or more Hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute Hospital and rehabilitative inpatient care and is duly licensed by the appropriate government agency to provide such services. It does not include institutions which provide only minimal care, custodial care, ambulatory or part-time care services, or an institution which primarily provides treatment of mental disorders, chemical dependency or tuberculosis except if such facility is licensed, certified or approved as a Rehabilitation Facility for the treatment of medical conditions or drug addiction or alcoholism in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

Residential Treatment Facility

A facility that meets all of the following:

- An accredited facility that provides care on a 24- hours- a -day, 7 days- a- week, live-in basis for the evaluation and treatment of residents with psychiatric or chemical dependency disorders who do not require care in an acute or more intensive medical setting.

- The facility must provide room and board as well as providing an individual treatment plan for the chemical, psychological and social needs of each of its residents.

- The facility must meet all regional, state and federal licensing requirements.

- The residential care treatment program is supervised by a professional staff of qualified Physician(s), licensed nurses, counselors and social workers.

Room and Board

Charges made by a Hospital for the cost of the room, general duty nursing care, and other services routinely provided to all Inpatients, not including Special Care Units.

Semi-Private Charge

The charge made by a Hospital for a room containing two (2) or more beds. This does not include charges for Special Care Units.

Skilled Nursing Facility

An institution or distinct part-thereof, operated pursuant to law and meeting all of the following requirements:

(1) maintains permanent and full-time facilities for bed care of 10 or more resident patients;

(2) has available at all times the services of a Physician;

(3) has a Registered Nurse (R.N.) or Physician on full-time duty in charge of patient care, and one or more Registered Nurses (R.N.'s), or Licensed Vocational Nurses (L.V.N.'s), or Licensed Practical Nurses (L.P.N.'s) on duty at all times;

(4) maintains a daily medical record for each patient;

(5) is primarily engaged in providing continuous skilled nursing care for sick or injured persons during the convalescent stage of their Illness or Injury;

(6) is operating lawfully as a Convalescent/Skilled Nursing Facility in the jurisdiction where it is located or meets the required standards of the Joint Commission on Accreditation of Hospitals; and

(7) has a written agreement with at least one other Hospital providing for the transfer of patients and medical information between the Hospital and Convalescent/Skilled Nursing Facility.

In no event, however, will Convalescent/Skilled Nursing Facility include an institution which is primarily: (1) a place for rest; (2) a place for the aged; (3) a place for drug addicts or alcoholics; (4) a place for the blind or deaf; (5) a hotel or similar place.

Special Care Unit

A Hospital unit which provides concentrated special equipment and highly skilled personnel for the care of critically ill patients requiring immediate, constant and continuous attention. This definition includes charges for intensive care, coronary care, and acute care units of a Hospital but does not include charges for a surgical recovery or post-operative room. The unit must meet the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Special Enrollee

The term "Special Enrollee" means an Employee or Dependent who is entitled to and who requests Special Enrollment (1) within 30 days of losing other health coverage; or (2) for a newly acquired Dependent, within 30 days of the marriage, birth, adoption, or placement for adoption.

Spinal Manipulation Treatment

Spinal manipulation therapy (defined as the manual manipulation of the spine to restore mobility to the joints and to allow vertebrae to assume their normal position) and other modalities of treatment, including examinations, laboratory services and x-rays provided in connection with such treatment or therapy.

Substance Abuse

Physical dependence on drugs or alcohol. This includes (but is not limited to) dependence on drugs that are medically prescribed.

Subrogation

This Plan’s rights to pursue the Covered Person’s claims for medical or dental charges against the other party.

Teledentistry

The delivery of dental services through the use of synchronous, real-time communication and the delivery of services of a dental hygienist or expanded function dental auxiliary pursuant to a dentist’s authorization.

Telemedicine Services

Certain services that are provided by a provider who is not at the same location as the patient, using an interactive two-way telecommunications system, which includes both an audio and video component.

Temporomandibular Joint (TMJ) Disturbances

Any jaw joint problems including temporomandibular joint syndrome and craniomandibular disorders, or other conditions of the joint that links the jaw bone and skull and the complex of muscles, nerves and other tissues related to that joint.

Therapy By Physical Means

Treatment given to relieve pain, restore maximum function and prevent disability following Illness, Injury or loss of body part. Services include hydrotherapy; heat or similar modalities; physical agents, hyperbaric therapy; bio-mechanical, neurophysiological principles and devices. Treatment must be Medically Necessary and non-maintenance to be eligible.

Total Disability

When the Covered Person, if an Employee or regularly employed Dependent Spouse, is prevented, solely because of a non-occupational Injury or non-occupational Illness, from engaging in his regular or customary occupation and is performing no work of any kind for compensation or profit; or when any other Dependent, is prevented, solely because of non-occupational Injury or non-occupational Illness, from engaging in all of the normal activities of a person of like age and in good health. Certification of Total Disability must be made by a Physician.

Waiting Period

The specified period of time, if any, an employee must be in an eligible Employee Class before becoming eligible for coverage under the Plan.

X

STANDARDS FOR PRIVACY OF PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

This provision is intended to bring your Health Benefit Plan into compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, (the regulations are referred to herein as the "HIPAA Privacy Rule") by establishing the extent to which the Plan Sponsor will receive, use and/or disclose Protected Health Information. The compliance date for "small health plans" is April 14, 2004. Accordingly, the Plan hereby includes the following:

Plan's Designation of Person/Entity to Act on its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates the Plan Sponsor to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule.

Definitions

All terms defined in the HIPAA Privacy Rule shall have the meaning set forth therein, together with the following additional terms defined below:

(1) **Plan** means the City of Stow Employee Group Health Benefit Plan.

(2) **Plan Documents** mean the Plan's governing documents and instruments (i.e., the documents under which the Plan was established and is maintained), including but not limited to the Health Plan Document of the City of Stow Health Benefit Plan.

(3) **Plan Sponsor** is City of Stow.

The Plan's disclosure of Protected Health Information to the Plan Sponsor agrees to comply with the Plan provisions as stated in this section.

The Plan will disclose Protected Health Information to the Plan Sponsor or provide for or permit the disclosure of Protected Health Information to the Plan Sponsor by an entity servicing the Plan, only if the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

(1) the Plan Documents state, or have been amended to state, the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the HIPAA Privacy Rule;

(2) the Plan Documents include, or have been amended to include, the Plan provisions set forth in this section; and

(3) the Plan Sponsor agrees to comply with the Plan provisions as stated in this.

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

(1) The Plan, or any entity servicing the Plan, will disclose individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions. Such disclosure will be consistent with the provisions of

this section.

(2) All disclosures of the Protected Health Information by any entity servicing the Plan, will comply with the restrictions and requirements set forth in this section, and in the HIPAA Privacy Rule.

(3) The Plan, may not, and may not permit any entity servicing the Plan to disclose individuals' Protected Health Information to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(4) The Plan Sponsor will not use or further disclose Protected Health Information other than as described in the Plan Documents and permitted by the HIPAA Privacy Rule.

(5) The Plan Sponsor will ensure that any agent to whom it provides Protected Health Information received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.

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

(7) The Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as stated or amended) and in the HIPAA Privacy Rule of which the Plan Sponsor becomes aware.

Disclosure of individuals' Protected Health Information – Disclosure by the Plan Sponsor

(1) The Plan Sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with HIPAA Privacy Rule.

(2) The Plan Sponsor will make Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with HIPAA Privacy Rule.

(3) The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of Protected Health Information that it must account for in accordance with HIPAA Privacy Rule.

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

(5) The Plan Sponsor will, if feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the

use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(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

The Plan, or any entity servicing the Plan, may disclose summary health information to the Plan Sponsor without the need to amend the Plan Documents, if the Plan Sponsor requests the summary health information for the purpose of:

(1) Obtaining premium bids for stop loss insurance coverage, or any other such coverage on behalf of the Plan; or

(2) Modifying, amending, or terminating the Plan.

The Plan, or any entity servicing 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

In accordance with the "504" provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan Sponsor who may be given access to individuals' Protected Health Information received from the Plan or from an entity servicing the Plan.

(1) Human Resources Personnel

(2) Public officials only as necessary

This list reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who may receive individuals' Protected Health Information relating to treatment, payment, health care operations of, or other matters pertaining to Plan administration functions that the Plan Sponsor provides for the Plan. The Plan Sponsor will maintain, separate from this document, a written list of the employees or workforce members under the control of the Plan Sponsor who are designated to receive Protected Health Information. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions and will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, the provisions of this section.

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.

Security of Electronic Protected Health Information

The following provision is intended to bring this Plan into compliance with the requirements of 45 C.F.R. § 164.314(b) (1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 (the regulations are referred to herein as the "HIPAA Security Standards"), effective April 21, 2005 (April 21, 2006 for small health plans). The Plan Sponsor's added obligations with respect to the security of Electronic Protected Health Information are shown in italics:

Definitions

(1) **Electronic Protected Health Information** – The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103 and generally means protected health information that is transmitted or maintained in any electronic media.

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

Plan Sponsor Obligations Regarding Electronic Protected Health Information

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

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

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

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

(4) Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

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

   b. Plan sponsor shall report to the Plan any other Security Incident on a periodic basis or upon the Plan's request.

XI
HOW TO USE YOUR BENEFITS

CLAIMS PROCEDURES

Types of Claims

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

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

> **Claim Involving Urgent Care** – A Claim Involving Urgent Care is any Pre-Service Care Claim for medical care or treatment with respect to which the application of the timeframes for making non-urgent care determinations (a) could seriously jeopardize your life or health or your ability to regain maximum function or (b) in the opinion of a Physician with knowledge of your medical Condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Determination of ***urgent*** will be made by an individual acting on behalf of the plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine; however, any Physician with knowledge of your medical Condition can determine that a claim involves urgent care. With respect to prior authorization requests submitted by health care practitioners (as defined in Ohio Revised Code 3923.041(A)) through the Plan's or its designee's electronic software system only, a Claim Involving Urgent Care also means a claim for Medical Care or other service for a Condition where the application of the timeframes for making non-urgent care determinations (a) could seriously jeopardize the life, health, or safety of the claimant or others due to the claimant's psychological state; or (b) in the opinion of a practitioner with knowledge of the claimant's medical or behavioral condition, would subject the claimant to adverse health consequences without the care or treatment that is the subject of the request.
>
> **Concurrent Care Claim** - A Concurrent Care Claim is a claim for an extension of the duration or number of treatments provided through a previously approved pre-service claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought. Additionally, if the Plan or its designee reduces or terminates a course of treatment before the end of the course previously approved (unless the reduction or termination of benefits is due to a health plan amendment or health plan termination), then the reduction or termination is considered an adverse benefit determination. The Plan or its designee will notify you, in advance, of the reduction or termination so that you may appeal and obtain an answer on the appeal before the benefit is reduced or terminated.

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

Who Must File

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

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

Time Limit for Filing a Claim

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

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

Where to File a Claim

Claims should be filed as indicated on your Identification Card.

What to File

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

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

Timing of Claims Determinations

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

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

If your health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submits a Claim Involving Urgent Care through the Plan's or its designee's electronic software system, the Plan or its designee will respond to the request within 48 hours of receipt and indicate whether the request is denied, approved, or if additional information is needed to process the request.

If additional information is needed to process the request, the Plan or its designee will notify the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) within 24 hours of receipt of the Claim Involving Urgent Care and the health care practitioner will have 48 hours to respond. Because we are required to make a decision within 48 hours after receipt of the Claim Involving Urgent Care, your claim may still be denied when we request additional information.

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

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

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

If your health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submits a Pre-Service Claim through the Plan's or its designee's electronic software system, the Plan or its designee will respond to the request within 10 days of receipt and indicate whether the request is denied, approved, or if additional information is needed to process the request. If additional information is needed to process the request, the health care practitioner will then have 45 days to respond with the additional information. If your health care practitioner does not provide the information, your claim may be denied.

For only those prior authorization requests that are submitted by a health care practitioner (as defined in Ohio Revised Code 3923.041(A)) through the Plan's or its designee's electronic software system that are approved by the Plan or its designee, except in cases of fraudulent or materially incorrect information, the Plan or its designee will not retroactively deny a prior authorization for a health care service, drug, or device when all of the following are met: (1) the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submits a prior authorization request to the Plan or its designee for a health care service, drug, or device; (2) the Plan or its designee approves the prior authorization request after determining that all of the following are true: (a) the claimant is eligible under the health benefit plan; (b) the health care service, drug, or device is covered under the claimant's health benefit plan; and (c) the health care service, drug, or device meets the Plan's or its designee's standards for medical necessity and prior authorization; (3) the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) renders the health care service, drug, or device pursuant to the approved prior authorization request and all of the terms and conditions of the health care practitioner's contract with the Plan or its designee; (4) on the date the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) renders the prior approved health care service, drug, or device, all of the following are true: (a) the claimant is eligible under the health benefit plan; the claimant's condition or circumstances related to the claimant's care has not changed; (c) the health care practitioner submits an accurate claim that matches the information submitted by the health care practitioner in the approved prior authorization request; and (5) if the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submits a claim that includes an unintentional error and the error results in a claim that does not match the information originally submitted by the health care practitioner in the approved prior authorization request, upon receiving a denial of services from the Plan or its designee, the health care practitioner may resubmit the claim with the information that matches the information included in the approved prior authorization.

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

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

If you file a Post-Service Claim for a service where prior authorization was required but not obtained, upon written request, the Plan or its Designee shall permit a retrospective review if the service in question meets all of the following: (i) the service is directly related to another service for which the health care practitioner (as defined in Ohio Revised Code 3923.041(A)) submitted a prior authorization request through the Plan's or its Designee's electronic software system, prior approval has already been obtained from the Plan or its Designee on such request, and the original prior authorized service has already been performed; (ii) the new service was not known to be needed at the time the original prior authorized service was performed; and (iii) the need for the new service was revealed at the time the original authorized service was performed. Once the written request and all necessary information is received, the Plan or its Designee will review the claim for coverage and medical necessity. The Plan or its Designee will not deny a claim for such a new service based solely on the fact that a prior authorization approval was not received for the new service in question.

Notice of Claims Denial (Adverse Benefit Determination)

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

1. Information sufficient to identify the claim or health care service involved, including the date of service, healthcare provider, and claim amount (if applicable);
2. The specific reason(s) for the adverse benefit determination, including the denial code and its corresponding meaning;
3. Reference to the specific plan provision(s) on which the adverse benefit determination was based;
4. If the adverse benefit determination relied upon any internal rules, guidelines or protocols, a statement that you may request a copy of the rule, guideline or protocol, which will be provided free of charge;
5. If the adverse benefit determination was based in whole or in part on Medical Necessity, Experimental/Investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided free of charge;
6. Notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
7. Disclosure of the availability of assistance with the appeal process from the Ohio Department of Insurance if your Plan is regulated by the Ohio Department of Insurance;
8. A description of additional material or information, if any, that is required to perfect the claim and an explanation of why the information is necessary; and
9. A description of the Plan's or its designee’s appeal procedures and applicable time limits, including the expedited appeal process, if applicable.

FILING A COMPLAINT

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

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

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

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

Additionally, the Customer Care Specialist will notify you of how to file an appeal.

APPEALS PROCEDURES

Definitions

For the purposes of this "APPEALS PROCEDURES" Section, the following terms are defined as follows:

Adverse Benefit Determination – a decision by a Health Plan Issuer:

- to deny, reduce, or terminate a requested Health Care Service or payment in whole or in part, including all of the following:
    - a determination that the Health Care Service does not meet the Health Plan Issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including Experimental or Investigational treatments;
    - a determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non-employer group, to participate in a plan or health insurance coverage;
    - a determination that a Health Care Service is not a Covered Service;
    - the imposition of an exclusion, including exclusions for pre-existing conditions, source of injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-employer group;
- To Rescind coverage on a Health Benefit Plan.

Authorized Representative – an individual who represents a Covered Person in an internal appeal process or external review process, who is any of the following: (1) a person to whom a Covered Person has given express written consent to represent that person in an internal appeal process or external review process; (2) a person authorized by law to provide substituted consent for a Covered Person; or (3) a family member or a treating health care professional, but only when the Covered Person is unable to provide consent.

Covered Service – please refer to the definition of this term in the Definitions Section in this SPD.

Covered Person – please refer to the definition of this term in the Definitions Section of this SPD.

Emergency Medical Condition – a medical Condition that manifests itself by such acute symptoms of sufficient severity, including severe pain that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the covered person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

Emergency Services –

- A medical screening examination, as required by federal law, that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition;
- Such further medical examination and treatment that are required by federal law to stabilize an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the hospital, including any trauma and burn center of the hospital.

Final Adverse Benefit Determination – an Adverse Benefit Determination that is upheld at the completion of the Plan's internal appeal process.

Health Benefit Plan – a policy, contract, certificate, or agreement offered by a Health Plan Issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of Health Care Services.

Health Care Services – services for the diagnosis, prevention, treatment, cure, or relief of a health Condition, illness, injury, or disease.

Health Plan Issuer – an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the Superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of Health Care Services under a Health Benefit Plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan.

"Health plan issuer" includes a third party administrator to the extent that the benefits that such an entity is contracted to administer under a Health Benefit Plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the Superintendent.

Independent Review Organization – an entity that is accredited to conduct independent external reviews of Adverse Benefit Determinations.

Rescission or to Rescind – a cancellation or discontinuance of coverage that has a retroactive effect. "Rescission" does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Stabilize – the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a Covered Person's medical Condition is likely to result from or occur during a transfer, if the medical Condition could result in any of the following:

- Placing the health of the Covered Person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
    - Serious impairment to bodily functions;
    - Serious dysfunction of any bodily organ or part.
- In the case of a woman having contractions, "stabilize" means such medical treatment as may be necessary to deliver, including the placenta.

Superintendent – the superintendent of insurance.

Utilization Review – a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings.

How and When to File a Claims Appeal

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

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

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

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

There is no fee to file an appeal. Appeals can be filed regardless of the claim amount at issue.

First Level Mandatory Internal Appeal

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

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

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

7. May request an external review at the same time you request an internal appeal for an urgent care claim or for a concurrent care claim that is urgent.

The claim review will be subject to the following rules:

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

Timetable for Deciding Appeals

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

Urgent Care Claims – as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receiving your request for a review. If your health care practitioner (as defined in Ohio Revised Code 3923.041(A)) uses the Plan or its designee's electronic software system to request an appeal of a Claim Involving Urgent Care, the Plan or its designee will respond to the appeal within 48 hours of receipt.

Pre-Service Claims – within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receiving your request for a review, if the Plan or its designee receives a pre-service claim appeal in writing. When the Plan or its designee receives a pre-service claim appeal from your health care practitioner (as defined in Ohio Revised Code 3923.041(A)) when you have authorized him or her to appeal on your behalf and the health care practitioner uses the Plan's or its designee's electronic software system for prior authorization, the Plan or its designee will respond to the appeal within 10 calendar days of receipt.

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

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

Notice of Final Adverse Benefit Determination after Appeal

If the appeal has been either partially or completely denied, you will be provided with a written notice of Final Adverse Benefit Determination in a culturally and linguistically appropriate manner containing the following information:

1. Information sufficient to identify the claim or health care service involved, including the date of service, healthcare provider, and claim amount (if applicable);
2. The specific reason(s) for the Final Adverse Benefit Determination, including the denial code and its corresponding meaning;
3. Reference to the specific plan provision(s) on which the Final Adverse Benefit Determination is based;
4. A statement that you may request reasonable access to and copies of all documents, records and other information relevant to your appealed claim for benefits, which shall be provided to you without charge;
5. If the Final Adverse Benefit Determination relied upon any internal rules, guidelines or protocols, a statement that you may request a copy of the rule, guideline or protocol, which will be provided to you without charge;
6. If the Final Adverse Benefit Determination was based in whole or in part on Medical Necessity, Experimental/Investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided to you without charge;
7. Notice of the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings, if applicable;
8. Disclosure of the availability of assistance with the appeal process from the Ohio Department of Insurance if your Plan is regulated by the Ohio Department of Insurance;
9. A discussion of the decision;
10. A description of the Plan's or its designee's applicable appeal procedures.

What Happens After the First Level Mandatory Internal Appeal

If your claim is denied at the mandatory first level internal appeal level, you may be eligible for either the External Review Process by an Independent Review Organization for Adverse Benefit Determinations involving medical judgment or the External Review Process by the Ohio Department of Insurance for contractual issues that do not involve medical judgment.

Second Level External Review Process for Non-Federal Governmental Health Plans

A. Contact Information for Filing an External Review

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

B. Understanding the External Review Process

Under Chapter 3922 of the Ohio Revised Code all Health Plan Issuers must provide a process that allows a person covered under a Health Benefit Plan or a person applying for Health Benefit Plan coverage to request an independent external review of an Adverse Benefit Determination. This is a summary of that external review process. An Adverse Benefit Determination is a decision by

the Plan to deny a requested Health Care Service or payment because services are not covered, are excluded, or limited under the plan, or the Covered Person is not eligible to receive the benefit.

The Adverse Benefit Determination may involve an issue of Medical Necessity, appropriateness, health care setting, or level of care or effectiveness. An Adverse Benefit Determination can also be a decision to deny Health Benefit Plan coverage or to Rescind coverage.

C. Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. The Covered Person does not pay for the external review. There is no minimum cost of Health Care Services denied in order to qualify for an external review. However, the Covered Person must generally exhaust the Plan's mandatory internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the Adverse Benefit Determination.

1. External Review by an IRO

A Covered Person is entitled to an external review by an IRO in the following instances:

- The Adverse Benefit Determination involves a medical judgment or is based on any medical information
- The Adverse Benefit Determination indicates the requested service is Experimental or Investigational, the requested Health Care Service is not explicitly excluded in the Covered Person's Health Benefit Plan, and the treating physician certifies at least one of the following:
    - Standard Health Care Services have not been effective in improving the Condition of the Covered Person
    - Standard Health Care Services are not medically appropriate for the Covered Person
    - No available standard Health Care Service covered by the Plan is more beneficial than the requested Health Care Service

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

- The Covered Person's treating physician certifies that the Adverse Benefit Determination involves a medical Condition that could seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal, and the Covered Person has filed a request for an expedited internal appeal.
- The Covered Person's treating physician certifies that the Final Adverse Benefit Determination involves a medical Condition that could seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function if treatment is delayed until after the time frame of a standard external review.
- The Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or Health Care Service for which the Covered Person received Emergency Services, but has not yet been discharged from a facility.
- An expedited internal appeal is already in progress for an Adverse Benefit Determination of Experimental or Investigational treatment and the Covered Person's treating physician certifies in writing that the recommended Health Care Service or treatment would be significantly less effective if not promptly initiated.

NOTE: An expedited external review is not available for retrospective Final Adverse Benefit Determinations (meaning the Health Care Service has already been provided to the Covered Person).

2. External Review by the Ohio Department of Insurance

A Covered Person is entitled to an external review by the Department in either of the following instances:

- The Adverse Benefit Determination is based on a contractual issue that does not involve a medical judgment or medical information.
- The Adverse Benefit Determination for an Emergency Medical Condition indicates that medical Condition did not meet the definition of emergency AND the Plan's decision has already been upheld through an external review by an IRO.

D. Request for External Review

Regardless of whether the external review case is to be reviewed by an IRO or the Department of Insurance, the Covered Person, or an Authorized Representative, must request an external review through the Plan within 180 days of the date of the notice of final adverse benefit determination issued by the Plan.

All requests must be in writing, including by electronic means, except for a request for an expedited external review. Expedited external reviews may be requested orally. The Covered Person will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete and eligible the Plan will initiate the external review and notify the Covered Person in writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the Covered Person that, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. The Plan will also forward all documents and information used to make the Adverse Benefit Determination to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete the Plan will inform the Covered Person in writing and specify what information is needed to make the request complete. If the Plan determines that the Adverse Benefit Determination is not eligible for external review, the Plan must notify the Covered Person in writing and provide the Covered Person with the reason for the denial and inform the Covered Person that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by the Plan and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the Health Benefit Plan and all applicable provisions of the law.

E. IRO Assignment

When the Plan initiates an external review by an IRO, the Ohio Department of Insurance web based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of Health Care Service. An IRO that has a conflict of interest with the Plan, the Covered Person, the health care provider or the health care facility will not be selected to conduct the review.

F. Reconsideration by the Plan

If you submit information to the Independent Review Organization or the Ohio Department of Insurance to consider, the Independent Review Organization or Ohio Department of Insurance will forward a copy of the information to the Plan. Upon receipt of the information, the Plan may reconsider its Adverse Benefit Determination and provide coverage for the Health Care Service in question. Reconsideration by the Plan will not delay or terminate an external review. If the Plan reverses an Adverse Benefit Determination, the Plan will notify you in writing and the Independent Review Organization will terminate the external review.

G. IRO Review and Decision

The IRO must consider all documents and information considered by the Plan in making the Adverse Benefit Determination, any information submitted by the Covered Person and other information such as; the Covered Person's medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the Health Benefit Plan, the most appropriate practice guidelines, clinical review criteria used by the Health Plan Issuer or its Utilization Review organization, and the opinions of the IRO's clinical reviewers.

The IRO will provide a written notice of its decision within 30 days of receipt by the Plan of a request for a standard review or within 72 hours of receipt by the Plan of a request for an expedited review. This notice will be sent to the Covered Person, the Plan and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review
- The date the Independent Review Organization was assigned by the Ohio Department of Insurance to conduct the external review
- The dates over which the external review was conducted
- The date on which the Independent Review Organization's decision was made
- The rationale for its decision
- References to the evidence or documentation, including any evidence-based standards, that were used or considered in reaching its decision

NOTE: Written decisions of an IRO concerning an Adverse Benefit Determination that involves a health care treatment or service that is stated to be Experimental or Investigational also includes the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

H. Binding Nature of External Review Decision

An external review decision is binding on the Plan except to the extent the Plan has other remedies available under state law. The decision is also binding on the Covered Person except to the extent the Covered Person has other remedies available under applicable state or federal law.

A Covered Person may not file a subsequent request for an external review involving the same Adverse Benefit Determination that was previously reviewed unless new medical or scientific evidence is submitted to the Plan.

I. If You Have Questions About Your Rights or Need Assistance

You may contact the Plan at the Customer Care Center telephone number listed on your identification card. You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300
Columbus, Ohio 43215-4186
Telephone: 800.686.1526 / 614-644-2673
Fax: 614-644-3744
TDD: 614-644-3745

Contact ODI Consumer Affairs:

http://insurance.ohio.gov/consumer/pages/healthcoverageappealtoolkit.aspx

File a Consumer Complaint:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

Legal Action

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

Foreign Travel

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

Health Care Fraud

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

Plan Amendments

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

Rescission of Coverage

A rescission of your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan.

Your coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by your employer. You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review.

Right To Release Claims and Receive Necessary Information

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

Facility of Payment

When another plan makes payment that should have been made under this Plan, the Plan shall have the right to directly reimburse the other plan making payment.

Right of Recovery

If the Plan makes any payment which is determined in excess of the Plan's benefits, the Plan shall have the right to recover the amount determined to be in error. The Plan shall have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

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).

PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010
SUMMARY OF MATERIAL MODIFICATIONS

On the Effective Date of this Summary Plan Description, certain benefits, terms, conditions, limitations, and exclusions in your Plan will be amended to comply with the requirements of the federal health care reform legislation, the Patient Protection and Affordable Care Act of 2010 (PPACA). Those provisions are outlined below:

Grandfathered Health Plan Disclosure

The City of Stow believes this Plan is a "grandfathered health plan" under the PPACA. As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your human resources department. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

The Plan will comply with the federal definition as mandated:

"Essential Health Benefits" is defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Your Plan may contain some or all of these types of benefits prior to 2014 when they become mandatory. If your Plan contains any of these benefits, there are certain requirements that may apply to those benefits.

Lifetime and Annual Dollar Limits

The Essential Health Benefits that may be provided by your Plan are not subject to a lifetime or annual dollar limit. Plan benefits that are not defined as Essential Health Benefits may have a lifetime and/or annual dollar limit as shown in the Schedule of Benefits.

Multi-Language Interpreter Services & Nondiscrimination Notice

MUTUAL HEALTH SERVICES℠

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

Spanish

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

Chinese

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

German

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

Arabic

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

Pennsylvania Dutch

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

Russian

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

French

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

Vietnamese

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

Navajo

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

Oromo

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

Korean

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

Italian

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

Japanese

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

Dutch

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

Ukrainian

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

Romanian

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

Tagalog

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

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

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

Nondiscrimination Notice

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

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

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

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

Email: CivilRightsCoordinator@MedMutual.com

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

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

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