

**HEALTHCOMP, INC. D/B/A
THE CENTER FOR HEALTH AFFAIRS
Non-Grandfathered
Employee Benefit Plan**

EFFECTIVE DATE
July 1, 2015

**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

THE COMPANY
PLAN CLARIFICATION

The Medical-Surgical Benefits entitled "Dental Services" is clarified as follows:

DENTAL SERVICES

For Accidental Injury

Dental services rendered by a Physician or dentist for an accidental Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident. Injury as a result of chewing or biting is not considered an accidental Injury.

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

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

The Company adopts the terms and conditions set forth in this Plan Clarification. This Plan Clarification 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.

HealthComp, Inc.
Company Name

All Plans
Plan Name

Lesley Forneris
Signature on behalf of the Plan

Lesley Forneris, Director, HR
Printed Name and Title

4/4/16
Date

HEALTHCOMP, INC. D/B/A
THE CENTER FOR HEALTH AFFAIRS
NON-GRANDFATHERED EMPLOYEE BENEFIT PLAN

PLAN AMENDMENT AND SUMMARY OF MATERIAL MODIFICATIONS

This Amendment amends your Employee Benefit Plan (Plan), and becomes a part of your Plan as of the effective dates as listed below. Please place this Amendment with your Plan Document/summary of benefits for future reference.

EFFECTIVE 7/1/15:

1. Dependent Eligibility is amended to INCLUDE the following:

Coverage Expansion to Age 28

In order for Dependent children to receive benefits to the age of 28, the unmarried child must be:

- The natural child, stepchild, or adopted child of the employee;
- An Ohio resident or a Full-Time Student* at an accredited public or private institution of higher education;
- Not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; and
- Not eligible for coverage under Medicaid or Medicare.

Please note that the older age child does not have to live with the parent, be financially dependent upon the parent or be a student.

An older age child may enroll at the following times:

- When the child reaches the Plan's limiting age.
- When the child experiences a change in circumstances.
- During the annual open enrollment period.

The full cost of the premium for the Dependent coverage will be the responsibility of the Employee/Dependent.

The coverage ends on the date in which the child attains age 28.

* Your unmarried child from age 26 to age 28 who are Full-time Students at a school, college, university or other accredited institution of post-secondary education. A child is a Full-time Student if he or she meets the definition of full-time status of the school in which he or she is enrolled. A child who completes a semester of study will be covered through the following semester break or summer if they are enrolled in the following semester of study. Once a child loses the status of Full-time Student, he or she can be reenrolled as an eligible Dependent if he or she regains the status of a Full-time Student.

Michelle's Law

The term "Eligible Dependent" shall also include an unmarried child, adopted child, stepchild or legal ward of the eligible Employee between ages 26 and 28 who is a Full-time Student and who is eligible for an extension of coverage as an Eligible Dependent due to a Medically Necessary Leave of Absence, but only as long as the child or ward remains eligible for the extension. Each quarter or semester, the Claims Administrator shall require proof of an Eligible Dependent's eligibility for extended coverage due to a Medically Necessary Leave of Absence.

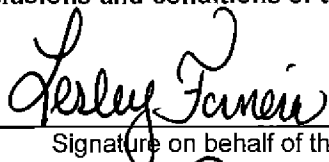
EFFECTIVE 1/1/16:

2. Dependent Eligibility is amended as follows:

All references to "Coverage Expansion to Age 28" are removed in their entirety.

Any Dependent currently covered by the Plan due to this provision will be terminated from the Plan effective midnight on December 31, 2015.

HealthComp, Inc. d/b/a The Center For Health Affairs adopts the terms and conditions set forth in this Amendment as of the effective dates as listed 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.



Signature on behalf of the Plan

Lesley Fomers, Director.HR

Printed Name and Title

1/12/15

Date

TABLE OF CONTENTS

INTRODUCTION	1
ELIGIBILITY.....	1
EMPLOYEE ELIGIBILITY	1
DEPENDENT ELIGIBILITY.....	1
OMNIBUS BUDGET RECONCILIATION ACT (OBRA).....	2
ILLEGAL ALIEN.....	2
QUALIFIED MEDICAL CHILD SUPPORT ORDERS	2
ENROLLMENT IN THE PLAN	3
OPEN ENROLLMENT	3
WAITING PERIOD	3
SPECIAL ENROLLMENT RIGHTS	4
LATE ENROLLMENT	5
VERIFICATION OF DEPENDENT STATUS.....	5
VERIFICATION OF INCAPACITATED DEPENDENT STATUS.....	5
PREFERRED PROVIDER ORGANIZATION (PPO)	6
SCHEDULE OF BENEFITS	7
COVERED SERVICES	8
PPO PROVISIONS.....	10
PRECERTIFICATION OF BENEFITS.....	12
COMPREHENSIVE MAJOR MEDICAL BENEFITS	13
BENEFITS PAYABLE	13
DEDUCTIBLE	13
LIFETIME AND ANNUAL DOLLAR LIMITS	13
OUT-OF-POCKET MAXIMUM.....	13
METHOD OF PAYMENT	13
COVERED SERVICES	14
HOSPITAL SERVICES	14
MEDICAL-SURGICAL BENEFITS	15
ALCOHOLISM & DRUG ABUSE BENEFITS	15
AMBULANCE SERVICE	15
ANESTHESIA.....	15
CLINICAL TRIALS.....	15
CONCURRENT MEDICAL CARE.....	17
CONSULTATION.....	17
DENTAL SERVICES.....	17
DIAGNOSTIC SERVICES	17
EMERGENCY SERVICES.....	18
HOME HEALTH CARE SERVICES	18
HOSPICE BENEFITS	19
HUMAN ORGAN AND TISSUE TRANSPLANTS.....	20
INPATIENT HOSPITAL MEDICAL CARE	21

MASTECTOMY	21
MATERNITY	22
MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES	23
MENTAL HEALTH BENEFITS	24
OUTPATIENT MEDICAL CARE	24
PRIVATE DUTY NURSING SERVICES	24
SKILLED NURSING FACILITY/REHABILITATION FACILITY BENEFITS	24
SURGICAL SERVICES	24
THERAPY SERVICES	26
URGENT CARE/WALK-IN CARE	27
WELLNESS BENEFITS	27
GENERAL LIMITATIONS AND EXCLUSIONS	29
PRESCRIPTION DRUG BENEFITS	35
COVERED PRESCRIPTION DRUGS	35
HOW THE PLAN WORKS	35
MAIL ORDER DRUG PROGRAM	36
EXCLUSIONS AND LIMITATIONS	36
GENERAL INFORMATION	38
HEALTH CARE FRAUD	46
PLAN AMENDMENTS	46
RIGHT TO RELEASE CLAIMS AND RECEIVE NECESSARY INFORMATION	46
PHYSICAL EXAMINATION	46
FACILITY OF PAYMENT	46
RESCISSION OF COVERAGE	46
RIGHT OF RECOVERY	46
GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)	47
LARGE CASE MANAGEMENT	47
COORDINATION OF BENEFITS	47
SUBROGATION AND RIGHT OF RECOVERY	48
PROVISIONS APPLICABLE TO ALL COVERAGE	51
TERMINATION OF EMPLOYEE COVERAGE	51
TERMINATION OF DEPENDENT CHILD COVERAGE	51
TERMINATION OF DEPENDENT SPOUSE COVERAGE	52
FAMILY AND MEDICAL LEAVE	52
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)	53
COBRA COVERAGE	56
SUMMARY OF RIGHTS AND OBLIGATIONS REGARDING CONTINUATION OF COVERAGE UNDER THE BENEFIT PLAN	56
USERRA	61
EFFECT OF MEDICARE ON THE PLAN	62
DEFINITIONS	64
STATEMENT OF ERISA RIGHTS	75
GENERAL PLAN INFORMATION	77

INTRODUCTION

This booklet (otherwise known as the “Summary Plan Description” or “SPD”) describes the health care benefits provided by HealthComp, Inc. d/b/a The Center for Health Affairs (hereafter referred to only as HealthComp, Inc.) for Eligible Employees and their covered Dependents. We encourage you to take the time to become familiar with this document and how best to utilize the benefits available to you.

You will find terms starting with capital letters throughout this booklet. To help you understand your benefits, most of these terms are defined in the Definitions section at the end of the booklet. As used in this booklet, the terms “you” and “your” refer to Employees eligible to participate in the Plan.

This Plan is a self-funded benefit plan. HealthComp, Inc. 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 HealthComp, Inc. HealthComp, Inc., 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 HealthComp, Inc. 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 HealthComp, Inc.

ELIGIBILITY

Upon enrollment in the Plan you, your Spouse, and your eligible Dependents shall become Participants eligible for the benefits provided by this Plan, subject to the limitations contained in the applicable Plan provisions.

EMPLOYEE ELIGIBILITY

All full-time Employees, who work an average of 30 hours or more per week (or 130 hours per month), are eligible for coverage. Should you wish to participate, you must complete an enrollment form. The Human Resource Department must receive the enrollment form within 31 days from the day you are eligible to enroll.

DEPENDENT ELIGIBILITY

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 date in which the child attains age 26.
- Effective January 1, 2016: 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.

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 to continue coverage and 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 HealthComp, Inc. or the Claims Administrator, that a child satisfies these eligibility criteria.

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

If both Spouses are Employees of HealthComp, Inc., both may elect coverage, but only one may elect Dependent coverage. In no event may an individual be covered both as an Employee and as a Dependent under the Plan. Dependent children may be covered as Dependents of either Spouse, but not both. In no event will a Dependent's coverage become effective before an Employee's coverage.

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

OMNIBUS BUDGET RECONCILIATION ACT (OBRA)

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

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

ILLEGAL ALIEN

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

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

If you are required by a "Qualified Medical Child Support Order", as defined in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), to provide coverage for your children, you can

enroll these children as timely enrollees as required by OBRA 93. If you are not already enrolled in the Plan, you must also enroll at the same time.

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

ENROLLMENT IN THE PLAN

An Employee contribution towards the cost of the Plan is required by HealthComp, Inc. for participation in the Plan. You are required to complete an enrollment form and return such form to the Human Resource Department within 31 days from the date you are eligible to enroll. You must furnish such information regarding your age, family status and other relevant matters as may be required.

You must enroll within 31 days of becoming eligible. If you enroll after the initial 31-day enrollment period, you must follow the open enrollment, special enrollment or late enrollment provisions.

If you enroll yourself and your Dependents when first eligible, coverage will commence following completion of the Waiting Period as described below.

NOTE: Newborn children: If the Plan Participant has previously enrolled in Dependent coverage and continues to cover his or her eligible Dependents, newborns will be eligible under this plan on the date of the new child's birth. However, no claims will be paid until a completed enrollment form is received by the Claims Administrator.

Plan Participants who have not previously enrolled for Dependent coverage will be required to complete and submit an enrollment form for the Newborn within 31 days of the child's birth for the child to be considered for coverage.

OPEN ENROLLMENT

Open enrollment will occur during the month of June with coverage becoming effective on July 1st. Open enrollment is available to Employees who initially did not enroll in the health care plan and for Employees and/or Dependents that did not enroll at the time that a special enrollment occurred.

WAITING PERIOD

Benefits will become effective the first of the month following (a) the date of hire or (b) the date you begin full-time status.

If you are absent due to any health status factor, or any other reason that must be treated as active service under any applicable law (such as FMLA, ADA or laws relating to military service, or a paid jury duty), such time will not be considered an absence for purposes of calculating your waiting period.

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. A situation in which an individual incurs a claim that would meet or exceed a medical plan lifetime limit on all benefits (additional requirements apply)
 - j. Termination of an Employee's or Dependent's coverage under Medicaid or under a state child health insurance plan (CHIP)
 - k. 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 "j" (termination of Medicaid or CHIP coverage) and "k" (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 "j" and "k" 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.

LATE ENROLLMENT

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

VERIFICATION OF DEPENDENT STATUS

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

VERIFICATION OF INCAPACITATED DEPENDENT STATUS

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

PREFERRED PROVIDER ORGANIZATION (PPO)

A Preferred Provider Organization (PPO) is a group of Hospitals, Physicians, and other Health Care 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. The PPO encourages Covered Persons to be cost-minded and become "Partners in Health Care". By using more cost-effective Preferred Providers, you will help stabilize health care coverage costs both to you and to your benefit plan. The PPO also protects your freedom to choose any Physician or Hospital you desire. Alternatives to the PPO include reducing your benefits and increasing your cost. The PPO is a much more attractive solution. The PPO will save you money. The PPO providers have agreed to charge cost-effective rates. You can use any Physician and any health care facility that qualifies under your health plan the same as you have in the past. You make the choice of using or not using a Preferred Provider each time you require services.

**Medical Mutual
SuperMed PPO**

Phone: 1-888-241-2583
Website: www.medmutual.com

First Health

Phone: 1-800-889-0277
Website: www.firsthealth.com

You may also view and print a copy of the provider directory by visiting the website listed above. You may request a printed copy of the provider directory by contacting the PPO phone number listed above. There is no charge for the directory.

**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.

All benefits will be based upon Allowed Amount

Overall Benefit Period Maximum..... Unlimited

Network (PPO Providers)

Calendar Year Deductible:

Per Individual	\$3,000.00
Per Family.....	\$6,000.00

After the Deductible is met all eligible charges will be paid at 100%.

Out-of-Pocket Maximum per Calendar Year (including any applicable Copayments, Deductible, and Coinsurance):

Per Individual	\$4,000.00
Per Family.....	\$8,000.00

Non-Network (Non-PPO Providers)

Calendar Year Deductible:

Per Individual	\$3,000.00
Per Family.....	\$6,000.00

After the Deductible is met all eligible charges will be paid at 90% until the Out-of-Pocket Maximum has been satisfied.

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

Out-of-Pocket Maximum per Calendar Year (including the Copayments, Deductible, and Coinsurance):

Per Individual	\$4,500.00
Per Family.....	\$9,000.00

Network and Non-Network Cross Apply

COVERED SERVICES

<u>Subject to Deductible unless otherwise stated:</u>	Percentage Payable	
	<u>Network</u>	<u>Non-Network</u>
<u>Emergency Services</u>		
Emergency Room (Medical/Accident) (Including Ancillaries and Physician).....	100%	
Non-Emergency Room (Including Ancillaries and Physician).....	90%	90%
<u>Inpatient Services</u>		
Anesthesia.....	100%	90%
Consultations.....	100%	90%
Newborn Care.....	100%	90%
Institutional Services.....	100%	90%
Physical Medicine and Rehabilitation..... 60 days per Benefit Period maximum combined with Skilled Nursing Facility	100%	90%
Professional Services.....	100%	90%
Skilled Nursing Facility..... 60 days per Benefit Period maximum combined with Physical Medicine and Rehabilitation	100%	90%
Surgical Services.....	100%	90%
<u>Mental Illness, Alcoholism and Drug Abuse</u>		
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.		
<u>Office Visit (Illness/Injury)</u>		
Physician/Specialist Office Visit/Consultations.....	100%	90%
Urgent Care Provider Office Visits.....	100%	90%
Urgent Care Related Services will be paid based on the services rendered		
<u>Outpatient Services</u>		
Allergy Testing/Treatment.....	100%	90%
Diagnostic Imaging/Lab/Medical Tests/X-ray.....	100%	90%
Education and Training including Diabetic (other than required by PPACA).....	100%	90%
Home Health Care..... 100 visits per Benefit Period maximum	100%	90%

COVERED SERVICES

<u>Subject to Deductible unless otherwise stated:</u>	Percentage Payable	
	<u>Network</u>	<u>Non-Network</u>
<u>Outpatient Services continued</u>		
Pre-Admission Testing.....	100%	90%
Surgical Services.....	100%	90%
Including: anesthesia, assistant surgeon, surgery professional and surgery facility		
<u>Outpatient Therapy</u>		
Cardiac Rehabilitation.....	100%	90%
36 visits per Benefit Period maximum		
Chemotherapy and Radiation Therapy.....	100%	90%
Chiropractic.....	100%	90%
Dialysis Treatment.....	100%	90%
Hyperbaric and Pulmonary Therapy.....	100%	90%
Physical, Occupational and Speech Therapy.....	100%	90%
20 visits per Benefit Period maximum combined		
Respiratory Therapy.....	100%	90%
<u>Preventive/Routine/Well Child Care- not subject to Deductible in Network unless stated otherwise</u>		
Health Care Reform Preventive Benefits.....	100%	90%
<u>Including but not limited to:</u>		
Women's Preventive Health Benefits.....	100%	90%
Immunizations.....	100%	90%
Physical Exam.....	100%	90%
Prostate Exam.....	100%	90%
Vision Exam	100%	90%
1 per Benefit Period maximum with refraction		
Bone Density Tests.....	100%	90%
Endoscopic Services.....	100%	90%
Lab, Medical Tests and X-rays.....	100% per PPACA	90%
100% after Deductible if not required by PPACA		
Mammogram.....	100%	90%

COVERED SERVICES

<u>Subject to Deductible unless otherwise stated:</u>	Percentage Payable	
	<u>Network</u>	<u>Non-Network</u>
<u>Preventive/Routine/Well Child Care continued- not subject to Deductible in Network</u>		
Pap Tests (includes GYN exam).....	100%	90%
PSA Tests.....	100%	90%
Well Child Care (birth to age 21)..... Including but not limited to: exams, hearing and vision exams, immunizations and labs	100%	90%
<u>Additional Services</u>		
Abortions (spontaneous miscarriages and therapeutic only).....	100%	90%
Ambulance (emergency).....	100%	100%
Ambulance (non-emergency).....	90%	90%
Durable Medical Equipment..... Including - wigs: 1 per lifetime maximum and bras following mastectomy: limited to 2 bras post mastectomy	100%	90%
Hospice.....	100%	90%
Medical Supplies.....	100%	90%
Oral Accident.....	100%	90%
Organ Transplant.....	100%	90%
Private Duty Nursing.....	100%	90%
Therapeutic Injections.....	100%	90%
TMJ.....	100%	90%
Sleep Study.....	100%	90%

PPO PROVISIONS

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

- Ancillary providers rendering care in a PPO facility (i.e.: pathologist, radiologist, anesthesiologist, emergency room physician);
- If a Covered Person has no choice of network providers in the specialty that the Covered Person is seeking within the PPO service area;
- If a Covered Person is out of the PPO and requires medical care;

- When a PPO provider utilizes the services of a Non-PPO provider for the reading or interpretation of x-ray or laboratory tests;
- If a Covered Person does not live within a 30 mile radius of a PPO facility;
- Eligible Dependent Children who reside outside of Primary PPO service area.

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.

PRESCRIPTION DRUG BENEFITS

Preventive Prescription Drugs in compliance with PPACA Plan pays 100%

Copayment after Deductible is met:

Retail Copayment (30 day supply):

Generic.....	\$0.00 after Deductible
Formulary	\$30.00 after Deductible
Non-Formulary	\$50.00 after Deductible

Mail Order Copayment (90 day supply):

Generic.....	\$0.00 after Deductible
Formulary	\$75.00 after Deductible
Non-Formulary	\$150.00 after Deductible

Specialty Drugs..... 25% up to \$150 then 100% after Deductible

Out-of-Pocket Maximum per Calendar Year:

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

However, if a brand name Prescription Drug is purchased when a generic Prescription Drug is available and medically appropriate (as determined by the Covered Person's Physician), the difference between the cost of the generic and brand name Prescription Drug that the Covered Person pays is not counted toward the Out-of-Pocket Maximum.

PRECERTIFICATION OF BENEFITS

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
- Therapy
- Home health care
- Weight loss surgery

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.

Medical-Surgical
(800) 338-4114

Behavioral Health
(800) 258-3186

COMPREHENSIVE MAJOR MEDICAL BENEFITS

BENEFITS PAYABLE

If you or a Dependent incur covered expenses after the effective date of your major medical coverage, payment will be made, at the appropriate Coinsurance level, for expenses Incurred during a Calendar Year which exceed the Deductible (and any applicable Copayment amounts) as listed in the Schedule of Benefits. These percentages apply until the Covered Person reaches the Out-of-Pocket Maximum; then eligible expenses will be payable at 100% of the Allowed Amount, unless otherwise specified, until the end of the Calendar Year.

DEDUCTIBLE

The Deductible will be applied only once during a Calendar Year.

Common Accident Deductible

If two or more Covered Persons of a family are injured in the same accident, only one Deductible will be applied toward those eligible expenses, which directly resulted from Injuries Incurred by family members in the same accident.

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.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum applies each Calendar Year. Once a Covered Person has met the Out-of-Pocket Maximum, benefits for that Covered Person's eligible expenses will be payable at 100% of the Allowed Amount for the remainder of the Calendar Year. The Out-of-Pocket Maximum does not include penalties for pre-certification non-compliance or charges exceeding the Allowed Amount.

METHOD OF PAYMENT

Your Benefit Plan bases its payment for Covered Services upon the Allowed Amount. These Covered Services will be paid at a rate that is equal to or lower than the Allowed Amount.

COVERED SERVICES

The following are Covered Services, payable as outlined in the Schedule of Benefits, and subject to the other terms, conditions and limitations described in this booklet.

HOSPITAL SERVICES

When you or your Dependent is admitted as a bed patient or as an outpatient to any state approved Hospital, the following services will be covered as needed and to the extent available for:

Inpatient Hospital Services - bed, board, and general nursing services:

- A room with two or more beds;
- A private room. The private room allowance is the Hospital's average semi-private room rate;
- A bed in a special care unit approved by the Plan. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients; and
- Miscellaneous Hospital expenses for a physical Injury or Illness received by a Covered Person while the Covered Person is Confined in a Hospital.

Ancillary Services - Inpatient and Outpatient; include but are not limited to:

- Operating, delivery and treatment rooms and equipment;
- Prescribed drugs;
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or Other Provider;
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic services; and
- Therapy services.

Blood and Blood Plasma

Whole blood, blood plasma, and blood products when not replaced by donation are eligible. This includes the processing and administration of services.

Outpatient Hospital Services

- **Diagnostic:** Lab and x-ray services.
- **Emergency Accident Care:** Services and supplies to treat injuries caused by an accident;
- **Emergency Medical Services:** for treatment of a medical condition;
- **Operating room and supplies;**
- **Preadmission Testing:** Outpatient tests and studies performed prior to a scheduled Hospital admission. Benefits are payable as shown in the Schedule of Benefits;
- **Surgery:** Surgical services and supplies.

MEDICAL-SURGICAL BENEFITS

In general, the Plan will pay for eligible charges for services that include the following:

ALCOHOLISM & DRUG ABUSE BENEFITS

Inpatient Benefits

The charges for inpatient services are payable as listed in the Schedule of Benefits.

Benefits are provided for inpatient and partial Hospitalization Alcoholism and Drug Abuse care only at a licensed facility. Inpatient services must be pre-certified before admission.

Outpatient Benefits

The charges for outpatient services are payable as listed in the Schedule of Benefits.

Benefits are provided for outpatient care by a licensed Psychologist, Psychiatrist, or Licensed Social Worker. Coverage will include services provided in a certified Day Treatment Program.

AMBULANCE SERVICE

Transportation by a vehicle designed, equipped and used only to transport the sick and injured:

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

Trips must be to the closest facility that can provide Covered Services appropriate for the Covered Person's Condition. If none, coverage is available for trips to the closest such facility outside the Covered Person's local area. Air ambulance service is covered under the Plan when Medically Necessary.

Transportation services provided by an ambulette or wheelchair van are not Covered Services.

ANESTHESIA

This Plan covers anesthesia for any Covered Service when administered by a Physician or Other Provider who is not the surgeon or the assistant at surgery. Some anesthesiologists are not considered in-network providers. Many anesthesiologists are independent contractors and not Hospital employees.

CLINICAL TRIALS

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

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

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

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

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

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

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

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

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

- A health care service, item, or drug that is the subject of the Approved Clinical Trial;
- A health care service, item, or drug provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;
- An Experimental or Investigational drug or device that has not been approved for market by the United States Food and Drug Administration;
- Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the Approved Clinical Trial;
- An item or drug provided by the Approved Clinical Trial sponsors free of charge for any patient;
- A service, item, or drug that is eligible for reimbursement by an entity other than Medical Mutual Market, including the sponsor of the Approved Clinical Trial;
- A service, item, or drug that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

CONCURRENT MEDICAL CARE

The Plan covers care for a medical Condition by a Physician who is not the Covered Person's surgeon while in the Hospital for surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of the Covered Person's Condition requires the skills of separate Physicians is also covered.

CONSULTATION

A personal bedside examination by another Physician when requested by the Covered Person's attending Physician. Staff consultations required by Hospital rules are excluded.

DENTAL SERVICES**For Accidental Injury**

Dental services rendered by a Physician or dentist for an accidental Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident. Injury as a result of chewing or biting is not considered an accidental Injury.

Oral Surgery

Oral surgical services, including related x-rays and anesthesia, but limited to the following procedures:

- Surgical removal of impacted, (non-erupted) teeth;
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;
- Surgical procedures to correct injuries to the jaw, cheeks, lips, tongue, roof, and floor of the mouth;
- Excision of extosis (bony outgrowth) of the jaws and hard palate;
- Frenotomy (incision of the membrane connecting the tongue to the floor of the mouth);
- Incision of drainage of cellulitis (tissue inflammation) of the mouth;
- Incision of accessory sinuses, salivary glands, or ducts;

DIAGNOSTIC SERVICES

The following services when performed for diagnosis of a Condition, disease, or Injury and the Physician's interpretation of these exams are covered under your Plan:

- Radiology, ultrasound and nuclear medicine;
- Laboratory and Pathology Services;
- Diagnostic Medical Examinations such as EKG's and EEG's, MRI's;
- Cardiographic, Encephalographic and Radioisotope Tests;
- Allergy Testing

Diagnostic services may be provided either in or out of a Hospital.

EMERGENCY SERVICES

“Stabilize” means, to provide such medical treatment of an Emergency Medical 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.

Your Plan covers Emergency Services for an Emergency Medical Condition treated in any Hospital emergency department.

Your Plan will not require prior authorization or impose any other administrative requirements or benefit limitations that are more restrictive if you receive Emergency Services from an out of network provider. However, an out of network provider of Emergency Services may send you a bill for any charges remaining after your Plan has paid (this is called “balance billing”).

Except where your Plan provides a better benefit, your Plan will apply the same Copayments and Coinsurance for out of network Emergency Services as it generally requires for in network Emergency Services. A Deductible may be imposed for out of network Emergency Services, only as part of the Deductible that generally applies to out of network benefits. Similarly, any Out-of-Pocket Maximum that generally applies to out of network benefits will apply to out of network Emergency Services.

Your Plan will calculate the amount to be paid for out of network Emergency Services in three different ways and pay the greatest of the three amounts: 1) the amount your Plan pays to in network providers for the Emergency Services furnished (this calculation is not required if your Plan does not have negotiated per service amounts with in 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 out of network services but substituting in 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 network Copayments or Coinsurance.

HOME HEALTH CARE SERVICES

This section applies only if charges for home care services are not covered elsewhere in the Plan. A licensed or Medicare-certified home health agency or certified rehabilitation agency must provide or coordinate the services. A Covered Person should make sure the agency meets this requirement before services are provided. The Plan will pay benefits for charges for the following services:

- Part-time or intermittent home nursing care by or under the supervision of a registered nurse;
- Part-time or intermittent home health aide services when part of the home care plan. The services must consist solely of care for the patient. A registered nurse or medical social worker must supervise them;
- Physical or occupational therapy or speech-language pathology or respiratory care;

- Medical supplies, drugs, and medications prescribed by a Physician; laboratory services by or on behalf of a Hospital is needed under the home care plan. These items are covered to the extent they would be if the Covered Person had been Hospitalized;
- Nutrition counseling provided or supervised by a registered dietician;
- Evaluation of the need for a home care plan by a registered nurse, Physician extender, or medical social worker. The Covered Person's attending Physician must request or approve this evaluation.
- Home care is not covered unless the Covered Person's attending Physician certifies that (a) Hospitalization or Confinement in a licensed Skilled Nursing Facility would be needed if the Covered Person didn't have home care; and (b) members of the Covered Person's immediate family, or others living with the Covered Person couldn't give the Covered Person the care and treatment he/she needs without undue hardship.
- If the Covered Person was hospitalized just before home care started, the Covered Person's primary Physician during his/her Hospital stay must also approve the home care plan.
- Each visit by a person providing services under a home care plan, evaluating the Covered Person's need or developing a plan counts as one visit. Each period of up to four straight hours of home health aide services in a 24-hour period counts as one home care visit.

HOSPICE BENEFITS

Hospice services consist of health care services provided to a Covered Person who is a patient with a reduced life expectancy due to advanced illness. Hospice services must be provided through a Hospice Facility or a Hospice program sponsored by a Hospital or Home Health Care Agency. Hospice services may be received by the Covered Person in a private residence.

Benefits for Hospice services are available when the prognosis of life expectancy is six months or less. Benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy. The following services and supplies are eligible:

- Professional services of a registered or licensed practical nurse;
- Treatment by physical means, occupational therapy, and speech therapy;
- Medical and surgical supplies;
- Prescription Drugs; (these Prescription Drugs must be required in order to relieve the symptoms of a condition, or to provide supportive care);
- Oxygen and its administration;
- Medical social services, such as the counseling of patients;
- Home health aide visits;
- Acute inpatient Hospice services;
- Respite care;
- Dietary guidance; counseling and training needed for a proper dietary program;
- Durable Medical Equipment; and
- Bereavement counseling for family members during the three-month period following death.

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

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

- Volunteer services;
- Spiritual counseling;
- Homemaker services;
- Food or home delivered meals;
- Custodial Care, rest care or care which is provided solely for someone's convenience.

HUMAN ORGAN AND TISSUE TRANSPLANTS

Prior approval must be obtained for benefits to be provided for Human Organ and Tissue Transplant Services, except for a cornea or kidney transplant. To obtain approval, contact the Claims Administrator as soon as your Physician suggests that your condition may require a transplant.

A list of PPO Provider transplant facilities can be obtained by contacting the Customer Care Center at the phone number shown on your identification card. If you receive your transplant from a PPO Provider facility, Covered Services will be payable at the designated level of benefits for organ transplants, subject to any Deductible and Coinsurance set forth in the Schedule of Benefits. Failure to use a PPO Provider facility will increase your out-of-pocket expense significantly. Refer to the Schedule of Benefits for any additional penalty that may apply.

When the recipient is the Covered Person, the donor's expenses will be considered expenses of the recipient and will apply toward the recipient's benefit for the transplant procedure as listed in the Schedule of Benefits.

Tissue Transplants

Benefits are payable for Tissue Transplants and all related charges which are described as Covered Services.

Benefits are payable as shown in the Schedule of Benefits for the following transplants:

- Cornea transplants;
- Allogenic and autologous bone marrow transplants for certain diagnoses.

In order for a tissue transplant to be considered eligible, it must not be considered Experimental and/or Investigative. The procedure must be a nationally acceptable protocol for the diagnosis requiring the transplant. Coverage may be provided for transplants that are still undergoing clinical trials if FDA approved and medical necessity is determined by a peer review organization.

Stem Cell Harvest without a planned transplant are payable only when in relation to diagnosis of:

- Acute Myelogenous Leukemia
- Acute Lymphoblastic Leukemia
- Pediatric Tumors

Human Organ Transplants

Benefits are payable for Human Organ Transplants and all related charges which are described as Covered Services including the acquisition, preparation, transportation, and storage of the human organ.

Benefits are payable as shown in the Schedule of Benefits for the following transplants:

- Heart transplants;
- Heart/Lung transplants;
- Liver transplants;
- Lung transplants;
- Pancreas transplants;
- Kidney transplants.

Additional transplant procedures may be eligible for coverage. If you require an organ transplant not specified above, contact the Claims Administrator for prior approval.

Exclusions

The following are not covered under this section. The Plan provides no benefits for:

- Lodging expenses, including meals;
- Expenses related to the recipient's transportation, except for Medically Necessary professionally licensed ambulance services as stated in this Plan;
- The purchase price of any bone marrow, organ, or tissue that is sold rather than donated;
- Treatment, services, and supplies not ordered by a Physician or surgeon;
- Transplants involving non-human or artificial organ or tissues;
- Human-to-human bone marrow, organ, or tissue transplants other than those specifically covered under this section;
- Treatment, services, and supplies not covered by the Plan.

INPATIENT HOSPITAL MEDICAL CARE

The Plan covers Physician's visits to a registered bed-patient in a Hospital.

MASTECTOMY

In compliance with the Women's Health and Cancer Rights Act of 1998, the following benefits are available to a Covered Person who elects breast reconstruction in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance, however, coverage is not provided for removal of a healthy breast for preventative or reconstructive purposes;
- Coverage for prostheses and physical complications of all stages of mastectomy including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

Such coverage will be subject to annual Deductibles and Coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the Plan or coverage.

MATERNITY (Statement of Rights under the Newborns' and Mothers' Health Protection Act)

Maternity is provided for all eligible Employees and their eligible Spouse only when covered under a family contract. Coverage will be paid as shown in the Schedule of Benefits.

Under Federal law, group health plans and health insurance issuers offering group health coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan 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 may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan 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. Therefore, if your Plan contains a precertification requirement, you or your Provider must still pre-certify the stay to avoid any additional out-of-pocket expenses; however, your stay will automatically be pre-certified for 48 or 96 hours as required by this Federal law.

Birthing Center

Treatment in a licensed Birthing Center, which meets all of the following criteria, is also eligible:

- It is primarily engaged in providing birthing services for low risk pregnancies;
- It is operated under the supervision of a Physician;
- It has at least one licensed registered nurse certified as a nurse midwife in attendance at all times;
- It has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

Newborn Exam

Inpatient visits to examine a newborn, including circumcision. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Surgical Sterilizations

Regardless of Medical Necessity, surgical sterilization procedures for either a covered Employee or an Employee's covered Spouse are provided under the Plan. Reversal of sterilization is not a Covered Service.

MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES

The Plan will allow a maximum of 150% markup on invoice and may require a copy of the Provider's invoice prior to payment.

Medical and Surgical Supplies

Syringes, needles, oxygen, casts, surgical dressings, trusses, braces (other than dental braces), crutches, splints and other similar items which serve only a medical purpose. These supplies prescribed by your Physician: catheters, colostomy bags, rings and belts, flotation pads, needles and syringes, and initial contact lenses or eyeglasses after cataract surgery will also be eligible for coverage. Covered services do not include items usually stocked in the home for general use like adhesive bandages, thermometers, and petroleum jelly.

Durable Medical Equipment

Rental of, or at the Plan's option, purchase of Durable Medical Equipment such as, but not limited to: wheel chairs; Hospital-type beds; and artificial respiration equipment. When the equipment is purchased, benefits are payable for subsequent repairs necessary to restore the equipment to a serviceable condition. Routine periodic maintenance and replacement of batteries are not covered. The equipment must be prescribed by the Physician. Benefits are payable only if the Plan approves the equipment as being appropriate for a Covered Person's medical Condition.

Note: The Plan will allow for only the standard equipment necessary, additional options and upgrades are not eligible.

Orthotic Devices

A rigid or semi-rigid supportive device which limits or stops motion of a weak or diseased body part, such as: casts, splints; strapping; orthopedic braces; and crutches.

Orthotic must be custom molded and prescribed by a Physician and not used only to improve comfort or appearance.

These do not include special shoes unless the device is a permanent part of an orthopedic brace.

Prosthetic Appliances

Purchase, fitting, needed adjustment and necessary repairs of prosthetic devices and supplies that:

- replace all or part of a missing body organ and its adjoining tissues; or
- replace all or part of the function of a permanently useless or malfunctioning body organ.

This benefit will also include replacements for children who, due to growth, must obtain a new prosthetic appliance.

MENTAL HEALTH BENEFITS

Benefits are provided as listed in the Schedule of Benefits for inpatient and partial Hospitalization, and Day Treatment Psychiatric Care only at a licensed facility. Inpatient services must be pre-certified before admission.

Benefits are provided for outpatient psychiatric care by a Licensed Psychologist, Psychiatrist, or Licensed Social Worker, including services provided in a Day Treatment Program as listed in the Schedule of Benefits

OUTPATIENT MEDICAL CARE

Office visits and consultations to examine, diagnose, and treat an eligible condition.

PRIVATE DUTY NURSING SERVICES

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

Benefits are not provided for a nurse who usually lives in your home nor is a member of your immediate family.

Inpatient Services

Services that are of such nature or degree of complexity that the Provider's regular nursing staff cannot provide them or due to the Hospital's Intensive Care Unit being full. Prior approval is required.

SKILLED NURSING FACILITY/REHABILITATION FACILITY BENEFITS

Benefits are available for Covered Services in a Skilled Nursing Facility / Rehabilitation Facility as listed in the Schedule of Benefits. No coverage is provided for services for Custodial Care or care for senile deterioration, mental deficiency, or mental retardation (except in accordance with Federal Mental Health Parity requirements).

Confinement in the facility:

- must begin within two days after the Covered Person has been Confined in a Hospital for which room and board charges were paid; and
- is for treatment of the Illness causing the Hospital Confinement; and
- is one for which a Physician visits the Covered Person at least once every 30 days; and
- is not for routine Custodial Care.

SURGICAL SERVICES

The Plan covers you for surgical services performed by a Physician both in and out of a Hospital. As well as covering most operative and cutting procedures, surgery includes treatment of burns, fractures, and dislocations. It includes surgical pathology examinations, cast, and suture removal.

Regardless of Medical Necessity, the Plan covers surgery to restore bodily function or correct deformity. Benefits are only for problems caused by disease, Injury, birth or growth defects, or previous treatments.

Surgical Assistance

An assistant Physician to assist your surgeon while performing covered surgery when a house staff member, intern, or resident cannot be present. Allowable charges cannot exceed 20% of the surgeon's Allowed Amount.

Multiple Surgical Procedures

If two or more surgical procedures are performed through the same body opening during the course of the same operative period, the total benefit shall be computed as follows: 100% for the procedure with the greatest benefit, plus 50% for each additional procedure. In no event shall any additional allowance be made for any incidental procedures performed during the operative session.

If two or more surgical procedures are performed through more than one body opening during the course of the same operative period, the total benefit shall be computed as follows: 100% for the procedure with the greatest benefit, plus 75% for each additional procedure. In no event shall any additional allowance be made for any incidental procedures performed during the operative session.

Note: Where a PPO discount applies, the percentages will be based on the discounted charges.

Second Surgical Opinion

A voluntary second surgical opinion is recommended for some elective (non-emergency) procedures. The intent of this is to provide patients with additional information before a decision is made in an attempt to promote the delivery of high quality health care and eliminate unnecessary surgery.

The second surgical opinion must be provided by a surgeon other than the first surgeon who recommended the surgery.

NOTE: A third opinion will be covered if the first two conflict.

Additional Services

In addition, coverage is provided for the following specified surgical services:

- sterilization, regardless of Medical Necessity;
- therapeutic abortions;
- removal of bony impacted teeth;
- maxillary or mandibular frenectomy;
- diagnostic endoscopic procedures, such as colonoscopy and sigmoidoscopy;
- Surgery to correct functional or physiological impairment which was caused by disease, trauma, birth defects, growth defects or prior therapeutic processes as determined by Mutual Health Services, subject to any appeal process.

Surgery to correct a deformity or birth defect for psychological reasons, where there is no functional impairment, is not covered.

THERAPY SERVICES

Eligible Hospital and Physician therapy services or supplies used to promote recovery from an illness or injury include:

Cardiac Rehabilitation

Phase I and II will be covered benefits.

Phase I begins approximately 2-4 days following a heart attack, or 24 hours post-Surgery. Patients are assisted through range of motion exercises, which gradually progress to walking or stair climbing by the time of discharge.

Phase II is an outpatient, Hospital-based program, usually of 2-3 months duration. Patients engage in a monitored program of exercise therapy, health education and individualized or group support sessions.

Chemotherapy

The treatment of malignant disease by chemical or biological antineoplastic agents.

Dialysis Treatments

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

Hyperbaric and Pulmonary Therapy

Introduction of high-density solutions into the lungs for treatment purposes. Treatment must be provided by a Hospital.

Occupational Therapy

The treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role.

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time. No benefits are provided for diversional, recreational, and vocational therapies (such as hobbies, arts and crafts). Therapy must be ordered by a Physician and provided on a regular basis.

Radiation Therapy

The treatment of disease by X-ray, radium, or radioactive isotopes.

Respiratory Therapy

Treatment by the introduction of dry or moist gases into the lungs, and other respiratory therapy related services.

Speech Therapy

Treatment for the correction of a speech impairment limited to medical illness and accident victims.

Spinal Treatment/Chiropractic (non-surgical)

Detection or non-surgical correction (by manual or mechanical means) of a condition of the vertebral column including distortion, misalignment or subluxation to relieve the effects of nerve interference which results from or relates to such Conditions of the vertebral column. Please refer to the Schedule of Benefits pages for Plan limitations.

Benefits for x-rays received in connection with non-surgical spinal treatment are payable in the same manner as they are for other covered x-rays.

Therapy by Physical Means

Treatment given to relieve pain, restore maximum function and prevent disability following disease, injury or loss of body part. Services include hydrotherapy; heat or similar modalities; physical agents; hyperbaric therapy; biomechanical, neurophysiological principles and devices.

Treatment must be Medically Necessary and non-maintenance to be eligible as a Therapy Benefit.

URGENT CARE/WALK-IN CARE

Urgent Care/Walk-in Care will be covered as described in the Schedule of Benefits.

WELLNESS BENEFITS**Preventive Health Benefits**

Your Plan includes coverage for preventive services. Depending upon your age, services may include:

- Behavioral counseling to promote a healthy diet;
- Various immunizations;
- Mammograms;
- Pap smears;
- Screenings such as diabetes, bone density, chlamydia, cholesterol, colorectal cancer and hepatitis B;
- Well baby and well child visits through age 21
- Periodic physical exams

Eligible services have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations. You will be notified, at least sixty (60) days in advance, if any item or service is removed from the list of eligible services. Eligible services will be updated annually to include any new recommendations or guidelines.

Women's Preventive Services

These services will be provided in accordance with the age and frequency requirements of the Affordable Care Act, including, but not limited to: well-woman visits; screening for gestational

diabetes, human papillomavirus (HPV), human immunodeficiency virus (HIV) and sexually transmitted disease; and counseling for contraceptive methods, breastfeeding and domestic violence.

Coverage is provided for FDA-approved contraceptive methods and counseling. Prescribed contraceptive medication will be paid in accordance with any applicable Prescription Drug benefit.

Additional Preventive Services

If not shown above as a Covered Service, the following services will also be covered without regard to any Deductible, Copayment or Coinsurance requirement that would otherwise apply:

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

Please refer to the phone number on the back of your identification card if you have any questions or need to determine whether a service is eligible for coverage as a preventive service. For a comprehensive list of recommended preventive services, please visit www.healthcare.gov/center/regulations/prevention.html. Newly added preventive services added by the advisory entities referenced by the Affordable Care Act will start to be covered on the first plan year beginning on or after the date that is one year after the new recommendations or guideline, went into effect.

Direct Access to Obstetricians and Gynecologists

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

Selection of a Primary Care Provider

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

GENERAL LIMITATIONS AND EXCLUSIONS

The following are not covered by the Benefit Plan:

1. **A particular health service** in the event that a Non-PPO Network Provider waives Copayments, Coinsurance (and/or Deductible per Benefit Period), no benefits are provided for the health service for which the Copayments, Coinsurance (and/or the Deductible per Benefit Period) are waived;
2. **Abdominal surgery.** Regardless of Medical Necessity, services and/or supplies for abdominal surgery and/or reconstructive surgery which is related but not limited to gastric related bypass surgery, or stomach stapling type surgery will not be eligible. This includes surgical intervention for infections, chaffing, pain, diabetes, etc;
3. **Abortions** that are nontherapeutic and elective in nature;
4. **Absence of coverage.** Charges which would not have been made had coverage not existed;
5. **Acupuncture / Acupressure;**
6. **After Hours Care;**
7. **Autism and developmental delay.** Treatment of Conditions related to an autistic disease of childhood, developmental delay, learning disabilities, hyperkinetic syndromes, behavioral problems or mental retardation, unless otherwise specified;
8. **Biofeedback.** Biofeedback, recreational, or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing;
9. **Blood.** Whole blood or plasma when donated or otherwise replaced by or on behalf of the patient;
10. **Chelation therapy.** The use of chemical solutions in an attempt to prevent or reverse cardiovascular problems. By binding tightly to calcium and other minerals, chelating agents are thought to remove such substances from atherosclerotic plaques.
11. **Civil insurrection or riot.** Treatment or services resulting from participating in a civil insurrection or riot;
12. **Close Relative.** Service provided by a "close relative," meaning Spouse, or Covered Person's or Spouse's parent, brother, sister or child, or the Spouse of the Covered Person's parent, brother, sister or child;
13. **Completion** of claim forms, or missed appointments;
14. **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan;
15. **Contraceptives.** For male contraceptives and over-the-counter birth control without a prescription;

16. **Cosmetic services.** Services rendered for cosmetic purposes, unless made necessary by accidental Injury. This includes, but is not limited to stomach stapling, breast augmentation and face lifting;
17. **Court ordered.** Charges for health care ordered by the court, (i.e. court ordered rehabilitative treatment or services)
18. **Custodial Care.** Services or supplies provided mainly as a rest cure, domiciliary or convalescent care, or Custodial Care;
19. **Dental procedures,** except as specified in the Plan or as required by PPACA;
20. **Diagnostic Hospital Admission.** Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting unless otherwise specified;
21. **Educational or vocational testing.** Services for educational or vocational testing or training, except as specified in the Plan or as required by PPACA;
22. **Excess charges.** Charges that exceed the Allowed Amount, if applicable;
23. **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy, as specified by this Plan. This exclusion includes exercise equipment;
24. **Experimental or Investigative services,** procedures, treatment, prescription drugs and supplies, or substances, which have not been recognized as accepted standards of medical protocol;
25. **Eye care.** Radial keratotomy or other eye surgery to correct sight, including refractions, lenses for the eyes and exams for their fitting, unless otherwise specified. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages, and initial cataract lenses after cataract surgery;
26. **Felony.** Services and/or supplies for treatment of an accident or Illness that resulted while committing a felony, unless due to a medical condition (physical or mental), this does not include services and/or supplies incurred by a victim of domestic violence;
27. **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease) and routine foot care; Nail trimming, Hygienic and preventative maintenance foot care including but not limited to:
 - Cleaning and soaking of feet
 - Applying skin creams in order to maintain skin tone
 - Other services that are performed when there is not a localized illness, injury or symptom involving the foot.
28. **For x-ray examinations made without film;**

-
29. **Fraudulent or misrepresented claims;**
 30. **Genetic counseling or testing.** Counseling or testing concerning inherited (genetic) disorders; except as required by PPACA;
 31. **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid, to Medicare or when otherwise prohibited by law;
 32. **Hair loss.** Care and treatment for hair loss including wigs, unless otherwise specified herein, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician;
 33. **Hazardous Activities.** Treatment for injuries sustained while hang gliding, bungee jumping, parachuting, riding an ATV (3 or 4 wheeler), or injuries sustained while racing any sort of motorized vehicle;
 34. **Hearing Care.** For all services related to hearing loss including hearing aids or examinations for prescribing or fitting them, except as specified; (other than newborn screening for hearing loss, as required by PPACA);
 35. **Housekeeping, shopping, or meal preparation services** (except as provided through an approved Home Health Care Program, as described in Covered Services in this booklet);
 36. **Hypnosis;**
 37. **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence not caused by organic disease;
 38. **Infertility.** Reproductive infertility services including but not limited to - family planning; fertility tests; infertility (male or female) including any services or supplies rendered for the purpose or with the intent of inducing conception. Examples of fertilization procedures are ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance the reproductive ability; premarital examinations;
 39. **Marital counseling.** Treatment, services and supplies for marriage counseling, health education, holistic medicine or other programs with an objective to provide complete personal fulfillment;
 40. **Massotherapy.** Charges billed by a massotherapist;
 41. **Medicare Part B.** Services for which payment was made or would have been made under Medicare Part B if benefits were claimed. This applies when the Covered Person is eligible for Medicare, even if the Covered Person did not apply for or claim Medicare benefits;
 42. **Milieu Therapy.** Confinement in an institution primarily to change or control one's environment;
-

-
43. **No charge.** Services for which there is no charge received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group;
 44. **No fault.** To the extent expenses are in any way reimbursable through “No-Fault” automobile insurance;
 45. **No patient present.** Services and/or supplies furnished during periods when the patient is temporarily absent from the Hospital;
 46. **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of the admission;
 47. **Not Medically Necessary.** Any services or supplies which are not Medically Necessary, except as expressly included herein;
 48. **No notice of claim.** Treatment, services and supplies for which proof of claim is not provided to the Plan in accordance with the When to File a Claim section;
 49. **No obligation to pay.** Charges Incurred for which the Covered Person has no legal obligation to pay;
 50. **No Physician recommendation.** Any expenses Incurred for any service or treatment which is not provided or recommended by a Physician;
 51. **Not performed within the scope of the provider’s license;**
 52. **Not specified as covered.** Services, treatment and supplies which are not specified as covered under the Plan;
 53. **Nuclear accident;**
 54. **Nutritional supplements.** Including those prescribed by a Physician; except as required by PPACA;
 55. **Obesity.** Care and treatment of obesity, weight loss or dietary control, whether or not it is a part of the treatment plan for another Illness. This exclusion includes any bariatric surgery and complications as a result of, which includes but is not limited to:
 - Gastric Bypass surgery (including Laparoscopic gastric bypass);
 - Gastroplasty;
 - Gastric banding
 56. **Outside United States -** Elective procedures performed outside the United States, unless pre-authorization from the Plan for outside the United States coverage has been obtained prior to treatment; Services or supplies purchased outside the United States unless the covered participant is a resident of the United States and the charges are incurred while traveling on business or for pleasure;
 57. **Payment prohibited by law** to the extent that payment under this Plan by any law to which you or your Dependent is subject at the time expenses are Incurred;
-

58. **Personal comfort items.** Personal comfort items or other equipment such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, hot tubs, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, first-aid supplies and non-Hospital adjustable beds;
59. **Research charges.** For charges for doing research with providers not directly responsible for your care;
60. **Received from other than a Hospital, Physician or Other Provider;**
61. **Reimbursable through any public program.** To the extent those expenses are in any way reimbursable through any public program, except as otherwise required by law;
62. **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by PPACA;
63. **Self-inflicted injuries, or threatened suicide,** whether sane or insane, unless due to a medical Condition. The Plan will not exclude coverage for self-inflicted injuries or injuries from attempted suicide if the injuries are otherwise covered by the Plan and if the injuries are the result of a medical Condition such as depression;
64. **Services before or after coverage.** Care, treatment or supplies for which a charge was Incurred before a person was covered under this Plan or after coverage ceased under this Plan;
65. **Services rendered or billed** for by a school or halfway house or by a member of its staff;
66. **Sex changes.** Care, services, or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery and medical treatment, both pre and post-operative care;
67. **Stand-by charges of a Physician;**
68. **Sterilization reversal.** Care and treatment for reversal of surgical sterilization;
69. **Surrogate Parent.** Care, services or treatment incurred as a result of any Covered Person acting as or contracting to be a surrogate parent;
70. **Telephone or internet consultations.** Any oral, written or electronic communications or consultations by a Provider with a Covered Person or another Provider that do not involve in-person contact with the Covered Person;
71. **The following examinations:**
 - Physical examinations or services required by an insurance company to obtain insurance;

- Physical examinations or services required by a governmental agency such as FAA and ODOT;
 - Physical examinations or services required by an employer in order to begin or continue working;
 - Premarital examinations;
72. **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as defined by the Plan;
73. **Undocumented charges in provider records;**
74. **Violation of law.** An Injury or Illness resulting from the voluntary use of prescription drugs, nonprescription drugs, or alcohol which the use of same constitutes or contributes to the violation of any state or federal law. It will be determined by the Plan that violation of a state or federal law has occurred if:
- a) the individual is convicted or found guilty of the applicable charges; or
 - b) there is sufficient evidence that a state or federal law has been violated and no charges were brought against the individual. Sufficient evidence is defined as, but not limited to: (1) blood alcohol levels which exceed established state or federal minimums, (2) the possession of illegal nonprescription drugs, or (3) prescription/legend drugs used or taken without a written prescription;
75. **War.** Disease or Injury resulting from participation in a war, or act of war, whether declared or undeclared;
76. **Weight Loss Drugs and Programs.** Weight loss drugs and programs whether or not they are under medical or Physician supervision. Weight loss drugs and programs for medical reasons are also excluded. Weight loss drugs and programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, etc.) or fasting programs.
77. **Without Cost.** Care received without cost under the laws of the United States or any other country or government entity;
78. **Work related.** Expenses Incurred as a result of accidental bodily Injury or sickness arising out of or in the course of any occupation or employment for wage or profit, or for which the Covered Person may be entitled to benefits under any Workers Compensation or occupational disease policy, whether or not any such policy is actually in force. However, this exclusion only applies to persons who can elect, or could have elected for them, coverage under a worker's compensation act, policy or similar law.

PRESCRIPTION DRUG BENEFITS

The Prescription Drug Benefits provided by this Plan help to meet the cost of legend drugs. A legend drug is a compound or substance that requires, under federal law, a written prescription by a licensed Physician of medicine or osteopathy, dentist or podiatrist who is legally licensed to prescribe medications. It is a drug or medication that cannot be sold over the counter without a written prescription.

EXPRESS SCRIPTS 1-800-922-1557

COVERED PRESCRIPTION DRUGS

Benefits include up to a 30-day supply of most legend drugs and compound prescriptions containing at least one legend drug.

The amount of drugs, including insulin, which is to be dispensed per prescription or refill, will be in quantities prescribed up to a 30-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.

The Plan also provides benefits for certain preventive drugs required by PPACA when a written prescription from your Physician is received. These PPACA-required drugs are covered at a zero Copayment/Coinsurance, but specific ages and quantity limits may apply.

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.

You will be charged the corresponding Copay for each prescription filled or refilled. The prescription card company pays any cost beyond that to the Pharmacy.

If you have a prescription filled at a Non-Participating Pharmacy or if you do not have your card with you at the time the prescription is filled, pay the pharmacist, then complete a reimbursement form and send that to the prescription card company listed on your identification card 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 Express Scripts at 1-800-922-1557.

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. Drugs obtained without a Physician's prescription;
2. Drugs for which the provider's Allowed Amount is less than the Copay amount of the Plan;
3. Covered drugs for which benefits are paid elsewhere under the Plan; including but not limited to: drugs used in connection with covered transplants under the transplant section;
4. Drugs not requiring a prescription under federal law;
5. Male contraceptives and over-the-counter birth control without a prescription;
6. Fertility drugs/agents;
7. Charges for growth hormones, unless prior approval is obtained by the Plan;
8. Charges for Retin-A or similar products for those over age 21;
9. Drugs which sole purpose are to promote or stimulate hair growth;
10. 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;
11. Any charge for administration of drugs or insulin;
12. The charge for more than a 30-day supply of retail legend drugs;
13. 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;
14. Immunizing agents, biological sera, blood or plasma, laterite;
15. Dietary supplements and vitamins except prenatal vitamins used while receiving maternity benefits and those required by PPACA;

16. Health and beauty aids;
17. Drugs labeled "Caution: limited by Federal law to investigational use" or experimental drugs, even though a charge is made;
18. Drugs taken or given while at a Hospital, convalescent care facility, or similar institution;
19. Fluoride preparations; except as required by PPACA;
20. Weight control/Anti-Obesity Drugs;
21. Impotency agents/Drugs (Viagra, MUSE, etc.) and injectable drugs; except as determined to treat a medical illness. Prior approval must be obtained by the Plan;
22. 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;
23. Drugs which do not have the required governmental approval when you receive them or are considered Experimental, investigative, or of a research nature; and
24. 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 card, you will be held responsible for payment of any charges Incurred on or after such termination date.

GENERAL INFORMATION

CLAIMS PROCEDURES

Types of Claims

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

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

Claims Involving Urgent Care – A Claim Involving Urgent Care is any Pre-Service Care Claim for medical care or treatment with respect to which the application of the timeframes for making non-urgent care determinations (a) could seriously jeopardize your life or health or your ability to regain maximum function or (b) in the opinion of a Physician with knowledge of your medical Condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies. Determination of *urgent* will be made by an individual acting on behalf of the plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine; however, any Physician with knowledge of your medical Condition can determine that a claim involves urgent care.

Concurrent Care Claim - A Concurrent Care Claim is a claim for an extension of the duration or number of treatments provided through a previously approved pre-service claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought. Additionally, if the Plan or its designee reduces or terminates a course of treatment before the end of the course previously approved (unless the reduction or termination of benefits is due to a health plan amendment or health plan termination), then the reduction or termination is considered an adverse benefit determination. The Plan or its designee will notify you, in advance, of the reduction or termination so that you may appeal and obtain an answer on the appeal before the benefit is reduced or terminated.

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

Who Must File

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

Appointing an Authorized Representative. If you or your Dependent wish to have someone act on your behalf for purposes of filing claims, making inquiries and filing appeals, you must furnish the Plan or its designee with a signed and dated written statement designating your authorized representative. You can appoint any individual as your authorized representative. A

Health Care Provider with knowledge of your medical condition can act as your authorized representative for purposes of a Claim Involving Urgent Care as defined above without a written designation as authorized representative. Once you appoint an authorized representative in writing, all subsequent communications regarding your claim will be provided to your authorized representative.

Time Limit for Filing a Claim

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

Method of Claims Delivery

Pre-Service Care Claims may be initiated by telephone. The Plan may require you to provide follow-up paperwork in support of your claim.

Other claims may be submitted by U.S. Mail, by hand delivery, by facsimile (FAX), or as a HIPAA compliant electronically filed claim.

Timing of Claims Determinations

Claims Involving Urgent Care. If you file a Claim Involving Urgent care in accordance with the claims procedures and sufficient information is received, you will be notified of the Plan's or its designee's benefit determination, whether adverse or not, as soon as is feasible, but not later than 72 hours after receipt of the claim. If you do not follow the claims procedures or the claim does not include sufficient information for the Plan or its designee to make a benefit determination, you will be notified within 24 hours after receipt of the claim of the applicable procedural deficiencies, or the specific deficiencies related to additional information necessary to make a benefit determination. You will have at least 48 hours to respond to correct the procedural deficiencies and/or provide the requested information. The Plan or its designee must inform you of the benefit determination, whether adverse or not, as soon as possible, taking into account all medical exigencies, but not later than 48 hours after receipt of the additional information. The Plan or its designee may notify you of its benefit determination decision orally and follow with written or electronic notification not later than three (3) days after the oral notification.

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

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

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

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

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

Notice of Claims Denial (Adverse Benefit Determination)

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

1. Information sufficient to identify the claim or health care service involved, including the date of service, 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. Notice of the availability of, and contact information for, an applicable office of consumer assistance established under the Public Health Service Act section 2793, if one is available;
8. A description of additional information, if any, that is required to perfect the claim and an explanation of why the information is necessary;
9. A description of the Plan's or its designee's appeal procedures and applicable time limits, including the expedited appeal process, if applicable; and
10. A statement of your right to bring a civil action under federal law following the denial of a claim after review on appeal, if your claim is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

FILING A COMPLAINT

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

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

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

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

APPEALS PROCEDURES

* Please note: The processes described here are based on the claims and appeals processes set forth in the Patient Protection and Affordable Care Act and related regulations and guidance. As those regulations and guidance are subject to change, the claims and appeals processes for this plan are subject to change. The rules and/or procedures set forth in the most current claims and appeals regulations and guidance at the time your claim or appeal is processed will govern your claims and appeals, even if they conflict with the claims and appeals processes set forth herein.

How and When to File a Claims Appeal

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

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

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

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

First Level Mandatory Internal Appeal

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

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

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

The claim review will be subject to the following rules:

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

Timetable for Deciding Appeals

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

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

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

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

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

Notice of Final Adverse Benefit Determination after Appeal

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

1. Information sufficient to identify the claim or healthcare service involved, including the date of service, healthcare provider, and claim amount (if applicable);
2. The specific reason(s) for the appeal final adverse benefit determination, including the denial code and its corresponding meaning;
3. Reference to the specific plan provision(s) on which the final adverse benefit determination is based;

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

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

Second Level Appeal

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

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

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

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

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

External Review for Non-Urgent Care Appeals

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

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

Expedited External Review for Urgent Care Appeals

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

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

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

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

LEGAL ACTION

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

HEALTH CARE FRAUD

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

PLAN AMENDMENTS

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

RIGHT TO RELEASE CLAIMS AND RECEIVE NECESSARY INFORMATION

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

PHYSICAL EXAMINATION

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

FACILITY OF PAYMENT

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.

RESCISSION OF COVERAGE

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

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

RIGHT OF RECOVERY

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

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).

LARGE CASE MANAGEMENT

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

When a Covered Person's condition warrants (i.e. chronic illness, catastrophic injury, etc.) the Plan shall have the right to initiate case management and waive the normal provisions of the Plan when it is reasonable to expect a cost effective result without sacrifice to the quality of patient care. The Case Manager will first contact the patient and/or the patient's family to introduce themselves and answer questions. The Case manager will also contact the patient's attending Physician and other medical providers to introduce themselves and to assure that all available resources are considered.

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

COORDINATION OF BENEFITS

Individuals might be covered under two or more plans and in the event of an accidental injury or illness, could possibly submit claims to the different companies. The end result might be that the total claim payments from the companies exceed the individual's total medical expenses. Therefore, the following Coordination of Benefits provision applies to this coverage:

This provision is not intended to deny you benefits, but to ensure that duplicate payments are not made when you are covered by this and any "Other Plan". Under this Plan of group coverage, all benefits will be coordinated with all "Other Plans" you or your Dependent might have coverage through, so that the total amount payable under all plans will not exceed 100% of your total allowable medical expense incurred during a Calendar Year. However, if your Dependents have coverage under any "Other Plan" and said Plan is considered a primary payor and the Dependent Spouse fails to comply with the requirements of the "Other Plan" or fails to utilize a Health Maintenance Organization (HMO) which has been selected by said Dependent Spouse under the "Other Plan" and the "Other Plan" would have been primary for the Dependent's actions, this Plan will not pay any portion of the allowable expenses incurred by that Dependent Spouse.

For a Dependent child who fails to utilize the services of the HMO, which would otherwise be considered as the primary payor for the Dependent, this Plan will pay its pro-rata share, up to one-half of the allowable benefits determined by this Plan.

With regard to Coordination of Benefits, "Other Plan(s)" shall mean:

- Any HMO's and other group or individual practice plans;
- Governmental programs, except:
 - Coverage provided under Medicare, Medicaid (Title XIX), or the Social Security Act of 1965, as amended;
 - Any plan where, by law, its benefits are excess to those of any private insurance plan or non-governmental plan;
- Coverage under labor-management trustee plans;
- Coverage under union welfare plans;
- Coverage under employer organization Plans or employee benefit organization Plans.

The order of benefit determination will be handled as follows:

1. The primary plan for husbands or wives is that which covers the person as an Employee or as the certificate holder.
2. For children's expenses, the primary plan is the plan of the parent whose birthday falls earlier in the Calendar Year.
3. For children's expenses when the parents are separated or divorced:
 - a. Primary will be the plan of the parent who, by court decree, is responsible for providing medical coverage.
 - b. Secondary will be the plan of the other natural parent. *
 - c. If any plan lacks a coordination of benefits' provision, it will be the primary plan.

* If there is no court decree stating who should provide benefits, then the plan of the parent with custody will be the primary payor. If the parent with custody has remarried, then the stepparent will be the secondary plan and the plan of the natural parent without custody will pay last.

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 and 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 or premises no-fault coverage, personal injury protection coverage, or medical payments coverage.

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) your right 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.

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.

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 any other source possessing 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, claims, or right 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 that 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 attorneys' fees to any attorneys 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. 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 and regardless of whether the settlement or judgment 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 shall provide all information requested by the Plan, the Claims Administrator, or its representative, including, but not limited to, completing and submitting any application 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 termination of your health benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the Plan's Subrogation and Recovery interests or to 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. If you fail to cooperate with the Plan in its efforts to Recover such amounts or do anything to hinder or prevent such a Recovery, you will cease to be entitled to any further Plan benefits. The Plan will also have the right to withhold or offset future benefit payments up to the amount of any settlement, judgment, or Recovery you obtain, regardless of whether the settlement, judgment, or Recovery is designated to cover future medical benefits or expenses.

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.

Interpretation

In the event that a 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.

PROVISIONS APPLICABLE TO ALL COVERAGE

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

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

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

TERMINATION OF EMPLOYEE COVERAGE

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

1. The date the Plan terminates and/or is dissolved.
2. The date you cease active work with HealthComp, Inc.
3. The date that you die.
4. When you cease your contributions toward the Plan.
5. The date you enter into military service, other than for a duty of less than 30 days, or as specified in the USERRA section of this plan.
6. The date you fail to return to work from an approved FMLA leave.

TERMINATION OF DEPENDENT CHILD COVERAGE

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

1. When the Employee's coverage terminates.
2. When the Employee ceases to make the required contribution regarding Dependent coverage.
3. The date the child becomes eligible and chooses to be covered as an Employee.
4. The date the child reaches the limiting age of 26, as described in the eligibility section.
5. Effective January 1, 2016: The last day of the calendar month the child reaches the limiting age of 26, as described in the eligibility section.
6. When this Plan is terminated and/or discontinued.

TERMINATION OF DEPENDENT SPOUSE COVERAGE

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

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

FAMILY AND MEDICAL LEAVE

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

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

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

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

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

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

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

If you decline coverage during the FMLA leave period, or if you elect to continue coverage during the Family or Medical Leave and fail to pay the required contributions, you will still be eligible for COBRA continuation at the end of the FMLA leave, if you do not return to work. COBRA continuation will become effective on the last day of the FMLA leave. You need not provide evidence of good health to elect COBRA continuation, even if there was a lapse in coverage during the FMLA leave period.

If coverage lapses for any reason during an FMLA leave and you return to work on a timely basis following an approved FMLA leave, coverage will be reinstated as if you have continued

performing services during the leave, including Dependent coverage. Reinstatement will be provided without having to satisfy any waiting period, or provide evidence of good health.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

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

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

- A. The Plan (and any business associate acting on behalf of the Plan), or any health care issuer servicing the Plan will disclose Individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of the HIPAA Regulations.
- B. All disclosures of the Protected Health Information of the Plan's Individuals by the Plan's business associate or health care issuer, to the Plan Sponsor will comply with the restrictions and requirements set forth in this document and in 45 C.F.R. §164.504 (the "504" provisions).
- C. The Plan (and any business associate acting on behalf of the Plan), may not permit a health care issuer, to disclose Individuals' Protected Health Information to the Plan Sponsor for employment-related actions and decisions in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- D. The Plan Sponsor will not use or further disclose Individuals' Protected Health Information other than as described in the Plan Documents and permitted by the "504" provisions.
- E. The Plan Sponsor will ensure that any agent(s), including a subcontractor, to whom it provides Individuals' Protected Health Information received from the Plan (or from the Plan's business associate or health care issuer), agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Protected Health Information.
- F. The Plan Sponsor will not use or disclose Individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- G. The Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, including any Breaches, of which the Plan Sponsor becomes aware.

Disclosure of Individuals' Protected Health Information - Disclosure by the Plan Sponsor

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

- B. The Plan Sponsor will make Individuals' Protected Health Information available for amendment and incorporate any amendments to Individuals' Protected Health Information in accordance with 45 C.F.R. § 164.526.
- C. The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of Individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. § 164.528.
- D. The Plan Sponsor will make its internal practices, books, and records relating to the use and disclosure of Individuals' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Regulations.
- E. The Plan Sponsor will, if feasible, return or destroy all Individuals' Protected Health Information received from the Plan (or a business associate or health care issuer with respect to the Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- F. The Plan Sponsor will ensure that the required adequate separation, described later in this section, is established and maintained.

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

- A. The Plan, or a business associate or health care issuer with respect to the Plan, may disclose summary health information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions, if the Plan Sponsor requests the summary health information for the purpose of:
 - 1. Obtaining premium bids from health plans for providing health coverage under the Plan; or
 - 2. Modifying, amending, or terminating the Plan.
- B. The Plan, or a business associate or health care issuer with respect to the Plan, may disclose enrollment and disenrollment information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

Required separation between the Plan and the Plan Sponsor

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

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

HIPAA Security Standards

Definitions

- A. *Electronic Protected Health Information* – The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.
- B. *Plan* – The term "Plan" means HealthComp, Inc. d/b/a The Center for Health Affairs Non-Grandfathered Employee Benefit Plan.
- C. *Plan Documents* – The term "Plan Documents" means the group health plan's governing documents and instruments (*i.e.*, the documents under which the group health plan was established and is maintained), including but not limited to HealthComp, Inc. d/b/a The Center for Health Affairs Non-Grandfathered Employee Benefit Plan Document.
- D. *Plan Sponsor* – The term "Plan Sponsor" means the entity as defined at section 3(16) (B) of ERISA, 29 U.S.C. § 1002(16) (B). The Plan Sponsor is Healthcomp, Inc. d/b/a The Center for Health Affairs.
- E. *Security Incidents* – The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Plan Sponsor Obligations

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

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

- B. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f) (2) (iii) of the HIPAA Regulations is supported by reasonable and appropriate security measures;
- C. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
- D. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - 1. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
 - 2. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

COBRA COVERAGE

SUMMARY OF RIGHTS AND OBLIGATIONS REGARDING CONTINUATION OF COVERAGE UNDER THE BENEFIT PLAN

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

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

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

Qualifying Events

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

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

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

1. The death of your Spouse.
2. A termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of employment with HealthComp, Inc.
3. Divorce or legal separation from your Spouse. (Also, if an Employee drops his or her Spouse from coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later event will be considered a qualifying event even though the ex-Spouse lost coverage earlier. If the ex-Spouse notifies the administrator within 60 days of divorce and can establish that the coverage was dropped earlier in anticipation of divorce, then COBRA coverage may be available for the period after the divorce or legal separation.)
4. Your Spouse becomes entitled to Medicare benefits.
5. Your Spouse becomes disabled.

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

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

Notices and Election Procedures

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

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

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

Notification of a disability determination must be made to the Plan Administrator within 60 days of the LATER of the date of determination, date of qualifying event, or date coverage is lost as a result of the qualifying event. Notification must be in writing as described in the above paragraph, and a copy of the SSA Determination, or another correspondence from the Social Security Administration that includes all the information Mutual Health Services will need from

the original determination letter to decide whether you are eligible for the extended coverage, must accompany your notice. Please note you have 30 days from the determination to notify Plan Administrator that you are no longer disabled.

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

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

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

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

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

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

Type of Coverage; Payments of Contributions

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

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

Maximum Coverage Periods

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

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

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

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

Exceptions. There are three exceptions:

1. If an Employee or family member is disabled at any time during the first 60 days of continuation coverage (running from the date of termination of employment or reduction in hours), the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to HealthComp, Inc. or the Plan Administrator both within the 18-month coverage period and within 60 days after the date of the determination.
2. If a second qualifying event that gives rise to a 36-month maximum coverage period (for example, the Employee dies or becomes divorced) occurs within an 18-month or 29-month coverage period, the maximum coverage period becomes 36 months from the date of the initial termination or reduction in hours for the Spouse or dependent child.
3. If within the 18 month period after Medicare entitlement, the Employee experiences a qualifying event (due to termination or reduction of hours worked) then the period of continuation for family members, other than the Employee, who are qualified beneficiaries, is up to 36 months from the date of Medicare entitlement.

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

If the Employee's Medicare entitlement follows an initial qualifying event (due to termination or reduction of hours worked) and would have resulted in a loss of coverage had it occurred before the initial qualifying event, then other family members who are qualified beneficiaries will

be allowed to elect COBRA coverage up to 36 months from the date of the initial qualifying event.

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

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

Termination of COBRA before the End of Maximum Coverage Period

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

1. HealthComp, Inc. no longer provides group health coverage to any of its Employees.
2. The premium for the qualified beneficiary's COBRA coverage is not timely paid.
3. After electing COBRA, you (Employee, Spouse or Dependent child) become covered under another group health plan (as an Employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the "other plan" has applicable exclusions or limitations, your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group health plan. Note that under Federal law (the Health Insurance Portability and Accountability Act of 1996), an exclusion, or limitation of the other group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group health plan.
4. After electing COBRA, you (Employee, Spouse or Dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
5. If you (Employee, Spouse or Dependent child) became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).
6. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered Employees or their Spouses or Dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of Federal law.

Other Information

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

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

HealthComp, Inc.
Attn: Human Resources
1226 Huron Road East
Cleveland, OH 44115
216-255-3670

USERRA

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

Continuation of Coverage Due to Military Leave

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

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

Reinstatement of Coverage Following Military Leave

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

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

1. You have given advance written or verbal notice of the military leave to HealthComp, Inc. (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 HealthComp, Inc. as follows:
 - a. On the first business day following completion of military service for a leave of thirty (30) days or less; or
 - b. Within fourteen (14) days of completion of military service for a leave of thirty-one (31) days to one hundred-eighty (180) days; or
 - c. Within ninety (90) days of completion of military service for a leave of more than one hundred-eighty days.

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

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

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

EFFECT OF MEDICARE ON THE PLAN

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

Coverage for a Covered Person will always be Primary if:

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

Coverage for a Covered Person will be Secondary if:

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

2. The Covered Person has been entitled to benefits under Medicare because of renal dialysis or kidney transplant for more than 30 months (coordination period). In this case, coverage under this Plan will be Secondary only after the first 30 months of the coordination period such person is so entitled; or
3. The Covered Person is entitled to Medicare on the basis of disability, and his/her employer has less than 100 Employees.
4. The Covered Person is a retired Employee or the covered Dependent of a retired Employee.

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

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

DEFINITIONS

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.

Allowed Amount - the negotiated amount with PPO Providers that the provider will accept as payment in full, as set forth in the applicable network's contracts. In the absence of a contract between the 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 PPO Providers for that service, and Medicare reimbursement rates for that service. In this case, the Allowed Amount will likely be less than the provider's Billed Charges. If you receive services from a Non-Participating Provider, 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 provider's Billed Charges, even if you have met your Out-of-Pocket Maximum.

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

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;
- provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- does not provide Inpatient accommodations; and
- is not, other than incidentally, used as an office or clinic for the private practice of a Physician or Professional Other Provider.

Benefit Period – the period of time specified in the Schedule of Benefits during which Covered Services are rendered, and benefit maximums, Deductibles, Copayments, Coinsurance and Out-of-Pocket Maximums are accumulated. The first and/or last Benefit Period may be less than 12 months depending on the Effective Date and the date your coverage terminates.

Billed Charges – the amount billed on the claim submitted by the Provider for services and supplies provided to a Covered Person.

Birthing Center - a facility which meets all of the following tests:

- It is primarily engaged in providing birthing services for low risk pregnancies;
- It is operated under the supervision of a doctor;
- It has at least one licensed registered nurse certified as a nurse midwife in attendance at all times;
- It has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

Calendar Year - the period that starts with the effective date on your identification card and ends on December 31st of such year. Each following Calendar Year shall start on January 1st of any year and end on December 31st of that year.

Child Support Performance and Incentive Act of 1998 (CSPIA) Information and Notification - requires a group health plan, insurance company, and HMO to honor a qualified medical child support order (QMCSO) submitted to the Plan and pay benefits to:

1. Any child who is an “alternate recipient” specified therein;
 2. The child’s custodial parent or guardian who incurs covered expenses on the child’s behalf; or
 3. An official of a state or political subdivision whose name and address has been substituted for that of any alternate payee in the order. This third alternative is effective for QMCSOs issued on or after August 5, 1997.
- If the Plan receives a court order to provide coverage for a qualified employee’s dependent child, the Plan Sponsor must notify the employee and determine if the child is eligible for coverage. Eligibility determinations will be made in accordance with federal child support order laws and regulations. The employee will be responsible for any required contributions.
 - The coverage provided in accordance with a child support order will be effective as of the date of the child support order and subject to all provisions of the group plan. The coverage required by a child support order will cease on the earlier of the date the support order expires or the date the dependent is enrolled for similar coverage. The Plan will not deny coverage or benefits because a person is eligible for other state or federal sponsored medical benefits.
 - If covered expenses for a dependent child are paid by a custodial parent or legal guardian who is not the covered employee and/or dependent, reimbursement must be made directly to the custodial parent or legal guardian rather than the covered employee and/or dependent. A custodial parent or legal guardian may also sign claim forms and assign Plan benefits.

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

Coinsurance - a percentage of the Allowed Amount, as specified in the Schedule of Benefits, that you are required to pay toward Covered Services.

Complications of Pregnancy - a Condition needing medical treatment before or after termination of pregnancy. The Condition must be diagnosed as distinct from pregnancy or as caused by it. Examples are: acute nephritis, cardiac decompensation; miscarriage; disease of the vascular, hemopoietic, nervous or endocrine systems; and similar Conditions that can’t be classified as a distinct complication of pregnancy but are connected with the management of a difficult pregnancy. Also included are: Medically Necessary cesarean sections; terminated ectopic pregnancy; spontaneous termination that occurs during pregnancy in which a viable birth is impossible; hyperemesis gravidarum; and preeclampsia.

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

Confinement/Confined - the period starting with a Covered Person's admission on an inpatient basis (more than 24 hours) to a Hospital or other licensed health care facility for treatment of an Illness or Injury. Confinement ends with the Covered Person's discharge from the same Hospital or other facility. If the Covered Person is transferred to another Hospital or other facility for continued treatment of the same or related Illness or Injury, it is considered one Confinement.

Consultant - a Physician or Professional Other Provider, as defined, who has special knowledge, training, and skill related to your Injury, Illness, or disease.

Convalescent Facility/Skilled Nursing Facility/Rehabilitation Facility

- A Skilled Nursing Facility, as the term is defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare, except for a Skilled Nursing Facility which is part of a Hospital, as defined; or
- An institution which fully meets all of the following:
 - a. It is operated in accordance with the applicable laws of the jurisdiction in which it is located;
 - b. It is under the supervision of a licensed Physician, or registered graduate nurse (R.N.) who is devoting full-time to such supervision;
 - c. It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness;
 - d. It maintains a daily medical record of each patient who is under the care of a duly licensed Physician;
 - e. It is authorized to administer medication to patients on the order of a duly licensed Physician;
 - f. It is not, other than incidentally, a home for the aged, the blind, the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill;
 - g. It is not a Hospital or part of a Hospital.

Copayment - A cost sharing arrangement whereby a Covered Person pays a set amount to a provider for a specific service.

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

Covered Service - a Provider's service or supply as described in this document for which benefits will be provided as listed in the Schedule of Benefits.

Custodial Care - care provided primarily for maintenance of the patient or care which is designed essentially to assist the patient in meeting his activities of daily living. This does not include care primarily provided for its therapeutic value in the treatment of an Illness, disease, bodily Injury, or Condition. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medications not requiring the constant attention of trained medical personnel.

Day Treatment Programs – non-residential programs for treatment of Alcoholism and Drug Abuse, which are operated by certified inpatient and outpatient Alcoholism and Drug Abuse

Treatment Facilities, that provide case management, counseling, medical care, and therapies on a routine basis for a scheduled part of the day and a scheduled number of days per week; also known as partial Hospitalization.

Deductible- an amount, usually stated in dollars, for which you are responsible each Benefit Period before the Plan will start to provide benefits.

Dependent - as defined in the Eligibility section of this booklet.

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

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.

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

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

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, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition and such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to Stabilize the patient.

Employee - Any common law employee of HealthComp, Inc. The term "Employee" excludes any person who is not classified by HealthComp, Inc. on its payroll records as an Employee for purposes of federal income tax withholding. Employees do not include individuals classified as independent contractors, even if the classification is determined to be erroneous or is retroactively revised (such as by a governmental agency or court order). If a person who was excluded from the definition of Employee is later determined to have been misclassified, the person shall continue to be treated as a non-Employee for all periods prior to the date the classification of the person should be revised for purposes of the Plan.

Essential Health Benefits - is defined under federal law (PPACA) as including benefits in at least the following categories: ambulatory patient services; emergency services; hospitalization;

maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental or Investigational Drug, Device, Medical Treatment or Procedure - a drug, device, medical treatment or procedure is Experimental or Investigational:

- if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is provided; or
- if reliable evidence shows that the drug, device, medical treatment or procedure is not considered to be the standard of care, is the subject of ongoing phase I, II or III clinical trials, or is under study to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis; or
- if reliable evidence shows that the consensus of opinion among experts is that the drug, device, medical treatment or procedure is not the standard of care and that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence may consist of any one or more of the following:

- published reports and articles in the authoritative medical and scientific literature;
- opinions expressed by expert consultants retained by Mutual Health Services to evaluate requests for coverage;
- the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure;
- the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure;
- corporate medical policies developed by Mutual Health Services; or
- any other findings, studies, research and other relevant information published by government agencies and nationally recognized organizations.

Even if a drug, device, or portion of a medical treatment or procedure is determined to be Experimental or Investigational, Mutual Health Services will cover those Medically Necessary services associated with the Experimental or Investigational drug, device, or portion of a medical treatment or procedure that Mutual Health Services would otherwise cover had those Medically Necessary services been provided on a non-Experimental or non-Investigational basis.

The determination of whether a drug, device, medical treatment or procedure is Experimental or Investigational shall be made by Mutual Health Services in its sole discretion, and that determination shall be final and conclusive, subject to any available appeal process.

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

Hospice - an agency that provides counseling, medical services and may provide room and board to a terminally ill eligible individual and which meets all of the following:

- It has obtained any required state or governmental Certificate of Need approval;
- It provides service 24 hours a day, 7 days a week;
- It is under the direct supervision of a doctor;
- It has a nurse coordinator who is a registered nurse (R.N.);
- It has a social service coordinator who is licensed;
- It is an agency that has as its primary purpose the provision of Hospice services;
- It has a full-time administrator;
- It maintains written records of services provided to the patient; and
- It is licensed, if licensing is required.

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.

Illness - any physical or mental sickness or disease which manifests treatable symptoms and which requires treatment of a Physician. This definition will also include pregnancy.

Incurred - a charge is considered Incurred on the date the Covered Person receives the service or supply for which the charge is made.

Injury - any accidental bodily damage or hurt sustained while the Covered Person is covered under the Plan and which requires treatment by a Physician. Damage caused by chewing is not an Injury.

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 (or Medical Necessity) – a Covered Service, supply and/or Prescription Drug that is required to diagnose or treat a Condition and which the Plan determines is:

- appropriate with regard to the standards of good medical practice and not Experimental or Investigational;
- not primarily for your convenience or the convenience of a Provider; and
- the most appropriate supply or level of service which can be safely proved to you. When applied to the care of an inpatient, this means that your medical symptoms or Condition require that the services cannot be safely or adequately provided to you as an outpatient. When applied to Prescription Drugs, this means the Prescription Drug is cost effective compared to alternative Prescription Drugs which will produce comparable effective clinical results.

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.

Miscellaneous Hospital Expense - the regular Hospital charges (but not room and board, nursing services and ambulance services) covered under the Plan for care for an Illness or Injury requiring inpatient Hospitalization.

Non-Covered Charges - Billed Charges for services and supplies which are not Covered Services.

Non-Participating - the status of a Physician, Other Professional Provider, Hospital or Other Facility Provider that does not have a signed agreement with the Plan's PPO Network regarding payment for Covered Services.

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

Other Professional Providers include the following:

- Dentist
- Doctor of Chiropractic Medicine
- Certified Registered Nurse Anesthetist (CRNA)
- Laboratory (must be Medicare approved)
- Licensed Mental Health and Alcoholism and Drug Abuse Counselors
- Licensed Social Worker
- Midwife
- Nurse Practitioner
- Occupational Therapist
- Physician Assistant (PA)
- Physical Therapist
- Podiatrist
- Psychologist

Other Provider Facilities include the following institutions:

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

- Dialysis Facility - a facility which mainly provides dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.
- Drug Abuse Treatment Facility - a facility which provides detoxification and rehabilitation treatment for Drug Abuse.
- Home Health Care Agency - a facility which:
 - a. provides skilled nursing and other services on a visiting basis in the Covered Person's home; and
 - b. is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- Psychiatric Hospital - a facility which is primarily engaged in providing diagnostic services and therapeutic services for the Inpatient treatment of mental illness. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.

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

Participant – an eligible Employee or Dependent who has selected and is participating in the Plan.

Pharmacy - an “Other Professional Provider” which is a licensed establishment where Prescription Drugs are dispensed by a pharmacist licensed under applicable state law.

Physician - a person who received a degree in medicine and is a medical doctor or surgeon licensed by the state in which he/she is located and provides services while he/she is acting within the lawful scope of his/her license. When the Plan is required by law to cover the services of any other licensed medical professional a Physician also includes such other licensed medical professional, for example, a chiropractor, podiatrist, dentist, or chiropractor who: (a) is acting within the lawful scope of his/her license; (b) performs a service which is covered under the Plan.

Plan – HealthComp, Inc. d/b/a/ The Center for Health Affairs Non-Grandfathered Employee Benefit Plan.

Plan Administrator – Same entity as Plan Sponsor.

Plan Documents – 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 this summary of benefits.

Plan Sponsor – means “Plan Sponsor” as defined at section 3(16) (B) of ERISA, 29 U.S.C. § 1002(16) (B). The Plan Sponsor is HealthComp, Inc. d/b/a The Center for Health Affairs.

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

PPO Provider - a Physician, Other Professional Provider, contracting Hospital or contracting Other Provider Facility which is included in a limited panel of providers for which the greatest benefit will be payable when one of these providers is used.

Pre-Admission Tests - tests performed on you or your Dependent prior to Confinement as an inpatient, provided:

1. such tests are related to the performance of scheduled surgery;
2. such tests have been ordered by a duly qualified Physician after a Condition requiring such surgery has been diagnosed and Hospital admission for such surgery has been requested by the Physician; and
3. you or your Dependent are subsequently admitted to the Hospital, or the Confinement is canceled or postponed because a Hospital bed is unavailable or because there is a change in your or your Dependent's Condition which precludes the surgery.

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

Prior Health Plan - the previous plan of medical insurance coverage.

Protected Health Information (PHI) – individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearing house and that relates to: (i) your past, present, or future physical or mental health or Condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

Psychologist - only a person who specializes in clinical psychology and fulfills the requirements specified in item (1) or (2) below, whichever is applicable:

1. A person who is licensed or certified as a Psychologist by the appropriate governmental authority having jurisdiction over such licensure or certification, as the case may be, in the jurisdiction where such person renders service to you or your dependent.
2. A person who is a Member or Fellow of the American Psychological Association, if there is no licensure or certification in the jurisdiction where such person renders service to you or your Dependent.

Qualified Medical Child Support Orders - the term “Qualified Medical Child Support Order”, (QMCSO), means a Medical Child Support Order, (MCSO), which creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to receive benefits for which a Participant or beneficiary is eligible under the Plan. The term “Medical Child Support Order” means any court issued judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which provides for child support with respect to a child of a Participant under the Plan or provides for health coverage to such a child pursuant to a state domestic relations law and relates to benefits under the Plan.

The term "Alternate Recipient" means any child of a Participant who is recognized under a MCSO as having a right to enrollment under the Plan with respect to such Participant.

A person who is an Alternate Recipient under a QMCSO shall be considered a beneficiary under the Plan.

Any payment for benefits by the Plan, pursuant to a MCSO in reimbursement for expense paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian, shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

Upon receipt of the MCSO, the Plan shall immediately determine if such child is qualified. The MCSO must include the following to be considered a QMCSO:

1. The name and last known mailing address of the Participant;
2. The name and address of each Alternate Recipient;
3. A reasonable description of the type of coverage to be provided by the group health plan or the manner in which such coverage is to be determined;
4. The period for which coverage must be provided; and
5. Each Plan to which the order applies.

After determining whether the MCSO is or is not a QMCSO, the Claims Administrator shall notify all affected parties (including the Alternate Recipient) in writing. They will be given the opportunity to represent themselves or to designate a representative to receive all communications. The determination as to whether the QMCSO Participant is qualified or not, and whether coverage will be extended, will be provided in writing within 30 days of receipt of all requested documentation.

HealthComp, Inc. shall not disenroll or eliminate coverage on such child until:

1. Satisfactory written evidence is provided that the court order or administrative order is no longer effective;
2. Satisfactory written evidence is provided that comparable coverage through another Plan will take effect no later than the disenrollment date; or
3. HealthComp, Inc. eliminates family coverage for all Participants.

Changes made in order to provide benefits for any Dependent pursuant to a QMCSO as provided by ERISA 609 (a) (A) (I) shall be made any time, irrespective of the normal enrollment dates, as required by the Revenue Reconciliation Act of 1993.

If it is determined that the MCSO is a QMCSO, thereafter, the Alternate Recipient, for the appropriate period, shall be treated as a beneficiary under the Plan.

Benefits shall be provided in accordance with the applicable requirements of any QMCSO. However, the QMCSO shall not cause the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan.

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.

Refund - repayment to this Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Illness.

Residential Treatment Facility – a facility that meets all of the following:

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

Skilled Nursing Care - care furnished on a Physician's orders which require the skill of professional personnel such as a registered or licensed practical nurse and is provided either directly by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

1. Minimal custodial, ambulatory, or part-time care; or
2. Treatment for pulmonary tuberculosis.

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.

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

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

- Covered Person: You are unable to perform the substantial duties of any occupation or business for which you are qualified and are not in fact engaged in any occupation for wage or profit; or
- Dependent: you are substantially unable to engage in the normal activities of an individual of the same age and sex.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

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

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

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

GENERAL PLAN INFORMATION

ERISA REQUIREMENT

Plan Name: HealthComp, Inc. d/b/a/ The Center for Health Affairs
Non-Grandfathered Employee Benefit Plan

Plan Sponsor: HealthComp, Inc. d/b/a The Center for Health Affairs
1226 Huron Road East
Cleveland, OH 44115

Employer Tax I.D. No.: 341607331

Claims Administrator: Mutual Health Services
P. O. Box 5700
Cleveland, Ohio 44101
(330) 666-0337
1-800-367-3762

Plan Number: 501

Type of Plan: Self-Funded Employee Benefit Plan - a Group Health Plan

Plan Year Ends: June 30th

Statutory Agent for
Service of Legal Process: The Plan Sponsor named above