WOOD COUNTY

EMPLOYEE HEALTH BENEFITS PLAN

PLAN DOCUMENT

Effective January 1, 2026

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ESTABLISHMENT OF THE PLAN

The Wood County Board of County Commissioners ("Plan Sponsor") has adopted this Plan Document for the Wood County Employee Health Benefits Plan (hereinafter referred to as the "Plan"), as set forth herein for the exclusive benefit of you and your eligible Dependents.

The use of the words, "you" and "your" throughout this Plan applies to eligible or covered employees and, where appropriate, their covered dependents.

Grandfathered Plan Status

The Wood County Board of County Commissioners believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act (ACA), a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted on March 23, 2010. Being a grandfathered health plan means your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans; for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime dollar limits on Essential Health Benefits. The ACA only applies to health and prescription coverage.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status, can be directed to the Plan at, One Courthouse Square, Bowling Green, OH 43402 or at (419) 354-9100. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Purpose of the Plan

The Plan Sponsor has established the Plan for your benefit and for the benefit of your eligible Dependents, on the terms and conditions described herein. The Plan Sponsor's purpose in establishing the Plan is to help to protect you and your family by offsetting some of the financial problems that may arise from an Injury or Illness. To accomplish this purpose, the Plan Sponsor must attempt to control health care costs through effective plan design and Plan Administrators must abide by the terms of the Plan Document and Summary Plan Description, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to manage their healthcare costs. To accomplish this, you may be required to provide supporting documentation as requested by the Plan.

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

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain health care expenses. This Plan Document is maintained by the Plan Sponsor and may be inspected at any time during normal working hours by you or your eligible Dependents.

Adoption of this Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan represents the Plan Document. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

The Plan Sponsor has caused this Plan Document to be executed as of January 1, 2026, as authorized on December 2, 2025 in Resolution 25-01455.

PLAN ADMINISTRATION

Delegation of Responsibility

The Plan Sponsor is a named fiduciary of the Plan with full discretionary authority for the control and management of the operation and administration of this self-insured Plan. The Plan Sponsor may delegate fiduciary and other responsibilities to any individual or entity. Any person to whom any responsibility is delegated may serve in more than one fiduciary capacity with respect to the Plan and may be a participant in the Plan.

Authority to Make Decisions

The Plan Sponsor has assigned administration of the Plan to various Plan Administrators. The Plan Sponsor has retained the services of Third-Party Administrators to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the Plan Sponsor to be a Plan Administrator and serve at the convenience of the Plan Sponsor. If a Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

Plan Administrators will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to you and/or your Dependent's rights and to decide questions of Plan interpretation and those of fact and law relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that you and/or your Dependent (as applicable) are entitled to them.

The duties of a Plan Administrator include the following:

1) To administer the Plan in accordance with its terms;

2) To determine all questions of eligibility, status, and coverage under the Plan;

3) To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;

4) To make factual findings;

5) To decide disputes which may arise relative to a Covered Person's rights;

6) To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials; or, alternatively, to appoint a qualified administrator to carry out these functions on the Plan Administrator's behalf;

7) To keep and maintain the Plan documents and all other records pertaining to the Plan;

8) To appoint and supervise Third Party Administrators to pay claims;

9) To perform all necessary reporting as required by federal or state law;

10) To establish and communicate procedures to determine whether a child support order or decree is a QMCSO;

11) To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate; and

12) To perform each and every function necessary for or related to the Plan's administration.

Amendment or Termination of Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend, or terminate the Plan in whole or in part.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of Covered Person*s* are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY

The Insurance Group Representative for your hiring department reports your information to the Plan by submitting ACA Compliance Reports at the time of your hire or change in hours/status. Following receipt of these reports, the Plan communicates benefit eligibility to you through your Insurance Group Representative. The Plan may require proof of eligibility for purposes of enrollment and on-going eligibility.

Employee Eligibility

Eligibility is based on your Hours of Service as required by the Affordable Care Act and its shared responsibility provision. Hours of Service include hours for which you are paid for the performance of duties or entitled to payment for paid leave such as vacation, holiday, sick leave, etc.

For purposes of the Plan, a benefit eligible (full-time) Employee is:

- One who regularly works 30 or more Hours of Service per week (i.e., 130 hours per month); or
- A part-time, seasonal, or variable hour Employee who upon completion of a look back period accrues 1,560 Hours of Service.

The Plan utilizes two Measurement Methods to determine benefit eligibility under the ACA: Monthly and Look-Back.

Monthly Method

The Monthly Method is used to count Hours of Service for new full-time or non-Seasonal Employees who are enrolled in the Plan and have not completed a full Standard Measurement Period under the Look Back Method.

- Requires an average of 30 Hours of Service per week (i.e.,130 hours per month) or more per calendar month until the Standard Stability Period can be applied.
- Eligibility may change month to month – If not eligible for a month, coverage will terminate retroactive to the last day of the prior month.

Failure to maintain the eligibility requirement during a month will result in your ineligibility for benefits and retroactive termination of benefits for that month if enrolled. Following loss of eligibility, enrollment is reinstated the first day of the month in which you meet the eligibility requirements. Employees transition to the Look-Back Method after completion of a full Standard Measurement Period which may take up to 24 months.

Look-Back Method

The Look Back Method is used to count Hours of Service for new hires who are part-time, seasonal, or variable hour, as well as on-going Employees. Employees with 1,560 Hours of Service during the Measurement Period are considered benefit-eligible during the Stability Period.

- Initial Look-Back Method: used for new hires who are part-time, seasonal or variable hour who are not benefit eligible at hire.
- Standard Look-Back Method: applies to all Employees on an annual basis provided they are employed for the full Standard Measurement Period.

Both methods are divided into three parts as defined below:

A Measurement Period counts Hours of Service.

- Initial: First full 26 consecutive pay periods after date of hire
- Standard: 26 consecutive pay periods predetermined by the Plan (mid-October to mid-October of following year as communicated in the Summary Plan Description)

Administrative Period: determine and communicate eligibility. Benefit eligible Employees must elect or waive coverage during this period.

- Initial: up to 30 days plus the remainder of the month following the completion of the Initial Measurement Period.
- Standard: up to 90 days following Standard Measurement Period (mid-October to December 31).

A Stability Period in which an Employee is considered benefit eligible or not benefit eligible.

- Initial: First day of the month following the Initial Administrative Period through the next 12 months. The beginning date of the Initial Stability Period cannot exceed 13 months from the date of hire (for those employees not hired on the first day of the month) plus the number of days to the end of the month.
- Standard: January 1 to December 31 following the Standard Measurement Period.

To maintain coverage, you must remain an active Employee with Hours of Service during the month of coverage or be eligible for FMLA or other protected leave.

You are not eligible to participate in the Plan if you are a part-time, intermittent, leased, or Seasonal Employee (unless otherwise determined during the look-back method); or serve as an independent contractor or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law employee by a court or governmental agency).

Special rules apply to Employees who are rehired, return from an unpaid leave, or change employment status. See the Reinstatement in the Plan section.

Dependent Eligibility

A benefit-eligible Employee's Dependents may be eligible for participation in this Plan as noted below.

The Plan utilizes a certification process to determine initial and ongoing Dependent eligibility and at any time may require documentation (in a form acceptable to the Plan) to establish an individual's status as an eligible Dependent. Failure to comply with the certification process and/or process deadlines will result in loss of eligibility for your Dependent(s).

Dependent eligibility continues provided eligibility rules are met. The Plan reserves the right to recover payments made during a period of time in which your Dependent failed to meet the requirements of an eligible Dependent.

Spouse

"Spouse" means any person who is lawfully married to you under any state law, who is neither divorced or legally separated. Specifically excluded from this definition is a spouse by reason of common law marriage, whether or not permitted in your state.

Based on your spouse's annual adjusted gross income, as determined through the certification process, your spouse may qualify for primary coverage with or without a spousal premium. If your spouse's annual adjusted gross income exceeds the amount setby the Plan, primary coverage is not available. To maintain consistent application of the eligibility rules, spousal eligibility is determined based on the adjusted gross income as it appears on their federal tax form, regardless of the source of income. See the Summary Plan Description (SPD) for the current income thresholds and spousal premium rates.

Spousal eligibility for secondary coverage requires submission of valid primary insurance information.

Child

Medical and Prescription: Your biological, adopted (includes placed for adoption), or stepchild is eligible for coverage on your family coverage from birth to the end of the month in which he/she attains age 26.

Vision and Dental: Your Child is eligible for coverage from birth until the end of the Calendar Year in which he/she reaches the limiting age of 19 or until the end of the Calendar Year in which he/she reaches the limiting age of 23 if he/she is a full-time Student at an accredited school.

A full-time Student is a Child who is attending an accredited college, university, or other educational institution for the number of credit hours required to be considered full-time by the institution. Full-time Student coverage continues between semesters/quarters only if your Child is enrolled as a full-time Student in the next regular semester/quarter, unless such student applies for and is approved a Medically Necessary Leave of Absence from the school under Michelle's Law. A Dependent Child must submit a written request to the Plan in order to continue vision and/or dental coverage under the Plan due to a Medically Necessary Leave of Absence from a postsecondary educational institution (including an institution of higher education as defined in Section 102 of the Higher Education Act of 1965). Such request must include a certification from the Dependent Child's treating physician indicating that the Child is suffering from Illness or Injury and that the Leave of Absence or change in enrollment status is Medically Necessary.

Child shall include natural, a legally adopted Child, or a Child placed with you in anticipation of adoption who is:

1) Unmarried; and

2) Not employed on a regular full-time basis; and

3) Not covered under the Plan as an Employee; and

4) Dependent on you or your Spouse for more than 50% of his/her financial support; and

5) Your Dependent for tax exemption purposes under Section 152 of the Internal Revenue Code.

6) The phrase "Child placed with you in anticipation of adoption" refers to a Child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term placed means the assumption and retention by such Employee of a legal obligation for total or partial support of the Child in anticipation of adoption of the Child. The Child must be available for adoption and the legal process must have commenced.

Stepchild or Child under you or your spouse's Legal Guardianship who meets all of the requirements listed above and:

1) Lives in your home for more than half of each Calendar Year in a regular parent-child relationship. (A regular parent-child relationship does not exist if the Child's parent, other than your Spouse, also resides within the household.); and

2) Is wholly dependent on you for financial support.

Qualified Medical Child Support Order

Any Child for whom the covered Employee is required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO), including any appropriately completed National Medical Support Notice (NMSN), shall be considered as having a right to Dependent coverage under this Plan. Procedures for determining a QMCSO may be obtained from the Plan at no cost.

<u>Limiting Age Exception</u>

For any Child who meets all of the necessary requirements listed above except that they have reached the limiting age for Dependent children, you must provide satisfactory written proof of your totally disabled Child and their dependency. You must provide this documentation to the Plan within 60 days after you first request enrollment of your Dependent or within 60 days following the Dependent's attainment of the limiting age, whichever is later.

Continued eligibility for coverage is subject to your Dependent Child becoming unable to support himself or herself financially because of a totally disabling mental or physical handicap prior to the date he or she reached the limiting age. The Plan may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the Child's disability and dependency. After such two-year period, the Plan may

require subsequent proof not more than once each year. The Plan reserves the right to have such Dependent examined by a Physician of the Plan's choice, at the Plan's expense, to determine the existence of such disability.

The following are excluded as Dependents:

1) Other individuals living in your home, but who are not eligible as defined;

2) Your legally separated or divorced former Spouse (even when a court order has been issued requiring you to provide health insurance for the divorced Spouse);

3) Any person who is on active duty in any military service of any country; or

4) Any person who is covered under the Plan as an Employee.

FUNDING

Your Employer shares the cost of coverage under this Plan with covered Employees as communicated in the Summary Plan Description. The level of your required contribution is set by the Plan Sponsor and the Plan Sponsor reserves the right to change the level of required contributions. Funding changes are applied on the first of the month following a mid-month change.

Monthly premiums are collected through payroll deduction and may be deducted on a pre-tax basis after authorization by the employee. See the Section 125 Plan in Appendix A for more information about pre-tax contributions. (Northwestern Water and Sewer District employees may contact their employer for pre-tax contribution information.)

During a month in which you are enrolled in coverage and your wages are insufficient to collect your portion of the premium for one or both scheduled payroll deductions, the payroll deduction will stop and you will be required to self-pay your portion of the premium to continue coverage. Payment is due by the last day of the month prior to the month of coverage. Checks should be made payable to the Wood County Treasurer and submitted to your insurance group representative.

If you fail to pay the premium timely, you are not permitted to re-enroll in the Plan for the remainder of the Stability Period unless a Special Enrollment or Status Change Event occurs. In addition, upon re-enrollment you must pay all premiums retroactive to the date of termination.

ENROLLMENT IN THE PLAN

Enrollment, any changes to enrollment, or waiver of coverage requires the submission of a completed, signed, written application (or electronic, if applicable) and any required forms within the applicable enrollment period.

You may elect the type (medical/prescription, vision, and/or dental) and level (individual/single or family) of coverage for each type of coverage. When you elect medical benefits, you are automatically enrolled in the prescription benefit. Life insurance is only offered to benefit eligible Employees and is mandatory.

Once you are eligible to participate in the Plan, you must enroll for coverage by completing all enrollment forms and submit them to the Plan within 31 days after satisfaction of the eligibility requirements. You will be required to provide your social security number, as well as the social security numbers of your Dependents. Divorced parents must provide a copy of the divorce decree and any documentation as required by the Plan to determine payment of benefits. Failure to provide any required information needed to determine eligibility and payment of benefits may result in loss of eligibility or loss of continued eligibility under the Plan.

If you waive enrollment for you and/or your Dependents, you must provide application/written statement to the Plan indicating that the reason you are declining enrollment is due to other health coverage. If such application is not provided, the Plan will not acknowledge enrollment in other coverage at time of waiver and will limit future enrollment to the Open Enrollment Period.

If you lose such other health coverage, it may constitute a Special Enrollment Event (described below) that gives you and/or your Dependents a right to enroll in the Plan mid-year due to such loss of coverage.

Only the benefit eligible Employee may make application or make changes to enrollment (e.g., add or remove coverage/Dependents) under the Plan.

Generally, your enrollment will remain in effect for the entire Benefit Period unless you experience a Special Enrollment Event or a Status Change Event (as permitted by the Plan's Section 125 Plan). If a Status Change Event occurs, you may make a new election under the Plan provided your new election is consistent with the Status Change Event. (To gain coverage **under this Plan**, you must experience a loss of coverage; likewise to drop coverage, you must gain coverage elsewhere. Note: you cannot gain coverage elsewhere and gain coverage under this Plan at the same time.)

No person may be covered under this Plan as both an Employee and a Dependent, or as a Dependent of more than one Employee.

1) You must elect family coverage in order to enroll a Dependent in coverage. When both you and your Spouse/eligible Dependent are covered Employees, you must enroll in one family contract or two single contracts.

2) If both parents are Employees, your children will be covered as Dependents of one of the parents, but not of both.

3) If two Employees are covered under the Plan on a family contract and one of the Employees loses eligibility, the contract may be continued by the other eligible Employee as long as coverage has been continuous and the remaining Employee makes timely application for coverage within thirty-one (31) days from the loss of coverage. All other eligibility rules apply, including the certification process.

4) If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the Status Change Event, credit will be given for all amounts applied to maximums.

Timely Enrollment/Enrollment Period

To be considered timely, you must elect or waive coverage by submitting a written application (or electronic, if applicable) and any required forms to the Plan within the enrollment period, no later than thirty-one (31) days following determination of eligibility. Other requirements may apply as defined in the Summary Plan Description.

Within thirty-one (31) days of becoming eligible for coverage and within thirty-one (31) days of marriage or the acquiring of children or birth of a Child, you may make application to enroll your eligible Dependents provided any applicable certification process is completed during the enrollment period.

1. A newborn Child of a covered Employee is not automatically enrolled in the Plan. Written application to the Plan is required within the enrollment period.

2. Your enrollment under a Special Enrollment Event will be timely if the completed application is received by the Plan no later than thirty-one (31) days after you or your Dependent become eligible for coverage.

Special Enrollment

Special Enrollment is a time outside the Open Enrollment period that allows you to enroll in or terminate coverage under the Plan. You qualify for Special Enrollment due to certain life events. In these circumstances, you and/or your eligible Dependents will be considered Special Enrollees and must submit the appropriate election and enrollment forms to the Plan within 31 days after the date of the event or as otherwise listed.

<u>Acquisition of a New Dependent</u>

If you acquire a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll for coverage under this Plan for yourself and your new Dependent, if otherwise eligible (tag-a-long rule is not applicable under this Plan).

<u>Loss of Other Coverage (other than under Medicaid or SCHIP)</u>

If you declined enrollment for yourself or your Dependents (including your Spouse) because you or your Dependents had other health coverage (including coverage under a group health plan sponsored by a governmental or educational institution, a medical care program of the Indian Health Service or of a tribal organization), you may enroll for coverage

for yourself and/or your Dependents under this Plan if the other health coverage is lost as a result of one of the following:

1) Loss of eligibility under the other health coverage (including as a result of legal separation, divorce, death, or termination of employment or reduction in the number of hours of employment) for reasons other than non-payment of the required contribution or premium, making a fraudulent claim or intentional misrepresentation of a material fact in connection with the other plan; or

2) The other health coverage was under COBRA and the maximum continuation period available under COBRA has been exhausted; or

3) Employer contributions cease for the other health coverage.

Loss of Coverage under Medicaid or SCHIP or Eligibility for a State Premium Assistance Subsidy

If you or your Dependents did not enroll in the Plan when initially eligible because you and/or your Dependents were covered under Medicaid or a state sponsored Children's Health Insurance Program (SCHIP) and your coverage terminates because you or your Dependents are no longer eligible for Medicaid or SCHIP or you or your Dependents become eligible for a state premium assistance subsidy under Medicaid or SCHIP, you may enroll for coverage under this Plan for yourself and your Dependents after Medicaid or SCHIP coverage terminates or after you or your Dependents' eligibility for a state assistance subsidy under Medicaid or SCHIP is determined.

You must submit the appropriate election and enrollment forms to the Plan within 60 days after coverage under Medicaid or SCHIP terminates or within 60 days after eligibility for a state premium assistance subsidy under Medicaid or SCHIP is determined. Coverage under the Plan will become effective on the first day of the month following the date you submit the appropriate election and enrollment forms to the Plan.

Qualified Medical Child Support Order

The Plan shall enroll for immediate coverage under this Plan any Child of an eligible Employee who is the subject of a "Qualified Medical Child Support Order" ("QMCSO"). If you are ordered to provide such coverage for a Child and you are eligible but not enrolled in the Plan at the time the Plan receives a QMCSO, the Plan shall also enroll you for immediate family coverage under this Plan. Any required contribution for coverage pursuant to this section will be deducted from your pay in accordance with the Employer's payroll schedule and policies.

Status Change Event

Changes in your or a covered Dependent's employment status that results in a gain or loss of eligibility for benefits, including but not limited to:

Change or increase in hours, a strike or lock-out, a change from full-time to part-time or vice versa.

Divorce, legal separation, or annulment.

Death of a Spouse.

For a complete list of change in status events, refer to the Irrevocability of Elections under Section 125 Plan located in Appendix A.

Late Enrollment

An enrollment is late if it is not made on a timely basis, either initially, under a Special Enrollment Event, or Status Change Event. Late Enrollees and their Dependents who are not eligible to join the Plan under a Special Enrollment Event or due to a Status Change Event may only apply for coverage during the Open Enrollment period.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period. A Late Enrollee's Effective Date will be determined by the Plan and such determination will be applied uniformly to all similarly situated Late Enrollees, i.e., January 1.

If you or your eligible dependent loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due

to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

Open Enrollment Period

You and your Dependents may enroll for coverage during the Plan's Open Enrollment period, designated by the Plan Sponsor and communicated to you prior to such Open Enrollment period. During this time, you will be permitted to make changes to any existing benefit elections. Benefit elections made during the Open Enrollment period will remain in effect until you or your Dependent experiences a Special Enrollment Event, Status Change Event, or request a change during a future Open Enrollment period.

Certificate of Creditable Coverage

A Certificate of Creditable Coverage identifying a Covered Person's enrollment in the Plan may be provided upon request to the Plan at any time while the individual is covered under the Plan and up to 24 months after the individual loses coverage under the Plan.

However, the Plan will not issue a Certificate of Creditable Coverage with a coverage end date for any person until the Plan has reason to know that coverage was lost under the Plan.

EFFECTIVE DATES

Provided you have enrolled for coverage and the required contributions are made, you and your eligible Dependents are covered under the Plan on the first day of the month following completion of 30 days of full-time (benefit eligible) employment or coinciding with a Status Change Event as noted below.

Special Enrollment/Late Enrollee

Under special enrollment, you and your eligible Dependents will be enrolled as follows, provided you enrolled them in the Plan within thirty-one (31) days of the Special Enrollment or Status Change Event:

1) In the case of marriage, the date of such marriage.

2) In the case of a Dependent's birth, the date of such birth.

3) In the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

4) In the case of Legal Guardianship, the date on which such Child is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as Legal Guardian for the Child.

5) Coverage under a QMCSO/NMSN will be effective as of the date specified in the order, the first day of the next month after the Plan receives such order, or as determined by the Child Support Enforcement Agency.

6) As the result of a loss of coverage, the first day of the month following the loss of coverage.

7) Other changes will be effective the date of the Status Change Event or first day of the month following the event as determined by the Plan and applied uniformly to all similarly situated circumstances.

Open Enrollment

Under open enrollment, any changes to coverage and enrollment will be effective on January 1 of the next Calendar Year.

TERMINATION OF COVERAGE

Your coverage typically ends when you separate employment (are no longer actively at work); but it can also happen in situations in which you or your covered Dependent(s) lose eligibility under the Plan or gain access to other coverage.

The Open Enrollment Period provides an opportunity to drop coverage without a Special Enrollment right or Status Change Event.

Like enrollment, termination from the Plan requires you to submit a completed, signed, written application (or electronic, if applicable). Only the benefit eligible Employee may terminate coverage (e.g., remove coverage/Dependents) under the Plan. This does not alter the Plan's right to terminate coverage for plan members when an Employee does not submit the signed, written application, make required contributions by applicable due dates, or are no longer eligible.

Except in certain circumstances, you and your covered Dependents may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the subsection entitled COBRA.

The Plan has the right to void the coverage of any Covered Person who engages in fraudulent conduct including but not limited to claims, application for coverage, use of an identification card under this coverage, or any other fraudulent act as determined by the Plan.

Effective Dates for Termination of Coverage

Coverage under the Plan will terminate at midnight on the earliest of the following dates:

1) The date in which you cease to meet the eligibility requirements of the Plan:

    a. If you are in a Stability Period, the last day of the calendar month (separation of employment/status change), as defined by the Employer's personnel policies, provided you had Hours of Service for that calendar month.

    b. If you are measured monthly or are in a Stability Period and have no Hours of Service for the calendar month, failure to maintain the eligibility requirement will result in retroactive termination of benefits to the last day of the calendar month in which eligibility was met.

    c. The date of your death.

2) The date a covered Dependent loses eligibility status under the Plan:

    a. The last day of the calendar month that a Dependent Child ceases to be a Dependent as defined by the Plan;

        i. If a student over age 19 does not continue enrollment as a full-time student vision and/or dental coverage will terminate retroactively to the last day of the calendar month in which the last attended school term ended, unless under a Medically Necessary Leave of Absence that has been approved by the Plan.

    b. The date of divorce, legal separation, annulment, or death.

    c. The date the employee's coverage under the Plan terminates for any reason, including death.

    d. The date the Plan discontinues dependent coverage for any and all Dependents.

3) The last day of the calendar month following notification to the Plan of the gain of other coverage, provided termination is requested within 30 days of the gain of other coverage.

4) The last day of the calendar month for which your required contributions have been paid, if the payment for the next calendar month is not paid when due.

5) The date the Covered Person becomes a full-time, active-duty member of the armed forces of any country.

6) The date the Plan Sponsor terminates the Plan and offers no other group health plan.

Termination of Benefits While Inpatient

If a Covered Person is an Inpatient of a Hospital or Skilled Nursing Facility on the day coverage stops, the benefits listed under the Eligible Medical Expenses, subsection Facility Services, subject to any changes in the Plan's benefits, will continue until the earliest of:

1) The Plan pays the maximum benefits; or

2) Discharge from the Hospital or Skilled Nursing Facility; or

3) The end of the period for which payment was made; or

4) Another group health coverage is in effect for the condition that requires the Inpatient Hospital or Skilled Nursing Facility care; or

5) The death of your death.

This provision applies only to the Covered Services specifically listed. No other services will be provided once coverage stops.

REINSTATEMENT IN THE PLAN

If you lost eligibility due to a change in status; an approved Leave of Absence without pay including FMLA or USERRA; or layoff from the Employer, you may be eligible for reinstatement of coverage as provided in this section. Reinstatement is limited to you and your Dependents who were previously covered under the Plan unless a Special Enrollment or Status Change Event occurs.

Employees in a Stability Period who lose coverage due to a failure to pay the premium are not permitted to re-enroll in the Plan for the remainder of the Stability Period unless a Special Enrollment or Status Change Event occurs, and premiums retroactive to the date of termination of coverage are paid upon re-enrollment.

You are not subject to the thirty (30) day waiting period if you are recalled from a layoff or regain eligibility prior to the end of your maximum COBRA continuation coverage period. However, if you or your Dependents were not covered under the Plan on the date of your loss of eligibility, you will be treated as a new Employee and will be required to satisfy the waiting period.

To reinstate coverage, you must submit the completed application for enrollment to the Plan within thirty-one (31) days with coverage effective the first day of the following month, with the exception of USERRA which is the first day back from leave.

If you return to work more than thirteen (13) weeks following your loss of eligibility, you will be considered a new Employee and will be subject to all eligibility requirements.

Prior benefits and limitations, such as Deductibles, Coinsurance, Essential Health Benefits/non-Essential Health Benefits maximum benefits shall be applied if within the same Benefit Period. If benefits are reduced for others in the eligible class, they will be reduced for those reinstated.

Continuation of Plan Coverage due to a Leave of Absence

Your Employer will continue coverage for you and your eligible Dependents during an approved Leave of Absence when utilizing available paid leave (e.g., sick leave, vacation, comp time). Coverage under this provision will continue in accordance with the same terms and conditions of an active Employee.

If you exhaust all available paid leave, you will be eligible for COBRA benefits. Please refer to the COBRA Continuation Coverage section of the Plan.

Family Medical Leave Act

The Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA), as amended, and as promulgated in regulations issued by the Department of Labor.

If your leave qualifies under FMLA, any continuation of coverage provided under this provision will run concurrent with FMLA.

1) During any leave taken under FMLA, you may maintain coverage under the Plan on the same conditions as coverage would have been provided if you had been continuously employed during the leave period.

a. The Employer will collect your portion of the monthly premiums through payroll deduction, provided sufficient wages are received for the first and second pay of the month of requested coverage.

i. During a month in which you are enrolled in coverage and your wages are insufficient to collect your portion of the premium for one or both scheduled payroll deductions, the payroll deduction will stop and you will be required to self-pay your portion of the premium to continue coverage. Payment is due by the last day of the month prior to the month of coverage. Checks should be made payable to the Wood County Treasurer and submitted to your insurance group representative.

ii. If your payment is not received, your Employer must give a 15-day notice before terminating coverage due to non-payment of premium.

iii. Failure to make required payments within 30 days of the due date established by your Employer will result in the retroactive termination of coverage for you and/or your eligible Dependents to the first day of the month in which payment was not received. All claims paid on a retroactively terminated policy will become your responsibility.

iv. If your benefits are terminated for this reason, you will no longer be eligible to re-enter the Plan during the leave.

2) If your coverage under the Plan terminated during the FMLA leave, coverage will be reinstated for you and your Covered Dependents the first day of the month following return to work.

a. Coverage will be reinstated only if the individual had coverage under this Plan when FMLA started, and will be reinstated to the same extent that it was in force when coverage terminated. While continued, coverage will be that which was in force on your last day worked. However, if benefits reduce for others in the eligible class, they will also be reduced for you upon your return to work.

3) If you fail to return to work after an unpaid FMLA leave, you must pay the Employer's share of premiums paid on your behalf. Limited exceptions are permitted as defined in the Family Medical Leave Act.

a. An employee who returns to work for at least 30 calendar days is considered to have returned to work for purposes of FMLA.

b. Benefits will cease as outlined in the Termination of Coverage section.

To the extent this Plan is required to comply with a state family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such state family and medical leave law, as well as under FMLA.

<u>Uniformed Services Employment and Reemployment Rights Act (USERRA)</u>

If your military leave is 30 consecutive days or less, your health benefits will continue subject to normal payroll deduction rates. You may be required to self-pay your premium if you do not have sufficient wages to cover your premium for the first and second pay of the month.

If you are absent from work for more than 30 consecutive days due to military service in the Uniformed Services you may elect to continue Plan coverage for yourself and any of your Dependents who were covered under the Plan at the time of your leave by self-paying the entire monthly premium plus 2% (COBRA rate).

To elect coverage, you must submit your election to continue coverage to the Plan within 60 days after the date of your leave. Your eligible Dependents do not have an independent right to elect coverage under USERRA; therefore, unless you elect to continue coverage on their behalf, your eligible Dependents will not be permitted to continue coverage under USERRA separately.

Coverage under the Plan will become effective as of the date of your leave and will continue for the lesser of:

1. 24 months (beginning on the date your absence begins); or

2. The period of time beginning on the date your absence begins and ending on the day after the date you return to employment with the Employer or fail to apply for or return to employment with the Employer within the time limit applicable under USERRA.

Continuation coverage provided under USERRA counts towards the maximum coverage period under COBRA continuation coverage.

If you participated in the Plan immediately before going on USERRA leave you have the right to resume coverage under the Plan on the date you return from USERRA leave, as long as you resume employment within the time limit that applies under USERRA.

- Active duty service of 30 days or less, immediately upon release from active duty.
- Active duty service of 31-180 days, within 14 days upon release from active duty.
- Active duty service in excess of 180 days, within 90 days upon release from active duty.

No waiting period will apply unless the waiting period would have applied to you if you had remained continuously employed during the period of military leave.

Retroactive Termination of Coverage

Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage or maintain eligibility for the Plan, the Plan will not retroactively terminate coverage unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) performs an act, practice or omission that constitutes fraud with respect to the Plan or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least 30 days advance written notice to you or your covered Dependent who is affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where your required contributions have not been paid by the applicable deadline or eligibility is not met. In those cases, no advance written notice is required.

GENERAL PROVISIONS OF THE PLAN

Choice of Providers

You have a free choice of any provider and you, together with your provider, are ultimately responsible for determining the appropriate course of treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

The Plan Sponsor has entered into agreements that provide access to one or more networks of Participating Providers (In-Network). Participating Providers are independent contractors; neither the Plan nor the Plan Sponsor makes any warranty as to the quality of care that may be rendered by any Participating Provider.

Using a Participating Provider will normally result in a lower cost to you as well as a lower cost for the Plan. However, penalties may apply to those services received from a Non-Participating Provider (Out-of-Network).

If you elect to receive care from Participating Providers, the Plan provides an increased level of benefits for most services as outlined in the Schedule of Benefits. In addition, since Participating Providers have agreed to accept the negotiated fee as full payment for their services, you are not responsible for any billed amount that exceeds the negotiated fee (balanced billing). These Providers have also agreed to bill the Plan directly, so the Covered Person does not have to submit claims on his own behalf.

Covered services rendered by a Non-Participating Provider will be paid at the Participating Provider level and balanced billing is prohibited when a:

1) Covered Person has an Emergency Medical Condition requiring immediate care.*

2) Covered Person receives anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services by a Non-Participating Provider who is under agreement with a network facility.*

3) Except as provided in 1) and 2) above, covered services rendered by a Non-Participating Provider will be paid at the Participating Provider level (with no balance billing protection under the Plan) when:

   a. The type of provider needed is not represented in the Participating Provider listing, the Participating Provider level of benefits is payable when the Medical Manager preapproves the use of a Non-Participating Provider of that type.

   b. There is no availability within the Participating Provider network, Covered Services will be payable at the Participating Provider level of benefits as determined by the Plan. The primary network must not have the provider or provider's specialty within a 35-mile radius of the Covered Person's home address and zip code.

   ***NOTE:** In the case of a Surprise Bill for covered services from a Non-Participating Provider who is under agreement with a network facility when a Covered Person seeks Emergency Services for an Emergency Medical Condition from a Non-Participating Provider, the cost share will be based on the median contract rate. See the Protection from Surprise Bills Section for more information.

Available networks are identified in the Summary Plan Description and/or the identification card. Links to current networks are also available on the employee website. If you do not have access to a computer, you may contact the Plan or the network at the phone number on your identification card.

You may have to find a new provider when:

1) The Plan's network changes and the provider you have now is not in the new network; or

2) You are already enrolled in the Plan and your provider stops participating in the Plan's network.

However, in some cases, you may be able to keep going to your current provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care and may continue for up to 90 days, until you no longer meet the criteria below, whichever occurs first. In order to be eligible, you must (a) have been under a treatment plan by a Participating Provider or Participating facility before the Plan's network changed or the provider

stopped participating in the Plan's network, (b) continue to be treated by that same provider or facility, and (c) you must be one of the following:

1) Undergoing a course of treatment for a serious and complex condition from the Participating Provider or Facility that is either:

   a) An acute Illness, meaning a condition serious enough to require specialized medical care to avoid the reasonable possibility of death or permanent harm.

   b) A chronic Illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time.

2) Undergoing inpatient or institutional care from the Participating Provider or facility.

3) Scheduled for non-elective surgical care with, including necessary postoperative care received by, the Participating Provider or facility.

4) Pregnant and undergoing a course of treatment from the Participating Provider or facility.

5) Terminally ill and receiving treatment for such Illness from the Participating Provider or facility.

Contact the phone number on the back of your identification card to obtain further information on how to submit a request for continuity of care. If your request is approved to keep going to your current provider, you will be informed how long you can continue to see the provider. Reimbursement for approved continuity of care will be at the applicable Participating Provider benefit level subject to the negotiated fee schedule.

Predetermination of Benefits

If you are unsure if a service will be covered under the Plan, you may request Predetermination of Benefits through the third-party administrator's customer service. It is recommended that a predetermination of benefits be completed prior to services being rendered as medical necessity would be required in order to have services covered. Predetermination is outside of any Pre-Certification requirements.

You should advise your provider to call for predetermination by contacting the customer service number on the medical id card. The provider will need to submit additional information to support the services.

The turnaround time for predeterminations is 15 to 30 business days. If the third-party administrator does not receive all of the medical documentation needed, and additional information is required, the review is closed. Following review of all new documents submitted, the timeframe is extended by another 15 to 30 days.

Costs

You must pay for a certain portion of the cost of eligible expenses under the Plan for each type of benefit (e.g., medical, prescription, vision, dental), including (as applicable) any Copay, Deductible and Coinsurance percentage that is not paid by the Plan.

Generally, each Covered Person must pay Deductibles and Coinsurance before the Plan begins to pay for covered services within the benefit period. Any number of covered family members may help satisfy the family (embedded) Deductible and Coinsurance, but no family member will incur more than the individual Deductible and/or Coinsurance amount.

Copay/Copayment

A copay/copayment is the portion of the expense that is your responsibility, as shown in the Schedule of Benefits. A Copay is applied for each occurrence of such covered service and is not applied toward satisfaction of the Deductible or Coinsurance.

Deductible

A Deductible is the total amount of eligible expenses as shown in the Schedule of Benefits, which must be Incurred by the Covered Person during any Benefit Period before eligible expenses are payable under the Plan.

Coinsurance

Coinsurance is the percentage of eligible expenses the Plan and the Covered Person are required to pay per Benefit Period. There may be differences in the Coinsurance percentage payable by the Plan depending upon whether you are using a Participating Provider or a Non-Participating Provider. These payment levels are also shown in the Schedule of Benefits.

Out-of-Pocket Maximum (Deductible plus Coinsurance)

An Out-of-Pocket Maximum (OOPM) is the maximum amount you and/or all of your family members will pay during a Benefit Period before the Plan covers 100% of the Allowed Amount of eligible expenses. Please note, however, that not all Covered Expenses are eligible to accumulate toward your Out-of-Pocket Maximum including:

1) Copays, including Prescription Drug Copays.

2) Precertification penalties.

3) Charges over the negotiated fee if utilizing a Non-Participating Provider.

4) Charges not covered under the Plan.

The single Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person reaches his or her Out-of-Pocket Maximum, the Plan will pay 100% of the Allowed Amount of eligible expenses for that individual during the remainder of that Benefit Period.

The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. The family Out-of-Pocket Maximum, if applicable, is the maximum amount that must be satisfied by covered family members during a Benefit Period. The entire family Out-of-Pocket Maximum must be satisfied; however, each individual in a family is not required to contribute more than the single Out-of-Pocket amount to the family Out-of-Pocket Maximum before the Plan will pay 100% of the Allowed Amount of eligible expenses during the remainder of that Benefit Period.

Your Out-of-Pocket Maximum may be higher for Non-Participating Providers than for Participating Providers.

The Plan will not reimburse any expense that is not an eligible expense. In addition, you must pay any expenses that are in excess of the negotiated fee if utilizing a Non-Participating Provider and any penalties for failure to comply with requirements of the Medical Management Program section of the Plan (if applicable) or any other penalty that is otherwise stated in this Plan. This could result in you having to pay a significant portion of your claim. None of these amounts will accumulate toward your Out-of-Pocket Maximum.

If you have any questions about whether an expense is an eligible expense or whether it is eligible for accumulation toward your Out-of-Pocket Maximum, please contact the Plan Administrator for assistance.

Integration of Deductibles and Out-of-Pocket Maximums

The amounts applied to the Non-Participating Provider Deductible and Out-of-Pocket Maximums will be applied toward the Participating Provider Deductibles and Out-of-Pocket Maximums, however, the amounts applied to the Participating Provider Deductible and Out-of-Pocket Maximums will not be used to satisfy the Non-Participating Provider Deductibles and Out-of-Pocket Maximums.

All other maximum amounts (e.g., Benefit Period or Lifetime) are combined.

Upon notification to the Plan, Covered Persons who experience any of the following employment conditions outlined below shall be treated as continuous participants in the Plan for accumulator purposes:

1) A transfer or change of employment between County departments or covered agencies;

2) A break in employment with a participating department or agency and a subsequent rehire by the same department or agency.

3) An approved unpaid leave (monthly measurement employee, FMLA, etc.); or

4) Changes in Dependent status under the Plan (e.g., covered Dependent becomes an employee; or employee becomes a covered Dependent).

If coverage under the Plan resumes within the same Benefit Period, the Plan will consider coverage continuously in force for purposes of applying the Deductible, Coinsurance, Out-of-Pocket Maximum, and Plan maximum.

Essential Health Benefits

Essential Health Benefit apply to medical and prescription coverage and has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as may be further defined by the Secretary of the United States Department of Health and Human Services. Essential Health Benefits includes the following general categories and the items and services covered within such categories: ambulatory patient services; Emergency Services; hospitalization; pregnancy, maternity and newborn care; mental health and Substance Use Disorder services (including behavioral health treatment); Prescription Drugs; rehabilitative and habilitative (services and devices); laboratory service; preventive and wellness services and chronic disease management; and pediatric services (including oral and vision care).

The Plan considers the following items or services to be Non-Essential Health Benefits including but not limited to:

1) Bariatric Surgery
2) Hearing aids/Cochlear Implant
3) Nutritional Support/Enteral Formulas
4) Orthotics
5) Routine Colonoscopies
6) Wigs

MEDICAL SCHEDULE OF BENEFITS

Services will be considered eligible only if the expenses are Medically Necessary due to Illness or Injury and are not Experimental and/or Investigational unless otherwise specified. All Covered Services are subject to those listed under Medical Exclusions and Limitations. To ensure Medical Necessity and coverage under the Plan, a Predetermination of Benefits may be requested prior to services being rendered. Predetermination is outside of any Pre-Certification requirements.

Generally, each Covered Person must pay Deductibles and Coinsurance before the *Plan* begins to pay for covered services within the Benefit Period. Copays do not apply to meeting any Deductibles and/or Coinsurance. Any number of covered family members may help to satisfy the family (embedded) Deductible and Coinsurance, but no family member will be responsible for more than the individual Deductible amount.

Non-Participating Provider (Out-of-Network) Deductible and Coinsurance limits will be applied toward the Participating Provider (In-Network) Deductible and Coinsurance limits; however, the amounts applied to the Participating Provider Deductible and Coinsurance limits will not be applied to the Non-Participating Provider limits.

Benefit Period: Calendar Year (January 1 – December 31)

MEDICAL BENEFITS (PPO PLAN) **See description under Covered Services for additional information.** *** Precertification required**	**PARTICIPATING PROVIDERS (IN-NETWORK)**	**NON-PARTICIPATING PROVIDERS (OUT-OF-NETWORK)** (Subject to Usual and Customary Charges.)
ESSENTIAL HEALTH BENEFITS: LIFETIME MAXIMUM BENEFIT	Unlimited	
NON-ESSENTIAL HEALTH BENEFITS: MAXIMUM BENEFIT per benefit period	Unlimited unless Benefit Maximum specified below	
COPAY Applies to the Physician office visit and services performed in an office setting/ER facility if charged. Not applied to Deductible or Coinsurance.	$15 Professional (Office Visit) $45 Technical (Emergency Room)	
DEDUCTIBLE per benefit period Single Family	 $150 $450	 $300 $900
COINSURANCE per benefit period (excludes Deductible) Single Family	 $250 $750	 $500 $1,500
OUT-OF-POCKET MAXIMUM per benefit period Single Family	 $400 $1,200	 $800 $2,400

The following charges do not apply to the Out-of-Pocket Maximum:

1) Copays, including Prescription Drug Copays.
2) Precertification penalties.
3) Charges over the negotiated fee if utilizing a Non-Participating Provider (balanced billing).
4) Charges not covered under the Plan.

Once the individual and/or family Out-of-Pocket Maximum is met during a Benefit Period, the Plan will pay 100% of the Allowed Amount of Covered Benefits for the remainder of the Benefit Period.

MEDICAL BENEFITS (PPO PLAN) **See description under Covered Services for additional information.** *** Precertification required**	**PARTICIPATING PROVIDERS (IN-NETWORK)**	**NON-PARTICIPATING PROVIDERS (OUT-OF-NETWORK)** (Subject to Usual and Customary Charges.)
Allergy Testing, Serums and Injections $15 Copay will apply (excludes serums and injections if no other services rendered)	80% after Deductible	60% after Deductible
Ambulance Services Land Air (severe, life-threatening only)	80% after Deductible	Paid at the Participating Provider level of benefits
Anesthetics	80% after Deductible	60% after Deductible
Autism Spectrum Disorder* Speech and language therapy or occupational therapy** for Covered Persons under the age of 18 $15 Copay will apply **** Precertification also required after the 15th visit of OT with a 30 visit maximum per Benefit Period** Mental or behavioral health outpatient service for Covered Persons under the age of 18 $15 Copay will apply	80% after Deductible	60% after Deductible
Blood and Blood Derivatives	80% after Deductible	60% after Deductible
Cardiac Rehabilitation (Phase 1 and Phase 2)	80% after Deductible	60% after Deductible
Chemotherapy* $15 Copay will apply	80% after Deductible	60% after Deductible
Chiropractic Care/Spinal Manipulation $15 Copay will apply **Benefit Period Maximum:** 12 visits	80% after Deductible	60% after Deductible
Contraceptives	80% after Deductible	60% after Deductible

MEDICAL BENEFITS (PPO PLAN) **See description under Covered Services for additional information.** *** Precertification required**	**PARTICIPATING PROVIDERS (IN-NETWORK)**	**NON-PARTICIPATING PROVIDERS (OUT-OF-NETWORK)** (Subject to Usual and Customary Charges.)
Diagnostic Testing, X-Ray, and Lab Services (Outpatient) The following colonoscopies are considered non-routine: performed due to family history, Medical Necessity, or with diagnosis of any Illness when billed in conjunction with a routine colonoscopy. See Routine Care for additional limits on colonoscopies.	80% after Deductible	60% after Deductible
Dialysis* $15 Copay will apply	80% after Deductible	60% after Deductible
Durable Medical Equipment (DME) **Lifetime Maximum Benefit:** Cochlear Implant repairs and replacement parts are subject to the $250,000 lifetime maximum benefit.	80% after Deductible	60% after Deductible
Emergency Services/ER $45 Copay (waived if directly admitted) **Medical Emergency or Injury** Treatment must be rendered within 72 hours of onset of symptoms **Non-Emergency Medical Condition** including the Emergency Room Physician charge	80% after Deductible Not Covered	Paid at the Participating Provider level of benefits Not Covered
Facility Services (expenses & facility) **Ambulatory Surgical Center** **Hospital** **Extended Care/Skilled Nursing Rehabilitation*** **Urgent Care Center** **Hospice***		
Pre-Admission Testing	Plan pays 100% of covered charges not subject to Deductible or Coinsurance	Plan pays 100% of covered charges not subject to Deductible or Coinsurance
Inpatient* Limited to Semi-Private Room rate	80% after Deductible	60% after Deductible
Outpatient	80% after Deductible	60% after Deductible

MEDICAL BENEFITS (PPO PLAN) **See description under Covered Services for additional information.** *** Precertification required**	**PARTICIPATING PROVIDERS (IN-NETWORK)**	**NON-PARTICIPATING PROVIDERS (OUT-OF-NETWORK)** (Subject to Usual and Customary Charges.)
Hearing Aids **Maximum Benefit:** $3,000 every 4 Calendar Years	80% after Deductible	60% after Deductible
Home Health Care **Benefit Period Maximum:** 120 visits	80% after Deductible	60% after Deductible
Infusion* Outpatient infusions/ injections/ treatments coordinate with Site of Care Program under Prescription Drug Benefit	80% after Deductible	60% after Deductible
Maternity Services $15 Copay will apply	80% after Deductible	60% after Deductible
Medical and Surgical Supplies **Benefit Period Maximum:** Compression hose – 3 pairs	80% after Deductible	60% after Deductible
Morbid Obesity/Weight Control $15 Copay will apply **Lifetime Maximum Benefit:** $15,000	80% after Deductible	60% after Deductible
Nutritional Counseling/Education $15 Copay will apply **Benefit Period Maximum:** 4 sessions	80% after Deductible	60% after Deductible
Orthotics	80% after Deductible	60% after Deductible

MEDICAL BENEFITS (PPO PLAN) **See description under Covered Services for additional information.** *** Precertification required**	**PARTICIPATING PROVIDERS (IN-NETWORK)**	**NON-PARTICIPATING PROVIDERS (OUT-OF-NETWORK)** (Subject to Usual and Customary Charges.)
Physician's Services $15 Copay will apply **Inpatient*/Outpatient Services** **Office Visit** **Telemedicine (Limited to 6 visits per Benefit Period)** **Physician Office Surgery** **Retail Clinics/Urgent Care** **Second Surgical Opinions**	80% after Deductible 100% of covered charges not subject to Deductible or Coinsurance	60% after Deductible 60% after Deductible
Podiatry Services $15 Copay will apply	80% after Deductible	60% after Deductible
Private Duty Nursing	80% after Deductible	60% after Deductible
Prosthetics **Benefit Maximum:** First breast prostheses and surgical brassiere following a mastectomy **Lifetime Maximum:** 1 Wig/Artificial Hair Piece **Lifetime Maximum:** 3 following chemotherapy or radiation therapy ($500 limit each) Lens(es) due to cataract Surgery/aphakic patients **Lifetime Maximum:** First Lens(es)Cochlear implant (surgery and any associated services **Lifetime Maximum**: $250,000	80% after Deductible	60% after Deductible
Radiation Therapy* (Outpatient – includes all related charges) $15 Copay will apply	80% after Deductible	60% after Deductible

MEDICAL BENEFITS (PPO PLAN) **See description under Covered Services for additional information.** *** Precertification required**	**PARTICIPATING PROVIDERS (IN-NETWORK)**	**NON-PARTICIPATING PROVIDERS (OUT-OF-NETWORK)** (Subject to Usual and Customary Charges.)
Routine Care $15 Copay will apply Well Child Care (Birth through age 18) Immunizations Labs and X-rays Routine Colonoscopy: Limited to those age 45 and over once every 10 years **Benefit Period Maximums:** The following are limited to 1 per benefit period: Routine Physical (18 and over), Mammogram, Gynecological Exam, Pap Test, Prostate Exam, and/or PSA $500 Benefit Period Limit applies to colonoscopies for covered person under age 45 or age 45 and over if receiving a second routine colonoscopy within the 10-year period. (Cologuard is not a covered benefit under the Plan.)	80% after Deductible	60% after Deductible
Sleep Disorders $15 Copay will apply	80% after Deductible	60% after Deductible
Temporomandibular Joint Dysfunction (TMJ) Limited to documented organic disease or physical trauma	80% after Deductible	60% after Deductible

MEDICAL BENEFITS (PPO PLAN) **See description under Covered Services for additional information.** *** Precertification required**	**PARTICIPATING PROVIDERS (IN-NETWORK)**	**NON-PARTICIPATING PROVIDERS (OUT-OF-NETWORK)** (Subject to Usual and Customary Charges.)
Therapy		
Occupational Therapy (OT)/ Physical Therapy (PT) Outpatient* $15 Copay will apply **Benefit Period Maximum:** 30 visits of combined OT/PT ***Precertification required after the 15th visit of OT/PT**	80% after Deductible	60% after Deductible
Respiratory/Pulmonary Therapy	80% after Deductible	60% after Deductible
Speech Therapy $15 Copay will apply Limited to services due to illness (other than a mental or nervous condition) or injury	80% after Deductible	60% after Deductible
Vision Therapy (diagnosis of Strabismus only) $15 Copay will apply **Lifetime Maximum Benefit:** 1 course of treatment, up to 32 visits – no coverage for home therapy	50% after Deductible	50% after Deductible
Transplants* Notification required upon being identified as potential organ or tissue transplant recipient Limited to Centers of Excellence	80% after Deductible	Not Covered
All Other Eligible Medical Expenses Genetic testing limited to treat a medical condition or; amniocentesis testing only Drugs over $1,000* Plan reserves the right to direct payment for services.	80% after Deductible	60% after Deductible

ELIGIBLE MEDICAL EXPENSES

Eligible expenses shall be the charges actually made for services provided to the Covered Person by Hospitals, Physicians, and Other Providers. **Services will be considered eligible only if the expenses are Medically Necessary due to Illness or Injury and are not Experimental and/or Investigational unless otherwise specified.** All Covered Services are subject to those listed under Medical Exclusions and Limitations.

Covered eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Allergy Services: Allergy testing, serum, and injections.

Ambulance Service: Professional ambulance service to transport the Covered Person:

1) To the nearest Hospital equipped to treat the specific Illness or Injury in an emergency situation; or

2) To another Hospital in the area when the first Hospital did not have services required and/or facilities to treat the Covered Person; or

3) To and from a Hospital during a period of Hospital confinement to another facility for special services which are not available at the first Hospital; or

4) From the Hospital to the patient's home or to a Skilled Nursing Facility, Rehabilitation Facility, or any other type of convalescent facility nearest to the patient's home when there is documentation the patient required ambulance transportation.

Ambulance Service is limited to surface transportation, unless the closest facility that can provide services appropriate for the condition is accessible only by other than surface transportation. Air Ambulance services are covered in life-threatening situations only.

The Physician must certify transportation services as Medically Necessary. Professional ambulance charges for convenience are not covered.

Anesthetics: Anesthetics and their professional administration who is not the surgeon or assistant surgeon.

Autism Spectrum Disorder: Services for:

1) Speech and language therapy or occupational therapy for a Covered Person under the age of 18 that is performed by a licensed therapist. Outpatient Occupational Therapy visits, in excess of 15 per Benefit Period are subject to the Pre-Certification requirements of this Plan and are limited to 30 visits per Benefit Period.

2) Mental or behavioral health outpatient services for a Covered Person under the age of 18 performed by any of the following providing consultation, assessment, development or oversight of treatment plans.

   a. Licensed psychologist

   b. Licensed physician, including a psychiatrist; or

   c. A clinical nurse specialist or certified nurse practitioner, including a psychiatric-mental health advanced practice registered nurse or a clinical nurse specialist or certified nurse practitioner specializing in pediatric or family health.

Services for Autism Spectrum Disorder are contingent upon

1) Receiving prior authorization for the services; and

2) That the services are prescribed or ordered by a psychologist trained in autism, a developmental pediatrician, or a clinical nurse specialist or certified nurse practitioner specializing in pediatric health.

Blood and Blood Derivatives: Whole blood, blood derivatives, blood plasma and blood components, (unless replaced by donation on behalf of the Covered Person), including administration and blood processing.

Cardiac Rehabilitation: Cardiac rehabilitation services which are rendered:

1) Under the supervision of a Physician; and

2) In connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery or any other medical condition if medically appropriate; and

3) Initiated within 12 weeks after other treatment for the medical condition ends; and

4) In a medical care facility.

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

Chemotherapy: Services and supplies related to the treatment of malignant disease by chemical or biological antineoplastic agents. Precertification is required.

Chiropractic Care/Spinal Manipulation: Skeletal adjustments, manipulation, or other treatment in connection with the correction by manual or mechanical means of structural imbalance or subluxation in the human body, including x-rays. Coverage is limited to 12 visits per Benefit Period.

Contraceptives: Contraceptive procedures including, but not limited to injections, diaphragms, intrauterine devices (IUD), implants and any related office visit. Oral medications and patches are covered under the Prescription Drug Program.

Diagnostic Testing, X-ray, and Laboratory Services: Hospital services and physician services for diagnostic testing, x-ray, laboratory services, cardiographic (EKG), encephalographic (EEG), radioisotope tests, and services of a professional radiologist or pathologist.

Pre-admission testing, outpatient tests and studies required for a scheduled admission as an Inpatient and performed prior to the date of admission to reduce the time required to be an Inpatient are not subject to the Deductible or Coinsurance.

The following colonoscopies are considered non-routine: performed due to family history, Medical Necessity, or with diagnosis of any Illness when billed in conjunction with a routine colonoscopy. See Routine Care for additional limits on colonoscopies.

Dental x-rays are not eligible expenses, except as specified under Dental Care.

Dialysis: Treatment of an acute or chronic kidney disorder by dialysis as an Inpatient in a Hospital or other facility, outpatient facility, or in the Covered Person’s home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces Inpatient or outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in the Covered Person’s home under Durable Medical Equipment.

Durable Medical Equipment: The rental of Durable Medical Equipment (e.g., oxygen, wheelchairs, walkers, special Hospital beds, iron lungs, etc.) that serves only a medical purpose and can withstand repeated use subject to the following:

1) The equipment must be prescribed by a Physician and Medically Necessary; and

2) The equipment will be provided on a rental basis; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental

cost of Durable Medical Equipment exceed the purchase price of the item (oxygen equipment is not limited to the purchase price); and

3) Benefits will be limited to standard models as determined by the Plan; and

4) The Plan will pay benefits for only one of the following (unless Medically Necessary due to growth of the Covered Person or if changes to the Covered Person's medical condition requires a different product) as determined by the Plan: a manual wheelchair or motorized wheelchair; and

5) If the equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible subject to prior approval by the Plan. In all cases, repairs, or replacement due to abuse or misuse, as determined by the Plan, are not covered.

Repairs and replacement of parts for cochlear implants are subject to the lifetime maximum benefit of $250,000.

Emergency Services/Emergency Room: Services and supplies for the initial treatment of injuries caused by an Accident or sudden and acute life-threatening medical condition (e.g., heart attack, kidney stones, stroke, loss of consciousness or respiration, convulsions, etc.) that requires prompt Medical Care. Treatment must be rendered within 72 hours of an Accident or onset of symptoms.

When you experience an Emergency Medical Condition, coverage for Emergency Services will continue until your condition is Stabilized. If you are furnished additional items or services after you are stabilized, the balanced bill protections described in the Protection From Surprise Bills Section will not apply to the extent and:

1) Your attending Physician determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another provider within a reasonable distance if you need more care; and

2) Your Non-Participating Provider delivering the services meets any applicable notice and consent criteria with respect to the post-stabilization services provided to you; and

3) You are in a condition to be able to receive such notice from the Non-Participating Provider delivering services and provide informed consent in accordance with the requirements under applicable state law.

If you go to an emergency room for what is not an Emergency Medical Condition, the Plan may not cover your expenses. See the Medical Schedule of Benefits and the General Exclusions and Limitations for specific Plan details. If your Physician decides you need to stay in the Hospital (emergency admission) post-stabilization or receive follow-up care, these are not Emergency Services. Different benefits and requirements apply.

For purposes of Emergency Services, “stabilized” means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of an individual from a facility or, if the Emergency Services are for an Emergency Medical Condition for a pregnant woman experiencing contractions, “stabilizes” means the woman has delivered (including the placenta).

Facility Services: Facility Charges, services and related supplies provided by the following:

1) Ambulatory Surgical Center

2) Hospital or Long-Term Acute Care Facility/Hospital including Pre-Admission Testing for outpatient pre-admission testing performed prior to a scheduled Inpatient hospitalization or Surgery

    a) Inpatient (Precertification required for admission exceeding 23 hours)

        i. Semi-Private Room and board, including all regular daily services in a Hospital or Long-Term Acute Care Facility/Hospital.

        ii. Care provided in an Intensive Care Unit (including cardiac care (CCU) and burn units).

iii. Miscellaneous services and supplies, including any additional Medically Necessary nursing services furnished while being treated on an Inpatient basis.

iv. A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.

v. Medical care visits are limited to one visit per day by any one Physician. A personal bedside examination by another Physician is covered only when requested by the original Physician. Staff consultations required by Hospital rules are excluded.

vi. Partial day confinements (at least 5 hours, but less than 12 hours per day) are made available as an Inpatient benefit. For the purpose of determining benefits, two days of partial confinement will count as one day of Inpatient confinement.

b) Outpatient

3) Rehabilitation/Skilled Nursing Facility (Precertification Required)

a) Inpatient care provided such confinement: (a) is under the recommendation and general supervision of a Physician; and (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Rehabilitation/Skilled Nursing Facility confinement.

No coverage is provided for Rehabilitation/Skilled Nursing Facility Services after the patient can no longer significantly improve from treatment, for Custodial Care, or care for senile deterioration, mental deficiency or developmental disability.

4) Urgent Care Facility

5) Hospice Care: Hospice care on either an Inpatient (Precertification required) or outpatient basis for a terminally ill person rendered under a Hospice treatment plan. The attending Physician must certify that the person is terminally ill with a life expectancy of 6 months or less. The Hospice Facility must have a written reimbursement agreement with the Plan or the Plan's designated preferred provider organization. The following are considered eligible services when prescribed by a Physician and approved by the Plan prior to the date treatment starts:

a) Room and board charges by the Hospice

b) Medical/surgical supplies, and Prescription Drugs prescribed by a Physician

c) Diagnostic/Laboratory services

d) Nursing care by or under the supervision of a registered nurse (R.N.) or licensed practical nurse (LPN)

e) Home health care services furnished in the patient's home by a Home Health Care Agency for the following:

i. Health aide services consisting primarily of caring for the patient (excluding housekeeping, meals, etc.); and

ii. Physical, speech, and respiratory/pulmonary therapy

f) Visits provided by a medical social worker (MSW);

g) Counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family. Bereavement counseling is not considered an eligible service

h) Nutritional guidance by a licensed dietician

Hearing Aids: Initial office and follow-up visits related to an examination for prescribing or fitting of hearing aid up to a maximum payment of $3,000 per Covered Person in a 48-month period, subject to any applicable Deductible or Coinsurance. (See: Prosthetics for coverage of cochlear implants.)

Home Health Care: Services provided by a Home Health Care Agency to a Covered Person in the home to a maximum of 120 visits per Benefit Period. The following are considered eligible home health care services when prescribed by a Physician and approved by the Plan prior to the date treatment starts:

1) Home nursing care

2) Services of a home health aide or licensed practical nurse (L.P.N.), under the supervision of a registered nurse (R.N.)

3) Visits provided by a medical social worker (MSW)

4) Physical, occupational, speech, or respiratory/pulmonary therapy if provided by the Home Health Care Agency

5) Medical/surgical supplies, and Prescription Drugs prescribed by a Physician.

6) Diagnostic/Laboratory services

7) Nutritional guidance by a licensed dietician

For the purpose of determining the benefits for home health care available to a Covered Person, each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and each four hours of home health aide services shall be considered as one home health care visit.

In no event will the services of a Close Relative, transportation services, housekeeping services and meals, etc., be considered an eligible expense.

Hospice Care: Hospice care on either an Inpatient (Precertification required) or outpatient basis for a terminally ill person rendered under a Hospice treatment plan. The attending Physician must certify that the person is terminally ill with a life expectancy of six months or less. The Hospice Facility must have a written reimbursement agreement with the Plan or the Plan's designated preferred provider organization. The following are considered eligible services when prescribed by a Physician and approved by the Plan prior to the date treatment starts:

1) Room and board charges by the Hospice.

2) Medical/surgical supplies, and Prescription Drugs prescribed by a Physician

3) Diagnostic/Laboratory services

4) Nursing care by or under the supervision of a registered nurse (R.N.).

5) Home health care services furnished in the patient's home on a part-time visiting basis by a Home Health Care Agency for the following:

    a) Health aide services consisting primarily of caring for the patient (excluding housekeeping, meals, etc.); and

    b) Physical, speech, and respiratory/pulmonary therapy.

6) Visits provided by a medical social worker (MSW);

7) Counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family. Bereavement counseling is not considered an eligible service.

8) Nutritional guidance by a licensed dietician.

Infusion: Services, supplies, and equipment necessary for infusion therapy.

Precertification is required through the Plan prior to receiving services. The Plan has established a Site of Care Program for the procurement and/or administration of high cost infusion/injectable prescription medications administered in an out-patient setting. This program is mandatory for Covered Persons receiving infusion/injectable treatment through the Plan's medical or prescription benefits. The Plan reserves the right to direct site of care. Note: Chemotherapy and Dialysis are defined under separate headings.

Maternity: Expenses incurred for:

1) Pregnancy, complications of pregnancy, miscarriage, therapeutic (Medically Necessary) abortion.

   When not prohibited by state or local laws, elective induced abortions only when carrying the fetus to full term would seriously endanger the life of the mother.

   If complications arise after the performance of any abortion, any expenses Incurred to treat those complications will be eligible, whether the abortion was eligible or not.

Complications of pregnancy include conditions that are adversely affected by pregnancy only when serious enough that an Inpatient Hospital admission is Medically Necessary that include: non-elective cesarean section; ectopic pregnancy; or spontaneous termination of pregnancy during a period of gestation in which viable birth is not possible. All other conditions must be distinct from the diagnosis of pregnancy in order to be considered complications of pregnancy, such as: acute nephritis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity.

Complications of pregnancy will not include: false labor; occasional spotting; Physician prescribed rest during the period of pregnancy; morning sickness; hypermesis gravidarum; pre-eclampsia; and similar conditions associated with the management of a difficult pregnancy.

2) Hospital and Surgical/Medical Services

   Up to two ultrasounds per pregnancy (more than two only when it is determined to be Medically Necessary).

   Hospital stays in connection with childbirth for either the mother or newborn may not be limited to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to precertify the maternity admission unless the stay extends past the applicable 48 or 96 hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth.

   If a newborn remains hospitalized beyond the time frames specified above, the confinement must be precertified or a penalty may be applied.

3) Ordinary routine nursery care for a well newborn

   If the newborn and the mother are released at the same time, newborn care including Hospital nursery expenses and routine pediatric care while confined following birth will be considered as part of the mother's expense. The first Inpatient visit to examine a newborn must be performed by a Physician other than the Physician who performed the obstetrical delivery.

   If the newborn Child's admission is longer than the mother's Hospital admission, Hospital charges for routine nursery care of the covered newborn Child are considered as the Child's own claim (separate from the mother's claim). You must request enrollment for the newborn Child within 31 days of birth.

Medical and Surgical Supplies: Medically Necessary supplies ordered by a Physician that serve only a medical purpose and are provided with an appropriate medical diagnosis.

Needles, diabetic lancets and strips, and glucometers used in the management and treatment of diabetes may be covered under the medical or prescription coverage, but not both.

Compression hose/stockings are limited to three pair per Benefit Period.

Covered Services do not include insulin, syringes, and items usually stocked in the home for general use like band-aids, thermometers, and petroleum jelly.

Morbid Obesity: Surgical treatment for Morbid Obesity will only be covered if Medically Necessary and all the following conditions are met:

1) The Covered Person has been diagnosed with Morbid Obesity (at least 100 pounds over or twice the ideal weight, whichever is less); and

2) The Morbid Obesity is the direct cause of an Illness.

   This benefit does not cover services prior to Surgery but does cover all surgically related procedures from the point of Surgery as well as any Medically Necessary follow-up services after Surgery, including but not limited to all related services that result from Surgery (e.g. surgical removal of excess skin).

   A $15,000 maximum benefit per Lifetime begins at the time that Surgery is Incurred and includes all related services that result from Surgery.

Nutrition Counseling/Education: Nutrition counseling and education provided by a certified, registered, or licensed healthcare professional. Coverage is limited to four sessions per Benefit Period.

Orthotic devices: A rigid or semi-rigid supportive device that limits or stops motion of a weak or diseased body part. (See Podiatry for additional information.)

Physician's Services: Services of a Physician or other professional provider for medical care visits and consultations to examine, diagnose, and treat an Injury, including Surgery. Telemedicine limited to six visits per Benefit Period. The Plan will not make separate payment for pre- and postoperative services.

1) Services performed in a Physician's office on the same day for the same or related diagnosis. Services include, but are not limited to: examinations, supplies, injections, x-ray, and laboratory tests (including the reading or processing of the tests), cast application and minor Surgery. If more than one Physician is seen in the same clinic on the same day, Copays will apply if billed separately by each provider.

   Diagnostic x-ray and laboratory services which are ordered on the same day as the office visit but performed or read at a later date and/or at another facility may be billed separately from the office visit.

   Prescription Drugs, injectables or supplies used for the treatment of a covered Illness or Injury, which are dispensed through the Physician's office, infusion center or other clinical setting, the Covered Person's home by a third party, or take-home Prescription Drugs from a Hospital may be covered under the major medical benefits of this Plan and separate from the Prescription Drug Card Program benefits. Precertification is required for outpatient Infusions, injectables, and medications over $1,000 as the Plan may direct site of care. In those cases, those drugs will only be payable under the major medical benefits if those drugs fall outside any Specialty Pharmacy Program, as applicable (as noted in the Prescription Drug Card Program section).

2) Second Surgical Opinion for a Physician's opinion and related Diagnostic Services to help determine the need for elective Surgery recommended by another Physician. Use of a second surgical opinion is at the member's option. If the first and second opinions differ, then a third opinion is covered for no additional cost.

3) Procedures/Surgery

   a) When more than one Surgical Procedure is performed through the same body opening during one operation, there is coverage only for the most complex procedure, unless more than one body system is involved or the procedures are needed for handling of multiple trauma.

   b) When more than one Surgical Procedure is performed through more than one body opening during one operation, there is coverage for the most complex procedure and for one-half of the benefit for the less complex procedure, or for each of the next three procedures. More than four procedures may be covered; however,

each case will be reviewed for Medical Necessity. For more than one Surgical Procedure performed through more than one body opening during one operation, the Plan will provide coverage for the most complex procedure charge considered will be: for the primary, most complex procedure; (ii) 50% for the secondary, less complex procedure, including any bilateral procedure; and (iii) 50% for each additional Medically Necessary procedure. This applies to all Surgical Procedures, except as determined by the Plan.

c) For surgical assistance by an Assistant Surgeon, when a house staff member, intern, or resident cannot be present, the Assistant Surgeon will be payable at 20% of the allowed amount of the surgeon's charges.

d) Administration of anesthesia by a Physician or Professional Other Provider who is not the surgeon or the assistant at Surgery.

4) Sterilization, regardless of Medical Necessity.

5) Reconstructive Surgery regardless of Medical Necessity only to restore bodily function or correct deformity for problems caused by disease, Injury, birth or growth defects, or previous treatments. Reconstructive Surgery does not include any Surgery that is specifically identified as an exclusion.

   a) Reconstructive mammoplasties will be eligible as follows. The manner in which breast reconstruction is performed will be determined in consultation with the attending Physician and the Covered Person.

      i. Reconstruction of the breast on which the mastectomy has been performed;

      ii. Surgery and reconstruction of the other breast to produce symmetrical appearance; and

      iii. Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

   b) Services and supplies related to cleft palate and cleft lip (a birth deformity in which the palate/the roof of the mouth fails to close, and/or a birth deformity in which the lip fails to close).

6) Dental services rendered by a Dentist or dental surgeon for dental work and oral Surgery if they are for the repair of an 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. All Dental Services must be submitted through the Covered Person's dental carrier as primary before this medical plan will consider payment.

   a) Surgery to treat disease and injuries of the upper and lower jaw.

   b) Surgical removal of impacted teeth. The teeth may be partly or wholly covered by bone or soft tissue.

   c) Apioceoctomy (dental root resection).

   d) Excision (cutting out) of a cyst of the tooth or tooth root.

   e) Alveolectomy (removal of tooth sockets) of six or more consecutive sockets, when it is done as an independent procedure, and not in connection with the removal of teeth.

   f) Gingivectomy (removal of diseased or infected gum tissue).

   g) Osseous Surgery (Surgery on the bone structure that supports the teeth).

   h) The only other dental expenses that are Covered Services are charges for Hospital services when the patient's medical condition or the dental procedure requires a Hospital setting to insure the safety of the patient.

Podiatry: Treatment for the following foot conditions: (a) bunions when an open cutting operation is performed; (b) non-routine treatment of corns or calluses; (c) toenails when at least part of the nail root is removed or treatment of ingrown toenails; (d) any Medically Necessary Surgical Procedure required for a foot condition. Orthopedic/corrective shoes when an integral part of a leg brace will also be covered. Care to only improve comfort or appearance is not covered.

Private Duty Nursing: Services include only Skilled Nursing Services ordered by a Physician and rendered in the home or as an Inpatient by a practicing registered nurse (RN) or licensed practical nurse (LPN). Skilled Nursing Services do not include Custodial Care or services that could be performed by the average non-medical person with proper training even if ordered by a Physician.

The Plan does not pay for services for a nurse who usually lives in the patient's home or who is a member of the patient's immediate family. Benefits will only be provided for the time actually spent performing Skilled Nursing Services, Services provided to allow the patient's family to work or to provide a periodic break for the family from the demands of caring for the patient are not covered.

Covered charges for this service will be included to the following extent:

1) Inpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit. Inpatient Private Duty Nursing must be supported by a certification from the attending Physician or facility provider.

2) Outpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial in nature. Charges covered for outpatient nursing care billed by a Home Health Care Agency are shown under Home Health Care Services and Supplies. Outpatient private duty nursing care not billed by a Home Health Care Agency must be supported by a certification and a treatment plan from the attending Physician.

Prosthetic Devices: Purchase, fitting, adjustment and repairs or replacements of prosthetic devices and supplies when Medically Necessary to replace all or part of a missing body organ and its adjoining tissue or the function of a permanently useless or malfunctioning body organ.

This benefit includes any necessary repairs to restore the prosthesis to a serviceable condition. If such prosthesis cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repairs, or replacement due to abuse or misuse, as determined by the Plan, are not covered.

The following are also covered as listed:

1) Soft lenses or sclera shells intended for use as corneal bandages.

2) Aphakic patients are eligible for initial pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye.

3) First lens(es) following cataract Surgery.

4) First breast prostheses and surgical brassiere following a mastectomy.

5) Purchase of a wig/scalp hair prosthesis when necessitated by hair loss due to chemotherapy or radiation. Maximum benefit is $500 per wig with a limit of 3 per lifetime.

6) Cochlear implant surgery, and any associated services (i.e., post-operative services, repairs, replacements, etc.) have a $250,000 lifetime maximum benefit.

Radiation Therapy: X-ray, radium and radioactive isotope therapy treatment.

Routine Care: Routine care including, but not limited to, the office visit, lab tests, x-rays, routine testing, vaccinations or immunizations, pap smears, mammograms, routine hearing exams, colon exams and PSA testing. Such services are subject to the Deductible, Coinsurance, and Copayment limits. If a diagnosis is indicated after a routine exam, the exam will still be payable under the routine care benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other Illness.

Some physicals, such as those required by a Child's school, are covered. Physical exams required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes, are not covered.

1) Well Child care for birth through age 18, for a periodic review including a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests performed in

accordance with the recommendations of the American Academy of Pediatrics. These services are provided regardless of Medical Necessity; however, the Plan will cover only the expenses of Child Health Supervision Services that are performed by one Physician or by a health care professional under the supervision of one Physician during the course of any one visit.

2) Immunizations

3) Labs and X-Rays: Benefits for routine screening mammography, routine cytologic screening (pap test), and routine prostate specific antigen (PSA test), including the office visit are covered one per person per Benefit Period regardless of Medical Necessity.

4) Routine Colonoscopy: Limited to those age 45 and over once every 10 years. $500 Benefit Period limit applies to colonoscopies for Covered Person under age 45 or age 45 and over if receiving a second routine colonoscopy within the 10-year period.

Sleep Disorders: Sleep disorder treatment and sleep studies that are Medically Necessary.

Temporomandibular Joint Dysfunction (TMJ): Treatment for Temporomandibular Joint Dysfunction (TMJ) or any related conditions referred to as TMJ, only as caused by documented organic disease or physical trauma.

Therapy: Therapy rendered by a qualified Physician or licensed therapist for the services sought or under the recommendation of a Physician. Expenses for Maintenance Therapy or therapy primarily for recreational or social interaction will not be considered eligible. The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable and predictable period of time.

1) **Occupational/Physical Therapy:** Rehabilitative occupational therapy activities to help regain performance skills lost through Illness or Injury, or Physical Therapy by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices. Such Therapy is given to relieve pain, restore maximum function, and to prevent disability following disease, Injury, or loss of body part. Outpatient Physical Therapy visits, combined with Occupational Therapy visits, in excess of 15 per Benefit Period are subject to the Pre-Certification requirements of this Plan and is limited to 30 visits of combined OT/PT per Benefit Period.

2) **Respiratory/Pulmonary Therapy:** Includes the administration of medicines, water vapors, gases, or anesthetics by inhalation.

3) **Speech Therapy:** Restorative or rehabilitative speech therapy provided by a licensed speech therapist to restore speech lost or correct speech impaired due to an Illness (other than a Mental or Nervous Condition) or Injury. Services for loss or impairment due to a psychological or functional nervous disorder, services to correct learning disabilities and developmental delays, and services that are otherwise provided by the public schools, Ohio's Complex Medical Help program or other public programs, are not covered.

4) **Vision Therapy:** Medically Necessary outpatient vision therapy/orthoptic therapy only for the treatment of strabismus. Treatment is limited to 32 visits per lifetime.

Transplants: Services and supplies in connection with Medically Necessary non-Experimental and/or non-Investigational transplant procedures. Precertification is required when a Covered Person's Physician suggests that their condition requires or may require Human Organ and/or Tissue Transplant. The Plan reserves the right to direct payment for transplant services to transplant Centers of Excellence at the Plan's discretion.

The following tissue and human organ transplants are covered including all related charges, including acquisition, preparation, and transportation:

1) Cornea

2) Allogenic and autologous bone marrow

3) Other types of tissue transplants that are not Experimental/Investigational

4) Heart

5) Intestinal

6) Kidney

7) Liver

8) Lung

9) Pancreas

10) Multiple organ transplants of those listed above, all others are excluded

If both the donor and the recipient are covered under this Plan, eligible expenses Incurred by each person will be treated separately for each person.

If the recipient is covered under this Plan and the donor is not covered, eligible expenses Incurred by the donor will be considered eligible if not covered by the donor's plan.

If the donor is covered under this Plan and the recipient is not covered, eligible expenses Incurred by the donor will not be covered.

If a human organ or tissue transplant is received prior to becoming a Covered Person, certain follow-up care may be covered. Follow-up care will be subject to the same requirements that apply when the transplant is received while covered under this Plan.

Fees of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology, and pathology fees for the removal of the organ and a Hospital's charge for storage or transportation of the organ.

Excluded services include those:

1) Furnished by or under the supervision of a center other than the Transplant Center where the Transplant was performed.

2) Provided more than five days prior to the day of the covered transplant, or otherwise outside the transplant period.

3) For other than a legally obtained human organ or for a human organ acquired outside the United States or Canada.

4) For travel time and the travel-related expenses of a Provider or Covered Person.

5) The purchase price of bone marrow, any organ, tissue, or any similar items which are sold rather than donated.

All Other Eligible Medical Expenses as listed below:

1) **Genetic Testing:** Diagnostic testing of Genetic Information if used to treat a medical condition or for amniocentesis testing.

MEDICAL MANAGEMENT PROGRAM/ PRECERTIFICATION REQUIREMENTS

Medical Management

Medical Management is a program designed to help ensure that you and your eligible Dependents receive necessary and appropriate healthcare in the most appropriate setting while avoiding unnecessary expenses.

Before you or your eligible Dependents are admitted to a medical facility or receive items or services that require precertification (prior authorization) on a non-Emergency Medical Condition basis (that is an Emergency Medical Condition is not involved), the Medical Management Program Administrator will, based on clinical information from the provider or facility, certify the care according to the Medical Management Program Administrator's policies, procedures and guidelines.

The Medical Management program consists of:

1) Precertification of Medical Necessity through the:

    a) Medical Management Program for Inpatient admissions as well as other non-Emergency Services as listed in the Schedule of Benefits.

        i. Hospital admissions of less than 23 hours are considered outpatient and do not require precertification. If a hospital admission is extended beyond 23 hours, precertification will be required.

    b) Medical Necessity Review Process under the Prescription Drug Benefit prior to receiving any

        i. Outpatient infusion/injectable prescription medications that are over $1,000.

        ii. Drugs that are listed in excluded/limited listing under the Prescription Benefit.

2) Concurrent Review for continued Inpatient stay.

3) Assistance with discharge planning activities.

All benefits/payments are subject to the patient's eligibility for benefits under the Plan. For benefit payment, services rendered must be considered an eligible expense under the Plan and are subject to all other provisions of the Plan. The fact that a service received precertification does not guarantee either payment of benefits or the amount of benefits payable. Eligibility for and payment of benefits cannot be determined until the Plan receives the claim for services. All initial notifications for Precertification are considered claims for purpose of the Department of Labor Claim Regulations.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other healthcare provider. This review program does not apply to the Covered Person for whom Medicare pays as primary and this Plan pays as secondary.

Precertification

Your provider should precertify your treatment for you; however, Out-of-Network Providers do not have a contractual obligation to precertify services on your behalf.

Prior to receiving any services, you should verify that your provider has obtained precertification. You can contact the Medical Management Program Administrator by calling the precertification number identified on the back of your medical insurance ID card.

If the provider did not precertify your treatment, you can request the Medical Management Program Administrator to create a generic case to document your call to show that precertification was made within the required timeframe. You

will be asked to provide the provider's name, phone number, and fax number. It is recommended that you document who you spoke with and the date and time of the call.

Follow-up with your provider is further recommended to ensure the needed information is provided to the Medical Management Program Administrator prior to receiving services.

The following timelines apply when precertification is required for medical services provided:

- At least seven (7) days before an elective Inpatient admission (e.g., Hospital stay of greater than 23 hours, Hospice, Skilled Nursing Facility for extended care or Rehabilitation Facility)
    - If the admission is scheduled less than seven (7) days in advance, the notification call must be made no later than 48 hours prior to the admission.
- Within 48 hours, or by the first business day (i.e., non-holidays, Monday through Friday) after an emergency Hospital admission.
- Within 24 hours of being notified of the need for a continuing Hospital stay of over 48 hours following vaginal delivery or over 96 hours following a cesarean section.
    - Hospital stays in connection with childbirth for either the mother or newborn may not be less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. You, the patient and the providers are NOT REQUIRED to obtain precertification for a maternity delivery admission, unless the stay extends past the applicable 48- or 96-hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. If a newborn remains hospitalized beyond the time frames specified above, the confinement must be precertified with the Medical Management Program Administrator or a penalty will be applied.
- Upon being identified as a potential organ or tissue transplant recipient.
- At least 48 hours before receiving any other services requiring Pre-Certification including,
    - 16th visit of combined outpatient physical and/or occupational therapy
    - Covered services for Autism
    - Submitting a completed Rx Medical Necessity Review form prior to obtaining any prescriptions over $1,000 including those at:
        - Pharmacy
        - Outpatient facility or Provider's office (i.e., injections/infusions)
    - The following items and/or services must be precertified before any medical services are provided, however no penalty will be applied for failure to obtain precertification:
        - Chemotherapy (all settings including services rendered in a Physician's office)
        - Radiation (all settings including services rendered in a Physician's office)
        - Dialysis

If your treatment is not precertified within the time periods described above, a retrospective review may be performed. Retrospective Review for Medical Necessity is where precertification is requested and denied, or required Precertification was not requested.

Failure to obtain precertification or notify the Medical Management Program Administrator within the time frame indicated above may result in eligible expenses being reduced or denied. Please refer to the penalty section below.

If the notification call is not made because a Covered Person is unconscious and no Close Relative is aware of the Precertification requirement, the claim will be automatically referred to the appeals process for retrospective review.

Precertification for Outpatient Infusion/Injectable Prescriptions over $1,000 or Excluded/Limited Drugs

The Covered Person must contact the Plan prior to receiving any services for outpatient infusion/injectable prescription medications over $1,000 or drugs that are listed in excluded/limited listing under the Prescription Drug Benefit. (See How to Obtain Medical Precertification for chemotherapy, radiation, and dialysis.)

The Covered Person and Provider must complete the Medical Necessity Review process under the Prescription Drug benefit. The Plan may direct site of care as noted in Eligible Medical Services. In those cases, those drugs will only be payable under the major medical benefits if those drugs fall outside any Specialty Pharmacy Program, as applicable (See the Prescription Drug Benefit section).

Failure to notify the Plan may delay treatment or result in a denial of the claim.

Medical Precertification

After the initial call is made, the Medical Management Program Administrator, in coordination with the facility and/or provider, will make a determination within 15 days of the initial notification. All notifications for Urgent Care Claims will be decided within 72 hours of initial notification.

The determination will be communicated by phone or written confirmation to the patient, Hospital, and/or Provider. If denied, alternate methods of providing appropriate care will be recommended.

If the confinement will last longer than the number of days certified, a representative of the Physician or the facility must call the Medical Management Program Administrator before those extra days begin and obtain certification for the additional time. If the additional days are not requested and certified, room and board expenses will not be payable for any days beyond those certified.

Penalty for Failure to Obtain Medical Precertification

If the Medical Management Program Administrator is not contacted within the time period described above, benefits under the Plan will be reduced as follows:

1) Services will be denied and depending on where services were rendered, you may be responsible for paying the full amount of the confinement and/or services.

2) The claim may be appealed to the Medical Management Program Administrator for review and if found to be Medically Necessary, charges may be paid at 50% of the allowed amount. The amount of the precertification penalty is not covered by the Plan and will not accumulate toward satisfying any Deductible, Coinsurance, or Out-of-Pocket Maximum.

NOTE: The precertification penalty does not apply to chemotherapy, dialysis or radiation therapy. In addition, the penalty will not apply to newly eligible members who submitted timely application to the Plan and are awaiting enrollment verification from the Plan.

If the Plan's required review procedures are not followed, a retrospective review will be conducted by the Medical Management Program Administrator to determine if the services provided met all other Plan provisions and requirements. If the review concludes the services were Medically Necessary and would have been approved had the required phone call been made, benefits will be considered subject to the penalty outlined above. However, any charges not deemed Medically Necessary will be denied.

Concurrent Review for Inpatient Stay

Once the Inpatient setting has been precertified, the on-going review of the course of treatment becomes the focus of the program. Working directly with your Physician, the Medical Management Program Administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses.

Discharge planning

Discharge planning needs are part of the Medical Management Program. The Medical Management Program Administrator will assist and coordinate the initial implementation of any services the patient will need post hospitalization with the attending Physician and the facility.

Retrospective Review for Medical Necessity

Adverse Benefit Determinations may be appealed as outlined in Claims Procedures.

Medical Case Management

Case management is a program whereby a Case Manager contacts the patient to obtain consent for case management services usually involving a catastrophic, chronic, or high cost condition. Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

The Case Manager will coordinate, implement, and monitor the case management program by providing guidance and information on available resources and suggesting the most appropriate, cost effective, treatment plan. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

This plan of care may include some or all of the following:

Personal support to the patient;

Contacting the family to offer assistance and support;

Monitoring Hospital or skilled nursing care or home health care;

Determining alternate care options; and

Assisting in obtaining any necessary equipment and services.

If you or your eligible Dependents are not currently utilizing the most cost-effective method, the case manager will direct you to the most cost efficient Participating Provider including the use of the Site of Care program. The program includes 1-on-1 coaching based on the terms of the Plan, support and education to improve adherence and avoid complications.

The Medical Management Program Administrator contact information for this Plan is identified on the Employee identification card and also in the Summary Plan Description.

Alternative Care Options

As noted above, case management may include an alternate treatment plan to benefit both the patient and the Plan. In developing an alternate treatment plan, the case manager will consider:

The Covered Person’s current medical status

The current treatment plan

The effectiveness of care, including short and long-term implications.

The Plan may elect to offer benefits for services furnished by any provider and may direct site of care. The Plan shall provide such alternate benefits at its sole discretion and only when and for so long as it determines the alternate treatment plan is Medically Necessary and cost effective.

If the Plan elects to provide alternate treatment plan benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for such Covered Person in any other instance or for other Covered Persons in any other instance, nor shall it be construed as a waiver of the Plan's right to administer this Plan thereafter in strict accordance with its express terms.

The Plan retains the right to review the Covered Person's medical status while the alternative treatment plan is in process, and to discontinue the treatment plan with respect to medical services and supplies while are not covered charges under the Plan if:

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

2) The goal of the alternative plan of treatment has been met;

3) The alternative plan of treatment is no longer beneficial to the Covered Person

If the Plan has approved a course of treatment and that treatment is later reduced or terminated, the Third-Party Administrator will at a time sufficiently in advance of the reduction or termination allow the claimant to file an appeal before the benefit is actually terminated or reduced.

The Plan, Third-Party Administrator, attending Physician, and patient and/or patient's family must all agree to the alternative treatment plan. The Plan reserves the right to alter or waive the normal provisions of the Plan to cover such alternative care.

PROTECTION FROM SURPRISE BILLS

The No Surprises Act of the Consolidated Appropriations Act, 2021 (the "CAA"), protects you from "surprise billing" or "balance billing" when you get Emergency Medical Care are at an Non-Participating Hospital or when you receive care from an Non-Participating Provider who is working at a Hospital or Ambulatory Surgical Center in your health plan's network.

A "balance bill" is a bill charged to you by an Non-Participating Provider or facility to make up the difference between what your health plan pays and the provider charges for the items or services rendered. "Surprise billing" is an unexpected balance bill you receive from a provider or facility. This can happen when you receive care from a facility that is a Participating facility but one of the providers at the facility is Non-Participating.

Under the No Surprises Act, you are protected from balance billing for Emergency Services provided by Non-Participating Providers, including services you may get after you are in stable condition (unless you give written consent and give up your protections against balanced billing for post-stabilization services). You are also protected from surprise bills from services you receive from Non-Participating Providers while at an Participating Hospital or ambulatory surgery center, such as services for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistance surgeon, hospitalist, or intensivist services. The most the providers can bill you is your Participating Provider cost-sharing amount, and they can't ask you to give up your protections from being balance billed. If you receive other services at these Participating Facilities, Non-Participating Providers cannot balance bill you unless you provide written consent. Written consent can never be required. Further, you can always choose to receive care at a participating facility or from a Participating Provider instead of receiving care from Non-Participating Provider or facility.

The Plan covers Emergency Services without requiring you to get approval for such services in advance, which is known as prior authorization. Further, the Plan covers Emergency Services even if those services are provided by providers who are outside the Plan's network. Your required cost sharing (co-pays, coinsurance, or deductibles) for emergency care received by an Non-Participating Provider or facility will be the same as what you pay a Provider or facility in the Plan's network. That amount will be included in your explanation of benefits. Finally, the amount of any cost-sharing you pay for Emergency Services or out-of-network services will count towards your applicable maximum annual deductible and out-of-pocket limits under the Plan.

Contact the Plan Administrator for more information.

MEDICAL EXCLUSIONS AND LIMITATIONS

The Plan will not provide benefits for any services, treatments, or supplies which are not specified as a covered benefit.

No payment will be eligible under any portion of this Plan for expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits and any such payment does not waive the written exclusions, limitations, or other terms of the Plan.

Abortions: Expenses related to elective abortions, except as specified under the Maternity benefit under Eligible Medical Expenses.

Acupuncture

Administrative Services: Expenses for completion of claim forms or medical records

After Termination Date: Expenses which are Incurred after the termination date of your coverage under the Plan, except as specified under Termination of Benefits While Inpatient.

Ambulance, if not for an Emergency Medical Condition: Expenses for air ambulance transportation that is not considered an Emergency Medical Condition.

Anesthesia: Expenses for topical anesthetics or standby anesthesia.

Behavioral Disorders: Treatment specifically related to Autism Spectrum Disorder, hyperkinetic syndromes, learning disabilities, behavioral problems and developmental delays, except as specified. Services that are otherwise provided by the public schools, Ohio's Complex Medical Help Program or other public programs are not covered.

Biofeedback

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

Close Relative: Expenses for services, care or supplies provided by a person who normally resides in the Covered Person's home or by a Close Relative.

Cognitive and Kinetic Therapy: Cognitive therapy is defined as therapy which embraces mental activities associated with thinking, learning and memory. Kinetic therapy is defined as therapy related to motion or movement (e.g., the study of motion, acceleration or rate of change).

Complications: Expenses for care, services or treatment required as a result of complications from a treatment or procedure not covered under the Plan, including procedures for Morbid Obesity or if a benefit maximum is reached. This exclusion does not apply to complications from non-covered abortions as specified under Eligible Medical Expenses.

Convenience Items: Expenses for personal hygiene and convenience items.

Cosmetic Procedures: Expenses for Cosmetic and reconstructive procedures will not be considered eligible, except as specified under Eligible Medical Expenses.

Counseling: Expenses for religious, marital, bereavement or relationship counseling, except as specified under Eligible Medical Expenses.

Court Ordered: Expenses for court ordered care, unless the Plan concurs that such services are Medically Necessary.

Custodial Care

Dental Care: Expenses Incurred in connection with dental care, treatment, x-rays, general anesthesia, or Hospital expenses, except as specified under Eligible Medical Expenses.

Department Maintained by an Employer: Expenses for services received from a dental or medical department maintained by an Employer, labor union, etc., where the individual is eligible under any group insurance plan.

Developmental Delays: Treatment specifically related to learning disabilities and developmental delays, except as specified. Services that are otherwise provided by the public schools, Ohio's Complex Medical Help Program or other public programs are not covered.

Diagnostic Admissions: Expenses for room and board, and general nursing care for Hospital admissions mainly for physical therapy or diagnostic studies.

Emergency Room, if not for an Emergency Medical Condition

Environmental: Expenses for hospitalization for environmental change.

Exams: Expenses not otherwise covered under the Plan for premarital examinations, screening exams, x-rays made without film, and/or physical exams required by an Employer in order to begin or continue working will not be considered eligible.

Excluded Charges: Deductibles, Coinsurance and Copays required under the Plan. Also excluded are charges that are not Medically Necessary if pre-certification was requested but denied by the Plan or for any days of Inpatient care that exceeds the number of days pre-certified/certified as appropriate for the condition, regardless of whether for an emergency or elective admission.

Exercise Programs: Expenses for exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.

Experimental and/or Investigational: Expenses for treatment, procedures, devices, drugs or medicines which are determined to be Experimental and/or Investigational, including any related complications.

Foot Care: Expenses for routine foot care only to improve comfort or appearance, treatment of weak, unstable, or flat feet, subluxations, calluses, toenails, and routine treatment of corns or bunions, and the like.

Fraud: Expenses for fraudulent or misrepresented claims.

Gender Reassignment: Expenses leading to or in connection with gender reassignment are excluded.

Gene and Cell Therapy: Expenses for gene and cell therapy procedures and medicines, as defined by the United States Food and Drug Administration ("FDA") will not be considered eligible. The FDA defines "gene therapy" to include cellular therapy products, human gene therapy products, and certain devices related to cell and gene therapy. Cellular therapy products include cellular immunotherapies, cancer vaccines, and other types of both autologous and allogeneic cells for certain therapeutic indications, including hematopoietic stem cells and adult and embryonic stem cells. Human gene therapy seeks to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use.

Governmental Agency: Expenses for services and supplies which are provided by any governmental agency, including military facilities, for which the Covered Person is not liable for payment. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military Dependents).

Hair Loss: Expenses for hair loss, hair transplants, wigs or any drug that promises hair growth, whether or not prescribed by a Physician, except as specified under Eligible Medical Expenses.

Hypnotherapy: Expenses for hypnotherapy will not be considered eligible.

Illegal Occupation/Felony: Expenses for or in connection with an Injury or Illness arising out of an illegal occupation, commission of a felony, civil disobedience, or committing or attempting to commit a crime, criminal act, assault, etc. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or due to an act of domestic violence.

Infertility/Fertilization: Expenses for drugs, tests, and any and all related services for infertility, in-vitro fertilization, and artificial insemination, with the exception of initial diagnosis of infertility only.

License: Expenses for services which are not performed within the scope of the provider's license.

Maintenance Services: Expenses for Maintenance Services of any type when the individual has reached the maximum level of improvement includes services to preserve present level or prevent regression.

Massage Therapy: Expenses for massage therapy or Rolfing.

Medically Necessary: Expenses which are determined not to be Medically Necessary except as specified.

Medicare: Expenses paid or would have been paid by Medicare regardless if the Covered Person enrolled or claimed Medicare benefits. This does not apply when the Covered Person is eligible for Medicare and this Plan is required to be primary under federal law.

Military: Expenses for a military service related injury, ailment, condition, disease, disorder or illness.

Missed Appointments

No Legal Obligation: Expenses for services provided for which the Covered Person has no legal obligation to pay. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires this Employer's Plan to be primary.

Non-Covered Procedures: Expenses for services related to a non-covered Surgery or procedure regardless of when the Surgery or procedure was performed.

Not Recommended or Performed Under the Direction of a Physician: Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician, or expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician.

Nutritional Counseling: Expenses related to nutritional counseling, except as otherwise specified under the Eligible Medical Expenses section of the Plan.

Nutritional Supplements: Expenses for nutritional supplements or other enteral supplementation, except as specified under Eligible Medical Expenses. Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

Obesity: Expenses for surgical and non-surgical care and treatment of obesity including weight loss, whether or not it is in any case a part of a treatment plan for another illness, including complications as a result of treatment. Additionally, expenses for non-surgical treatment of Morbid Obesity, except as specified under Eligible Medical Expenses.

Occupational Therapy: Expenses for occupational therapy primarily for recreational or social interaction.

Operated by the Government: Expenses for treatment at a facility owned or operated by the government unless the Covered Person is legally obligated to pay. This does not apply to Covered Expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury.

Orphan Drugs: Expenses for orphan drugs, as defined by the United States Food and Drug Administration ("FDA") will not be considered eligible. "An orphan drug is defined in the 1984 amendments of the U.S. Orphan Drug Act (ODA) as a drug intended to treat a condition affecting fewer than 200,000 persons in the United States, or which will not be profitable within 7 years following approval by the FDA."

Outside the United States (U.S.): Expenses for services or supplies if the Covered Person leaves the U.S. or the U.S. Territories for the express purpose of receiving medical treatment.

Penalties: The amount of charges required to satisfy the non-compliance penalty for services which require Pre-Certification when the Covered Person fails to request precertification, even if the Plan would have approved the services had the precertification been made on a timely basis.

Plan Maximums: Expenses for charges in excess of Plan maximums.

Prior to Effective Date: Expenses which are Incurred prior to the effective date of your coverage under the Plan.

Radioactive Contamination: Expenses Incurred as the result of radioactive contamination or the hazardous properties of nuclear material.

Recreational and Educational Therapy: Expenses for recreational and educational services; vocational testing or training; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies.

Refractive Errors: Expenses for radial keratotomy, Lasik Surgery, or any Surgical Procedure to correct refractive errors of the eye.

Required by Law: In any case where an individual is required by law to maintain insurance coverage (or to maintain any other security or reserve amount in lieu of insurance coverage), expenses of a Covered Person that would be paid by such insurance coverage, regardless of whether the individual is in fact covered under such coverage. For purposes of any required automobile, motorcycle or other vehicle coverage, otherwise eligible expenses below the minimum required coverage or the actual coverage elected, whichever is higher, will be excluded from coverage under this Plan.

Riot/Revolt: Expenses resulting from a Covered Person's voluntary participation in a riot, civil disobedience, or revolt.

Services Not Permitted Under Applicable State or Local Laws: Some state or local laws restrict the scope of health care services that a provider may render. In such cases, the Plan will not cover such health care services.

Sexual Dysfunction/Impotence: Expenses for services, supplies or drugs related to sexual dysfunction/ impotence not related to organic disease. Expenses for sex therapy will not be considered eligible.

Smoking Cessation: Expenses for smoking and tobacco cessation programs, including smoking/tobacco deterrents.

Speech Therapy: Expenses for services due to a psychological or functional nervous disorder, services to correct learning disabilities and developmental delays, and services that are otherwise provided by the public schools, Ohio's Complex Medical Help Program or other public programs are not covered

Stand-by Physician: Expenses for technical medical assistance or stand-by Physician services.

Sterilization: Expenses for the reversal of elective sterilization.

Surrogate: Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan and for any Covered Person other than the Employee and Spouse, including but not limited to pre-pregnancy, conception, prenatal, childbirth and postnatal expenses.

Telemedicine: Telephone or video consultations/visits that are not in person are limited to six visits per benefit period.

Temporomandibular Joint Dysfunction (TMJ): Expenses for treatment due to Temporomandibular Joint Dysfunction (TMJ) with intraoral prosthetic devices or by any other method to alter vertical dimension; or for the treatment of TMJ not caused by documented organic disease or physical trauma.

Travel: Expenses for travel, except as specified under Eligible Medical Expenses.

Usual and Customary Charge: Expenses in excess of the Usual and Customary Charge.

Vision Care: Expenses for vision care, including routine eye exams, professional services for the fitting and/or supply of lenses, frames, contact lenses and other fabricated optical devices. However, benefits will be provided for the necessary initial placement of a pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye for aphakic patients; soft lenses or sclera shells intended for use as corneal bandages; or vision therapy as specified under Eligible Medical Expenses.

War: Expenses for the treatment of Illness or Injury resulting from actively participating in a war or any act of war or terrorism, whether declared or undeclared, civil war, hostilities, or invasion, or while in the armed forces of any country or international organization.

Workers' Compensation: Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Workers' Compensation Law or occupational disease law or similar legislation, regardless of whether enrolled or a claim is filed. Expenses for Injuries or Illness which were eligible for payment under Workers' Compensation or similar law and have reached the maximum reimbursement paid under Workers' Compensation or similar law.

Additional Plan exclusions may be found under the Prescription Drug, Vision Care, Dental Care or Life coverage.

PRESCRIPTION DRUG BENEFIT

Prescription Drug Benefits are available to you and your covered family members when provided through the Prescription Savings Program, a participating retail pharmacy or through the mail order vendor contracting with the Plan. There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.

A Formulary identifies Federal legend drugs that the Plan may consider for payment. Select over-the-counter (OTC) drugs are included in the formulary with a valid prescription. Note that not all medications are covered under the Formulary.

At each new or refilled prescription, you are responsible for a Copayment as listed in the Schedule of Benefits below.

The Plan has partnered with the Community Health Center to identify possible cost savings in your drug coverage, and also provides an Outpatient Site of Care Program for the administration of high-cost outpatient infusions and injectable therapies.

Vaccinations can also be administered under the prescription drug benefit.

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

Benefit Period: Calendar Year (January 1 – December 31)

Precertification is required by contacting the Plan prior to receiving high-cost outpatient infusion/injectable prescription medications over $1,000 or drugs that are listed in excluded/limited listing under the Prescription Benefit. The Plan will determine the purchase point and/or will direct the member to the Site of Care program.

The Plan retains discretion to limit benefits for Prescription Drugs if the only clinical results are deemed to be lifestyle improvements and not necessarily for the cure or prevention of disease, Illness or Injury.

BENEFIT DESCRIPTION	**PRESCRIPTION SAVINGS PROGRAM**	**PARTICIPATING RETAIL PHARMACY** Up to a 34-Day Supply	**MAIL ORDER PROGRAM** Up to a 90-Day Supply
Tier 1 Generic or Select Over-the-Counter (OTC) Vaccinations	$5 Copay up to a 90-day supply	$5 Copay	$10 Copay
Tier 2 Preferred Brand Name	$5 Copay up to a 90-day supply	$20 Copay + 20% of Total Claim Charge $45 maximum	$40 Copay + 20% of Total Claim Charge $90 maximum
Tier 3 Non-Preferred Brand Name	$5 Copay up to a 90-day supply	$20 Copay + 20% of TCC $85 maximum	$40 Copay + 20% of TCC $170 maximum
Medical Necessity Review Limited/Excluded	$5 Copay may be limited to a 30-day supply	$20 Copay + 50% of TCC $200 maximum	N/A

Total Claim Charge (TCC) = Drug Ingredient Cost plus Dispensing Fee

Prescription Savings Program

The Plan has partnered with the Wood County Community Health Center to combine quality medical care for ongoing, routine treatment with low cost copays for prescription medications (including medications under the Medical Necessity Review process). The Prescription Savings Program is available to you and Dependents enrolled in the Plan as primary and does not coordinate benefits with other coverage.

To access the Program, the Covered Person must transfer primary care services to the Center. This grants full access to the Center's on-site Pharmacy. You can continue to seek treatment from your specialist who may prescribe medications to be filled at the Center.

To ensure the effectiveness of a medication, any prescription for a new medication will be limited to a 30-day fill. After that, a 90-day fill will be available with the exception of any prescription over $1,000. Please note that not all medications are available through this program. Contact the Plan with questions regarding this program.

Prescription Formulary

A prescription Formulary is utilized for members seeking prescriptions outside the Prescription Savings Program.

The Formulary identifies those medications most frequently prescribed and places them within tiers to create steerage to effective, lower net ingredient cost drugs. Updates to the Formulary are made throughout the year based on market trends resulting in tier and/or coverage changes. While a drug may be listed in the Formulary, the drug may fall under the Plan's Excluded and Limited Services.

You are responsible for your copay based on the drug tier of the covered medication and the Plan pays the balance.

To see what tier medications fall under in the Formulary, visit the vendor listed in the Summary Plan Description. This an on-line tool provides access to your prescription claims history, printable list of prescribed medications, Formulary listing/drug look-up tool, cost comparisons, drug information, and a pharmacy locator. To register for this tool, visit the insurance page of the employee website.

Select Over-the-Counter (OTC) Medications

Select OTC medications are covered under the Plan. To receive the benefit at the retail pharmacy, the Covered Person must submit a valid prescription at the pharmacy counter for payment through the Prescription Drug Benefit. Select OTC medications may also be purchased through the mail order program by sending in a valid prescription. Refer to the Summary Plan Description for the complete list of covered OTC medications.

Mail Order Program

You may receive up to a 90-day supply through the Mail Order program. The initial order requires the original prescription from your physician. Allow additional time for initial set up, processing, and delivery. Additional information on this program may be obtained from the employee website or directly from the Third Party Administrator or your Insurance Group Representative. Refills may be obtained by calling a toll free number or the Third Party Administrator's website as listed in the Summary Plan Description.

Mandatory Generic Program

The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent, the Covered Person is responsible for the copay along with the cost difference between the Generic and Preferred or Non-Preferred Drug, unless DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Outpatient Prescriptions/Site of Care Program

The Plan has established a Site of Care Program for the procurement and/or administration of high cost medications including outpatient infusion/injectable prescription medications over $1,000 and excluded/limited drugs approved under medical necessity review. This program is mandatory for a Covered Person receiving services through the Plan's medical or prescription benefits. Precertification is required through the Plan prior to receiving services. The Plan reserves the right to direct site of care.

Claim Submission

The Covered Person must present the prescription and Prescription Drug Card at a participating pharmacy. The participating pharmacy will bill the Plan for the prescription. The Covered Person is responsible for the copayment requirement at the time of purchase.

If you purchase a drug while out of the area at a Non-Participating Provider, you must pay the full cost of the prescription and may request reimbursement by submitting a claim form and detailed receipt to the Third Party Administrator within 90 days of purchase. Claim forms may be obtained from the employee website or directly from Plan or the Insurance Group Representative.

The Plan is not liable for consideration and/or payment of any claim, unless it receives written notice that Covered Services have been received by a Participant. The notice must be given within 12 months of receiving the Covered Services, and must have the data the Plan requires to determine benefits. An expense is considered Incurred on the date the service or supply was given.

Coordination of Benefits

Coordination of benefits is not available through the Medical Benefit. Syringes associated with the administration of insulin are available under this benefit. Diabetic supplies may be covered by the prescription plan or the medical plan, but not both.

Secondary coverage beyond the plans Copayments may be reimbursable under the Plan upon submission of a receipt and claim form.

Coordination of Benefits for the Prescription Drug Program follows those provisions outlined in the General Provisions section under Coordination of Benefits.

Excluded and Limited Services

1) Drugs not requiring a prescription by federal law unless otherwise noted under Covered Services (including drugs requiring a prescription by state law, but not by federal law).

2) The cost differential between brand-name product dispensed and the available generic equivalent when the brand product is dispensed solely at the request of the member.

3) Injectable drugs other than insulin, Epi-Pen, Ana-Kit, Ana-Guard/Glucagon.

4) Topical products for Cosmetic purposes with the exception of drugs for the treatment of acne for those under age 35.

5) Charges for drugs classed as dietary aids or food supplements.

6) Anorexics (any drug used for the purpose of weight control).

7) Smoking cessation or deterrent drugs. These may be eligible for reimbursement through the Wellness Program.

8) Vitamins, including Legend vitamins (other than prenatal vitamins prescribed by a licensed provider).

9) Charges for growth hormones.

10) Immunosuppressants.

11) Fertility medication.

12) Therapeutic devices or appliances, including support garments and other non-medicinal substances, hypodermic needles and syringes except in conjunction with insulin.

13) Charges for allergy extracts, biological sera, blood or blood components.

14) Prescriptions that eligible Participants are entitled to receive without charge from any Workers' Compensation Laws, and municipal, state, or federal program.

15) Drugs labeled: "Caution: Limited by Federal Law to investigational use", or Experimental drugs, even though a charge is made to the Participant.

16) Any prescription filled in excess of the Plan limits, the number specified by the physician, or any refill dispensed after one year from the physician's original order or exceeding the recommended maximum daily dosage and any quantity limits defined in the Formulary.

17) Any drug for the treatment of alopecia (hair loss).

18) Charges Incurred on or after the date coverage under this Plan is terminated.

19) Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home or

similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

20) Medications for migraines will have a quantity limit per 30 calendar days. Migraine nasal spray and injectable drugs are excluded.

21) All drugs for erectile dysfunction regardless of cause.

22) Drugs over $1,000 shall be subject to prior approval before dispensing, compounded medications have a limit of $150 and must contain at least one medicinal substance (Federal Legend Drug).

23) Neuraminidase (Flu) inhibitors – 2 treatment courses per year – retail pharmacy setting only.

24) Any charges above Usual and Customary amount.

25) Drugs purchased at non-preferred providers.

26) Soaps/Shampoos.

27) All drugs newly on the market – excluded for three years from approval by the FDA.

28) Requests for reimbursement for drugs purchased at an out-of-area, Non-Participating Provider after 90 days of purchase.

29) Gene and cell therapy.

30) Orphan Drugs as defined by the FDA.

Medical Necessity Review

Coverage for Excluded and Limited Services may be authorized and approved by the Medical Manager and/or Plan based on Medical Necessity and other Plan design features. Approval is required prior to Plan payment.

Prior to purchase, you and your physician must complete a Medical Necessity Review form. Insufficient or incomplete information may result in a delay or denial of claim. The form may be obtained from the employee website or directly from the Plan.

The Plan will notify you upon completion of the review and will notify you of any limitations that may apply, including site of care. All approvals and reviews are subject to Plan design changes and are limited to a maximum of one year.

If approved by the Medical Manager, coverage is effective on the date the Medical Necessity Review form is signed by the provider. Such prescriptions are covered at the following level:

Rx Savings Program: $5 Copay, may be limited to a 30-day supply

Pharmacy: $20 plus $50% of the TCC ; maximum $200 out-of-pocket

VISION CARE SERVICES PROGRAM

The Vision Care Services Program is designed to offer retrospective payment for services related to vision correction.

You are eligible to receive financial assistance up to the program's reimbursement limit for covered vision care services for yourself and Covered Dependents. Services must be performed by a Physician (ophthalmologist), optometrist, or dispensing optician.

VISION CARE BENEFITS

Benefit Period: Calendar Year (January 1 – December 31)

Reimbursement Limit	$150 per covered member
Coordination of Benefits	Not available. Plan only pays as Primary. Secondary coverage is not available.
Covered Services	
Eye Examination	Charges for any examination or analysis of the eyes and related structures in order to determine the presence of vision problems.
Lenses	Any necessary lenses prescribed for the purpose of correcting vision problems.
Frames	Frames associated with lenses prescribed for the purpose of correcting vision problems.
Contact Lenses	Prescribed for the purpose of correcting vision problems.
Refractive Surgery	Surgery to the eye performed by a licensed provider such as radial keratotomy, lasik Surgery or similar procedures intended to correct refractive errors.

Claim Submission

To request reimbursement for yourself or a Covered Dependent, you must submit a Vision Services Claim Submission Form and the original, detailed invoice(s) for covered services to your Insurance Group Representative.

Vision claims are processed once a month by the Plan with reimbursement paid from the Health Benefits Trust Fund directly to the employee. Any remaining reimbursement at the end of the benefit period will carry over into the next benefit period. The amount carried over will be exhausted prior to utilizing the reimbursement amount from the new benefit period. In no event will funds be carried over more than one benefit period.

All vision claims for the benefit period must be submitted to your Insurance Group Representative by March 31 of the next calendar year.

An expense is considered Incurred as of the date of:

1) The eye examination or refractive Surgery.

2) The original, detailed receipt for frames, lenses, and/or contact lenses.

The Plan is not liable for consideration and/or payment of any claim, unless it receives written notice that Covered Services have been received by a Covered Person and the detailed information required by the Plan is received.

The Wood County Vision Services Program, Wood County, county employees, and officials, assume no liability with respect to any relationship you or your Covered Dependents incur in conjunction with seeking and/or receiving vision service cares.

Vision Care Benefit Excluded Services

The Plan will not provide benefits for any services which are not specified as a covered benefit.

No payment will be eligible under any portion of this Plan for expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits and any such payment does not waive the written exclusions, limitations, or other terms of the Plan.

1. **Cosmetic/Non-Corrective:** Contact lenses, lenses or frames associated with non-corrective lenses including non-corrective sunglasses.
2. **Excluded Charges:** Premiums, Deductibles, Coinsurance, Copays, services, or materials provided by any other vision care plan, discount plan, or group benefit plan (including other Wood County benefit programs) containing benefits for vision care.
3. **Medical/Surgical Services**: Services rendered to the eye and related structures that are the result of disease and/or Injury.
4. **Orthoptics or vision training**
5. **Service Maintenance Agreements:** Any service maintenance agreements, accident/replacement insurance, warranties, etc.
6. **Supplies:** Any supplies used in conjunction with glasses or contact lenses.
7. **Worker's Compensation**: Services or materials provided as a result of any Workers' Compensation law or similar legislation.

DENTAL CARE BENEFIT

Dental Care Benefits are available to you and your Covered Dependents when provided by a licensed dentist.

Choice of Providers

You have a free choice of any provider and you, together with your provider, are ultimately responsible for determining the appropriate course of treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

The Plan Sponsor has entered into agreements that provide access to one or more networks of Participating Providers (In-Network). Participating Providers are independent contractors; neither the Plan nor the Plan Sponsor makes any warranty as to the quality of care that may be rendered by any Participating Provider. Refer to the Summary Plan Description on cost saving measures realized by you and the Plan by using participating providers. The maximum fee allowed per procedure for services rendered by a Nonparticipating Dentist are determined by the Plan and you are responsible for the difference between the Nonparticipating Dentist's bill and the amount allowed by the Plan (balanced billing).

DENTAL SCHEDULE OF BENEFITS

Benefit Period: Calendar Year (January 1 – December 31)

Co-Insurance	Class I: 0% Class II: 20% Class III and Class IV: 50%
Deductible	$100 per Covered Person (not applicable to Class I and orthodontic services)
Maximum Benefit	$1,500 per Benefit Period (excluding Class I services and orthodontic services) $1,500 per eligible Covered Person per lifetime for orthodontic services
Covered Services	**Participating Provider**
CLASS I: **Diagnostic/Preventative Services** Emergency palliative treatment to temporarily relieve pain The following are limited to two per Benefit Period: • Oral Exams • Periodontal prophylaxes (cleaning) • Fluoride treatments • Brush biopsy to detect oral cancer The following are limited to one per Benefit Period: • Bitewing Radiographs The following are limited per tooth per lifetime: • Sealants to prevent decay of permanent molars To age 9 for first molars To age 14 for second molars	100% Not Subject to Deductible or Copay

CLASS II: Basic Services Radiographs • Full mouth x-rays are limited to once every five years. Minor Restorative Services • Composite resin (white) limited to anterior teeth Endodontic Services Periodontic Services to treat gum disease • Frequency limitations may apply based on treatment area Oral Surgery for extractions/dental Surgery Other basic services Relines and repairs to bridges, implants and dentures	80% after Deductible
CLASS III: Major Services Major Restorative Services Porcelain and resin facings on crowns are limited anterior teeth Prosthodonotic Services The following are limited to once per tooth every five years: Implants Crowns over implants	50% after Deductible
CLASS IV: Orthodontic Services Limited to the end of the calendar year of age 19	50% not subject to Deductible

Predetermination of Benefits

You are not required to seek a Predetermination prior to seeking services; however, an estimate of the costs of covered services may be requested before services are provided and is recommended before the dentist provides any services where the total charges will likely exceed $200. Predetermination is merely a convenience so that you will know before the dental service is provided how much, if any, of the costs of that service is not covered by the Plan. Benefits payable under the Plan are the same whether or not a Predetermination is requested.

ELIGIBLE DENTAL EXPENSES

All Covered Services are subject to the exclusions listed under Exclusions and Limitations.

Class I Benefits

Diagnostic Services include oral examinations and emergency palliative treatment.

Preventative Services payable twice per Benefit Period include prophylaxes (cleanings), bitewing radiographs, and fluoride treatments.

Sealants to prevent decay of permanent molars (to age nine on first molars; to age 14 on second molars). Sealants are payable once per tooth per lifetime. The surface must be free from decay and restorations.

Members with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. Contact the Dental Administrator for additional information prior to seeking treatment beyond that specified above.

Class II Benefits

Radiographs include X-rays, as required and in conjunction with the diagnosis of a specific condition requiring treatment. (Full mouth x-rays/panorex are a benefit once in a five-year period).

Oral Surgery includes extractions and other surgical dental procedures employed by dentists, including pre-operative and post-operative care.

Minor Restorative Services include amalgams (silver fillings) and resin restorations and relines and repairs to prosthetic appliances. Resin restorations are optional for posterior teeth and you will be responsible for the cost difference between the amalgam filling and the resin restoration.

Peridontics include procedures employed by dentists to treat diseases of the gums and supporting structures of the teeth.

Endontics include procedures employed by dentists to treat teeth with diseased or damaged nerves (for example, root canals).

Class III Benefits

Prosthodontics includes procedures for the construction of bridges, partial dentures, and complete dentures.

Major Restorative Services include cast restorations and crowns, but only when the tooth cannot be restored with another filling material. Porcelain and resin facings on crowns are optional treatment on posterior teeth and you will be responsible for the difference.

Implants are payable once per tooth in any five-year period.

Crowns over implants are payable once per tooth in any five-year period.

Class IV Benefits

Orthodontics includes treatment and procedures required for the correction of malposed teeth (to the end of the Calendar Year in which the covered member reaches age 19).

When orthodontic treatment begins, your dentist will submit a payment plan to the Plan based on your projected course of treatment. An initial payment will be made equal to the stated copayment on 30% of the maximum payment for orthodontic services. Additional payments will be made based on 50% of the monthly fee charged by your dentist based upon the agreed upon payment plan provided by your dentist.

Exclusions and Limitations

The Plan will make no payment for the following exclusions and limitations as noted below. All charges for these services will be your responsibility.

Composite resin (white) restorations are optional treatment on posterior teeth. The member is responsible for the cost difference.

Porcelain and resin facings on crowns are optional treatment on posterior teeth. The member is responsible for the cost difference.

Certain Periodontal services have frequency limitations based on treatment area. Please contact Customer Service for Specific Procedure limitations/information.

See Appendix B for a full listing of the Dental Administrator’s exclusions and limitations.

LIFE INSURANCE

Enrollment in the life insurance benefit is mandatory for benefit eligible employees and requires completion of the confidential Mandatory Wellness Screening for enrollment, even if waiving benefits.

Continuation coverage, conversion privileges and disability waiver information may be available. Contact the Plan for available options.

LIFE INSURANCE BENEFIT

Benefit Period:	Condition of Employment
Benefit Amount:	$20,000*

* Board of Development Disabilities employees refer to the Board of Developmental Disabilities Life Certificate on the employee website.

Claim Submission

A death benefit is payable upon your death. Beneficiary designation will follow state designation unless otherwise communicated in writing to the Plan. Contact the Plan for assistance when filing a death claim.

CLAIM PROCEDURES

You will receive an identification card which will contain important information, including precertification requirements, claim filing directions and contact information. At the time you receive treatment, present the identification card to your provider of service.

To receive benefits under the Plan, the claimant (i.e., you and your covered Dependents) must follow the procedures outlined in this section.

Participating Providers will file your claims on your behalf. Should you have to file the claim yourself, you must submit the required claim form and itemized copy of billed charges to the address on the identification card. Claim forms are available on the employee website.

Claims for Covered Services may not be received in the same order in which services were rendered. Regardless of the order claims are Incurred, the Deductible and Co-Payment will be applied in the sequence in which claims are received and processed for payment.

A call from a provider who wants to know if an individual is covered under the Plan or if a certain procedure or treatment is a Covered Expense before the treatment is rendered, is not a “claim” since an actual written claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Timely Filing

All claims must be filed with the Plan within 12 months following the date services were Incurred. All vision claims for the benefit period must be submitted to your Insurance Group Representative by March 31 of the next calendar year. Claims filed after this time period will be denied.

Calculation of Time Periods

For purposes of the time periods described in the Plan's claim procedures, the period of time during which a benefit determination is required to be made begins at the time a claim (or a request for review of an adverse benefit determination) is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary for a claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to you until the date you respond or, if earlier, until 45 days from the date you receive (or were reasonably expected to receive) the notice requesting additional information.

Procedures for all Claims

The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed. Days means calendar days.

There are 4 different types of claims: 1) Post-Service Claims; 2) Pre-Service Claims; 3) Urgent Care Claims; and 4) Concurrent Care Claims. The procedures for each type of claim are more fully described below:

<u>Post-Service Claims</u>

Most claims under the Plan will be “post service claims.” A “post service claim” is a claim for a benefit under the Plan after the services have been rendered.

1) Post service claims must include the following information in order to be considered filed with the Plan:

   a) The date of service;

   b) The name, address, telephone number and tax identification number of the provider of the services or supplies;

   c) The place where the services were rendered;

   d) The diagnosis and procedure codes;

e) The amount of charges (including network repricing information);

f) The name of the Plan;

g) The name of the covered Employee; and

h) The name of the patient.

2) For a post-service claim, the Plan will notify you of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim.

a) If, due to special circumstances, the Plan needs additional time to process a claim, the Plan may extend the time for notifying you of the Plan's benefit determination on a one-time basis for up to 15 days provided that the Plan notifies you within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision.

b) However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Pre-Service Claims

A claim for benefits is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question. A pre-service claim review does not guarantee payment. The Plan's payment for predetermined services depends on continued eligibility and all other provisions of the Plan.

1) For a medical pre-service claim, the Plan will notify you of the Plan's 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 Plan receives the claim.

a) If, due to matters beyond the control of the Plan, the Plan needs additional time to process a claim, the Plan may extend the time to notify you of the Plan's benefit determination for up to 15 days provided that the Plan notifies you within 15 days after the Plan receives the claim, of those special circumstances and of when the Plan expects to make its decision.

b) However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

2) A dental predetermination (pre-service claim), is merely a convenience so that you will know before the dental service is provided how much, if any, of the cost of that service is not covered under your Plan. Since you may be responsible for any cost not covered under your Plan, this is likely to be useful information for you when deciding whether to incur those costs. You are not required to seek a predetermination. You will receive the same benefits under your Plan whether or not a predetermination is requested.

Urgent Care Claims

A claim for benefits is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

1) If your claim is considered an urgent care claim, the Plan will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless you fail to provide sufficient information to determine whether or to what extent, benefits are covered or payable under the Plan.

a) If you fail to provide sufficient information for the Plan to decide your claim, the Plan will notify you as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be

afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

Concurrent Care Claims

Any request by you to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies and the Plan will notify you of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Plan will notify you of the adverse determination at a time sufficiently in advance of the reduction or termination to allow you, the claimant, to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Adverse Determination

For purposes of the Plan's claim procedures, an "adverse determination" is a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan and including a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary or appropriate. Adverse determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

Manner and Content of Notice of Initial Adverse Determination

If the Plan denies a claim, it must provide to you in writing or by electronic communication:

1) An explanation of the specific reasons for the denial;

2) A reference to the Plan provision or insurance contract provision upon which the denial is based;

3) A description of any additional information or material that you must provide in order to perfect the claim;

4) An explanation of why the additional material or information is necessary;

5) Notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;

6) A statement describing your right to request a second level appeal, or if applicable, to bring an action for judicial review;

7) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon your request and without charge); and

8) If the adverse determination is based on the Plan's Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances or (b) a statement that the same will be provided upon your request and without charge.

For an adverse determination concerning an urgent care claim, the information described in this Section may be provided to you orally within the permitted time frame provided that a written or electronic notification in accordance with this section is furnished to you no later than 3 days after the oral notification.

Filing an Appeal of an Adverse Determination

If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the appeal procedures described below.

The Plan will make full and fair review of the claim and may require additional documentation to make such review. Failure to appeal on time will result in losing any rights to file suit in court, as failure to exhaust any internal administrative appeal rights are generally a prerequisite to bringing suit. The Plan has allowed for two levels of appeals for reviews on all claim denials. All initial appeals should be submitted to the Plan.

You have 180 calendar days after you receive notice of an initial adverse benefit determination within which to request a review of the adverse determination. Such request may be initiated orally or in writing; however, additional written documentation may be required.

All requests for review of adverse benefit determinations (including all relevant information) must be submitted to the Plan as listed in the Summary Plan Description, within the applicable time period noted below. You may submit written comments, documents, records and other information relating to the claim. You may be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Upon receipt of an appeal, the review will meet the following requirements:

1) The Plan will provide a review that does not afford deference to the adverse determination that is being appealed; and

2) The review will be conducted by an appropriate named fiduciary of the Plan who did not make the adverse determination that is the subject of the appeal and who is not a subordinate of the individual who made that adverse determination.

The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental and/or Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the adverse determination that is the subject of the appeal, nor a subordinate of any such individual.

The Plan will identify any medical or vocational experts whose advice is obtained on behalf of the Plan in connection with the Plan’s review of an adverse determination, without regard to whether the advice is relied upon in making the adverse determination on review.

For a requested review of an adverse determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and you by telephone, facsimile, or other available similarly expeditious method.

The reviewer will afford you an opportunity to review and receive, without charge, all relevant documents, information, and records relating to the claim and to submit issues and comments relating to the claim in writing to the Plan. The reviewer will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

Deadline for Internal Review of Appeal/Adverse Benefit Determination

1) Urgent Care Claims. For each level of appeal, the reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 36 hours after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

2) Pre-Service Claims. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 days

after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

3) Post-Service Claims. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

Notice of Decision on Internal Review of Appeal/Adverse Benefit Determinations

Upon completion of its review of an initial adverse determination (or a first-level appeal adverse determination), the reviewer will give you, in writing or by electronic notification, a notice of its benefit determination. For an adverse determination, the notice will include:

1) A description of the Plan's decision;

2) The specific reasons for the decision;

3) The relevant Plan provisions or insurance contract provisions on which its decision is based;

4) A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of, all documents, records and other information in the Plan's files which is relevant to your claim for benefits;

5) A statement describing your right to request a second level appeal or, if applicable, to bring an action for judicial review;

6) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol, or other similar criterion will be provided without charge to you upon request;

If the adverse determination on review is based on a Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances or (b) a statement that such an explanation will be provided without charge upon request.

You may request a second internal level appeal within 60 days after you receive notice of an adverse determination at the first internal level of appeal.

External Review of Adverse Benefit Determinations

If you have exhausted the Plan's internal appeal process for claims specifically related to compliance with federal protections for Surprise Billing and associated cost-sharing, you may request an external review of the Plan's final adverse determination.

The Plan will provide for an external review process in accordance with federal law.

1) You have four months following the date you receive notice of the Plan's final internal adverse determination specifically related to Surprise Billing and associated cost-sharing, within which to request an external review. The request for an external review must be submitted to the Plan as noted in the Summary Plan Description.

2) Within five business days following the date the Plan receives your external review request the Plan will complete a preliminary review. The Plan will notify you in writing within one business day after it completes the preliminary review whether the claim is eligible for the external review process:

    a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the Employee Benefits Security Administration.

b) If the request is not complete, the notice will describe information or materials needed to make the request complete. If the request is not complete and additional information or materials are needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an Independent Review Organization (IRO) (as soon as administratively feasible) to make a determination on the request for external review. Within 5 business days following assignment of the IRO, the Plan will forward to the IRO all information and materials relevant to the final internal adverse determination.

The assigned IRO will notify you in writing (within a reasonable period of time) of the request's eligibility and acceptance for external review. The notice will include a statement regarding your right to submit any additional information, within 10 business days from the date of receipt of the notice, for the IRO to consider as part of the external review process. Any such additional information received by the IRO will be forwarded on and shared with the Plan. The Plan, based upon any new information received, may reconsider its final internal adverse determination. Reconsideration by the Plan will not delay the external review process. If the Plan does not reconsider its final internal adverse benefits determination, the IRO will continue to proceed with the external review process.

Within 45 days after the IRO receives the external review request from the Plan, the IRO must provide written notice of its external review determination to you and the Plan. The IRO's notice is required to contain the following:

1) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

3) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

5) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;

6) A statement that judicial review may be available to you; and

7) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Effect of External Review Determination

A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable state or federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

Plan's Failure to Follow Procedures

If the Plan fails to follow the claim procedures described above, you will be deemed to have exhausted the Plan internal claim procedures and you will be entitled to pursue any available remedy under state or federal law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

State Insurance Laws

Nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable state law.

Statute of Limitations for Plan Claims

No legal action may be commenced or maintained to recover benefits under the Plan more than three years after the final review/appeal decision by the Plan has been rendered (or deemed rendered).

Appointment of Authorized Representative

A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan. However, in connection with a claim involving urgent care or services rendered by a Participating Provider, the Plan will permit a health care professional with knowledge of the Covered Person’s medical condition to act as the Covered Person’s authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan, in writing, to the contrary.

Physical Examinations

The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition for coverage.

COORDINATION OF BENEFITS

Coordination of Benefits sets out rules for the order of payment for Covered Expenses when you or your Covered Dependents are enrolled in two or more plans – including Medicare. This provision applies to all benefits provided under any section of this Plan. The Plan's eligibility rules also apply when determining Coordination of Benefits. A plan without a coordinating provision will always be the primary plan.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

Excess Insurance

The benefits under the Plan shall pay only after all other sources of coverage have paid (including, but not limited to, coverage resulting from a judgment at law or settlements).

The Plan's benefits will be secondary to any of the following (excess to) whenever possible and permitted by federal regulations:

1) Any primary payer besides the Plan;

2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

3) Any policy of insurance from any insurance company or guarantor of a third-party;

4) Workers' Compensation or other liability insurance company; or

5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Order of Benefit Determination

The Plan will consider the following rules establishing the order of benefit determination in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim.

The plan covering the person directly (as the named policy holder) rather than as an employee's Dependent is primary and the other plans are secondary.

1) The plan which covers a person as an employee, member, insured, subscriber or retiree, other than as a dependent, are determined before those of a plan which covers the person as a dependent.

    a. However, the benefits of a plan covering the person as a Dependent are determined before the benefits of a plan covering the person as other than a dependent if the person is a Medicare beneficiary, and as a result of Title XVIII of the Social Security Act and its implementing regulations:

        i. Medicare is secondary to the plan covering the person as a dependent; and

        ii. Medicare is primary to the plan covering the person as other than a dependent (e.g. a retired employee).

2) For Dependent children covered under more than one plan:

    a. Dependent children of parents who are married (not separated or divorced) or are living together, whether or not they have ever been married:

        i. The plan covering the parent whose birthday falls earlier in the year pays first.

ii. The plan covering the parent whose birthday falls later in the year pays second.

iii. If both parents have the same birthday, the benefit plan which covered the member for a longer period of time is primary.

b. Dependent children of separated or divorced parents, or parents who do not live together, whether or not they have ever been married:

i. A court decree may state which parent is financially responsible for health care expenses for the Dependent. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item does not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

iii. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Dependent, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

iv. If there is a court decree that would otherwise establish financial responsibility for the Child's health care expenses, the benefits of the plan that covers the Child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan that covers the Child as a Dependent Child:

i. The plan of the parent with custody pays first;

ii. The plan of the Spouse of the parent (step-parent) with custody pays next;

iii. The plan of the non-custodial parent pays next; and

iv. The plan of the Spouse of the non-custodial parent pays last.

3) A retired or laid-off Employee covered under one policy as an active worker and another policy as a retired worker: the benefits of the plan that lists the individual as an active employee is the primary plan. This would also apply to an individual covered as a Dependent under both of those policies.

4) Continuation of Coverage (COBRA): If a person whose coverage is provided under a right of continuation pursuant to state or federal law (e.g., COBRA) is also covered under another plan:

a. The plan covering the person as an employee, member, subscriber, or retiree (or as that person's Dependent) is primary.

b. The continuation coverage is secondary.

Application to Benefit Determinations

The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. When this Plan is secondary, the amount of benefits paid by plans primary to this Plan will be subtracted from the total allowable amount. The difference between the total allowable amount and the benefits paid by the primary plan(s) will become the total allowable expense under this Plan, subject to any Deductibles, Copayments, and Coinsurance. At no time will the total amount paid by all plans exceed the total allowable expense.

Vehicle Limitation

When medical payments are available (or, under applicable law should be available) under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy Deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title, or classification. If medical payments would have been available under a vehicle insurance policy if minimum legally required levels of coverage had been in effect, but the minimum level of coverage was not in effect, the Plan shall pay excess benefits only, determined as if the minimum legally required level of coverage had been in effect at the applicable time.

Allowable Expenses

"Allowable expenses" shall mean any Medically Necessary item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered in the amount that would be payable in accordance with the terms of the Plan shall be deemed to be the benefit.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will not consider as allowable expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

Other Plan

"Other Plan" means any of the following plans, other than this Plan, providing benefits or services for medical or dental care or treatment:

1) Group, blanket, or franchise insurance coverage;

2) Any group Hospital service prepayment, group medical or dental service prepayment, group practice or other group prepayment coverage;

3) Any coverage under labor-management trusteed plans, union welfare plans, Employer organization plans, school insurance or employee benefit organization plans;

4) Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;

5) Coverage under any Health Maintenance Organization (HMO); or

6) Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of Injuries arising out of a motor vehicle accident and any other medical and liability benefits received under any automobile policy.

Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this coordination of benefits provision or any provision of similar purpose of any other plan, this Plan may, without notice to any person, release to, or obtain from any insurance company or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan is deemed to consent to the release and receipt of such information and agrees to furnish to the Plan such information as may be necessary to implement this provision.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Right of Recovery

Whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Payments provision of this Plan.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations, or exclusions or should otherwise not have been paid by the Plan. This Plan may also inadvertently pay benefits that are later found to be greater than the maximum allowable charge. In this case, this Plan may recover the amount of the overpayment from the person or entity to which it was paid, primary payers or from the party on whose behalf the charge(s) were paid. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan has the right to recover any such erroneous payment.

A Covered Person, provider, another benefit plan, insurer or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan shall have discretion in deciding whether to obtain payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for any other Injury or Illness) under the Plan by the amount due as reimbursement to the Plan. The Plan may also, in its sole discretion, deny or reduce future benefits (including future benefits for any other Injury or Illness) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, most recent edition of the ICD or CPT standards, Medicare guidelines, HCPCS standards or other standards approved by the Plan or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then that Covered Person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, a Covered Person and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative or assigns ("Plan Participants") shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s) or damages arising from another party's act or omission for which the Plan has not already been reimbursed.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1) In error;

2) Pursuant to a misstatement contained in a proof of loss or a fraudulent act;

3) Pursuant to a misstatement made to obtain coverage under this Plan within 2 years after the date such coverage commences;

4) With respect to an ineligible person;

5) In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Subrogation, Third Party Recovery and Reimbursement provisions; or

6) Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Covered Person if such payment is made with respect to the Covered Person.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

Medicaid Coverage

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

Coordination of Benefits with Medicaid

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

Coordination of Benefits with Medicare

When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare.

When you, your Spouse or Dependents (as applicable) are eligible for or entitled to Medicare and covered by the Plan, the Plan at all times will be operated in accordance with any applicable Medicare secondary payer and non-discrimination rules. These rules include, where applicable, but are not necessarily limited to, rules concerning individuals with end stage renal disease, rules concerning active Employees age 65 or over and rules concerning working disabled individuals (as discussed below).

In accordance with federal law, the following rules apply in determining whether Medicare or Plan coverage is primary health care coverage:

1) The Working Aged Rule: Medicare benefits are secondary to benefits payable under the Plan for individuals entitled to Medicare due to being age 65 or over and who have Plan coverage as a result of his or her current employment status (or the current employment status of a Spouse). When you or your Spouse become eligible for Medicare due to the attainment of age 65, you or your Spouse may still be eligible for benefits provided under the Plan based on your current employment status.

2) If, as a result, you have or your Spouse has primary coverage under the Plan, the Plan will pay the portion of your Incurred expenses that are normally covered by the Plan. All or part of the remaining amount, if any, may be paid by Medicare if the expenses are covered expenses under Medicare and the portion of the expenses covered by Medicare exceeds the portion covered by the Plan. If the expenses are not covered by the Plan but are Medicare-covered expenses, then Medicare will process its payment of the expenses as if you do not have Plan coverage.

3) The Working Disabled Rule: Medicare benefits are secondary to benefits payable under the Plan for covered individuals under age 65 entitled to Medicare on the basis of disability (other than end-stage renal disease) and who are covered under the Plan as a result of current employment status with an Employer. That is, if you or your Dependents are covered by the Plan based on your current employment status, Medicare benefits are secondary

for you or your covered Dependents entitled to Medicare on the basis of disability (other than end-stage renal disease). In this case the Plan is primary.

4) End-Stage Renal Disease Rule: Medicare benefits are secondary to benefits payable under the Plan for covered individuals eligible for or entitled to Medicare benefits on the basis of end-stage renal disease ("ESRD"), for a period not to exceed 30 months generally beginning the first day of the month of eligibility or entitlement to Medicare due to ESRD. (Special rules apply if you were entitled to Medicare based on age or disability prior to becoming eligible for Medicare due to ESRD.) Because an ESRD patient can have up to a 3-month wait to obtain Medicare coverage, the Plan's primary payment responsibility may vary up to 3 months. If the basis of your entitlement to Medicare changes from ESRD to age or disability, the Plan's primary payment responsibility may terminate on the month before the month in which the change is effective and the rules set forth above, if applicable, will apply. Your Employer can provide you with more detailed information on how this rule works.

Medicare and COBRA

For most COBRA beneficiaries (e.g., the working aged or disabled Medicare beneficiaries), Medicare rules state that Medicare will be primary to COBRA continuation coverage and this would apply to this Plan’s Continuation of Benefits (COBRA) coverage. For an ESRD-related Medicare beneficiary, COBRA continuation coverage (if elected) is generally primary to Medicare during the 30-month coordination period.

Coordination of Benefits with TRICARE

The Plan at all times will be operated in accordance with any applicable TRICARE secondary payer and non-discrimination rules issued by the Department of Defense.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of you and/or your Dependents, plan beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other insurance or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

The Covered Person, his or her attorney, and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person settles, recovers, or is reimbursed by any Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation, or entity and to any Coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person fails to so pursue such rights or action.

If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Covered Person, commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

The Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Persons and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims if the Covered Person fails to file a claim or pursue damages against:

1) The responsible party, its insurer, or any other source on behalf of that party;

2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

3) Any policy of insurance from any insurance company or guarantor of a third party;

4) Workers' Compensation or other liability insurance company; or

5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, disease, or disability.

Covered Person is a Trustee Over Plan Assets

Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Covered Person understands that he/she is required to:

1) Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

2) Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

3) In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment, or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

4) Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of Injury, Illness, disease or disability, there is available or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for under the Plan's "Coordination of Benefits" section.

The Plan's benefits shall be excess to any of the following:

1) The responsible party, its insurer, or any other source on behalf of that party;

2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

3) Any policy of insurance from any insurance company or guarantor of a third party;

4) Workers' Compensation or other liability insurance company; or

5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person or filing of bankruptcy by the Covered Person, will not affect the Plan's equitable lien, the funds over which the Plan has a lien or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Covered Person dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

Obligations

It is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the Plan:

1) To cooperate with the Plan or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and cooperating in trial to preserve the Plan's rights;

2) To provide the Plan with pertinent information regarding the Illness, disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;

3) To take such action and execute such documents as the Plan may require facilitating enforcement of its subrogation and reimbursement rights;

4) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;

5) To promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received;

6) To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;

7) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or coverage;

8) To instruct his/her attorney to ensure that the Plan or its authorized representative is included as a payee on any settlement draft;

9) In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and

10) To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

If the Covered Person and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Persons' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

Minor Status

In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

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

Severability

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

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

COBRA CONTINUATION COVERAGE

The right to COBRA Continuation Coverage was created by a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and/or your eligible Dependents when your coverage under the Plan ends because of a life event known as a "qualifying event".

Qualified Beneficiary

In general, you, your Spouse and any Dependent Child covered under the Plan on the day before a qualifying event that causes you to lose coverage under the Plan is considered a "qualified beneficiary".

In addition, any Dependent Child who is born to or placed for adoption with you during a period of COBRA continuation coverage is considered a "qualified beneficiary".

Each qualified beneficiary (including a Child who is born to or placed for adoption with a covered Retiree during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

Qualifying Event

If you are a covered Employee, you, your Spouse and/or Dependent Child will become a qualified beneficiary if you lose your coverage under the Plan because of either one of the following qualifying events:

1) Your hours of employment are reduced; or

2) Your employment ends for any reason other than your gross misconduct.

You, your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 18 months provided you elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage.

You, your Spouse and Dependent Child have an independent right to elect COBRA Continuation Coverage. You and/or your Spouse may elect coverage on behalf of either one of you and parents may elect coverage on behalf of their Dependent Child.

If you are the Spouse and/or Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events:

1) Your Spouse/parent-Employee dies;

2) Your Spouse/parent-Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or

3) You/your parents become divorced or legally separated.

Your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 36 months provided such Spouse and/or Dependent Child provide notice of the qualifying event to the Employer and elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date they are given notice of their rights to elect COBRA Continuation Coverage and their obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If you are a Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose coverage under the Plan because you cease to be eligible for coverage under the Plan as a Dependent Child. You may elect to continue coverage under the Plan for up to a maximum period of 36 months provided you provide notice of the qualifying event to the Employer and elect to enroll in COBRA within 60 days following the later of; (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to

elect COBRA Continuation Coverage and your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If you, your Spouse or Dependent Child is determined to be disabled by the Social Security Act (SSA); you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To qualify for this extension in coverage, notification must be given to your Employer on a date that is both within 60 days after the later of (a) the date of the SSA determination; (b) the date coverage under the Plan would end due to the qualifying event; or (c) the date you are given notice of your obligation to provide such notice and before the end of the initial 18-month period of coverage. If you are later determined not disabled by SSA, you must notify your Employer within 30 days following the later of (a) the date of the SSA determination; or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and any Dependent Child in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. To qualify for this extension in coverage, notification must be given to your Employer within 60 days after the later of (a) the date coverage under the Plan would end due to the qualifying event or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

Notice Requirement

The notice must be postmarked (if mailed) or received by the Plan (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage is lost and if you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan or if you are eligible for an extension of COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

For qualifying events such as divorce or legal separation of the Employee and Spouse or a Dependent Child's loss of eligibility under the Plan, the notice must contain the following information:

1) Name and address of the covered Employee or former Employee;

2) Name and address of your Spouse, former Spouse, and any Dependent Child;

3) Description of the qualifying event; and

4) Date of the qualifying event.

In addition to the information above, if you, your Spouse, or any Dependent Child is determined by SSA to be disabled within 60 days after your COBRA continuation coverage begins, the notice must also contain the following information:

1) Name of person deemed disabled;

2) Date of disability determination; and

3) Copy of SSA determination letter.

If you cannot provide a copy of the SSA's determination by the deadline, complete and provide the notice as instructed and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage or extension of such coverage will be available until the copy of the SSA's determination is provided.

If the notice does not contain all of the required information, the Plan may request additional information. If the individual fails to provide such information within the time period specified in the request, the notice may be rejected.

In addition to accepting a letter with the information described above, the Plan, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse may obtain a copy by requesting it from the Plan at the address provided in this notice.

Notice must be sent to the Plan at:

Wood County Board of County Commissioners
One Courthouse Square
Bowling Green, OH 43402

Termination of COBRA Continuation Coverage

COBRA continuation coverage automatically ends 18, 29 or 36 months (whichever is applicable) after the date of the qualifying event; however, coverage may end before the end of the maximum period on the earliest of the following events:

1) The date the Plan Sponsor ceases to provide any group health plan coverage;

2) The date on which the qualified beneficiary fails to pay the required contribution;

3) The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise) or entitled to either Medicare Part A or Part B (whichever comes first); or

4) The first day of the month that begins more than 30 days after the date of the SSA's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA Continuation Coverage

Once COBRA continuation coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated. The amount you are required to pay for COBRA continuation coverage is 102% of the actual cost of coverage you elect unless you qualify for the 11-month period of extended coverage due to disability (as specified above). In the event of disability, you may be required to pay up to 150% of the actual cost of coverage you elect for the 11-month extension period.

Medicare

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

The month after your employment ends; or

The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you and https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Other Coverage Options

You may also be eligible for Medicaid or Children's Health Insurance Program (CHIP), which, if eligible, may be a coverage option in lieu of COBRA and may cost less than COBRA continuation coverage. You can learn more about these options at: www.healthcare.gov or https://www.healthcare.gov/medicaid-chip/childrens-health-insurance-program.

Additional Information

Additional information about the Plan and COBRA continuation coverage is available from the Plan Administrator, who is identified in the General Plan Information section.

Current Addresses

In order to protect your family's rights, you should keep the Plan informed of any changes in the addresses of family members.

HIPAA PRIVACY PRACTICES

The Notice of Privacy Practices describes your rights to access and control your protected health information (PHI). This notice and associated forms are posted on the Employee Website and are available through your Insurance Group Representative or the Commissioners' Office. The Plan does not share PHI or genetic information with any appointing authority or use the information for employment related purposes.

If you wish to permit your Spouse or other designee to discuss coverage with the Plan, a Covered Member must sign-off permitting the designee access to the protected health information on an annual basis. Under HIPAA regulations, a separate sign-off is required for the Plan and each Plan Administrator.

The following is a description of certain rules that apply to the Plan Sponsor regarding uses and disclosures of your health information.

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with HIPAA's standards for privacy of individually identifiable health information (the "privacy standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

1) Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or

2) Modifying, amending, or terminating the Plan.

"Summary health information" is information, which may include individually identifiable health information, that summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but that excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by 5-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

Except as described under "Disclosure of Summary Health Information to the Plan Sponsor" above or under "Disclosure of Certain Enrollment Information to the Plan Sponsor" below or under the terms of an applicable individual authorization, the Plan may disclose PHI to the Plan Sponsor and may permit the disclosure of PHI by a health insurance issuer with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the PHI to administer the Plan. The Plan Sponsor by formally adopting this Plan document certifies that it agrees to:

1) Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;

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

3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

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

5) Make available PHI in accordance with section 164.524 of the privacy standards;

6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards;

7) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards;

8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services ("HHS"), for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards;

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

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

a) The Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions, access to PHI. The Plan Sponsor will maintain a list of those persons and that list is incorporated into this document by this reference. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the Plan.

b) In the event any of the individuals described in (a) above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan administration" functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

1) The Plan documents have been amended to incorporate the above provisions; and

2) The Plan Sponsor agrees to comply with such provisions.

Disclosure of Enrollment Information to the Plan Sponsor

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

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage; Disclosures of Genetic Information

Except as otherwise provided below, the Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

The Plan will not use or disclose Genetic Information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is otherwise permitted under the privacy standards and other applicable law, but any PHI that is used or disclosed for underwriting purposes will not include Genetic Information.

"Underwriting purposes" is defined for this purpose under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in Deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); and (3) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, "underwriting purposes" does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

In accordance with HIPAA's standards for security (the "Security Standards"), to enable the Plan Sponsor to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

1) Implement and maintain administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.

3) Ensure that any agent, including any business associate or subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI.

4) Report to the Plan any security incident of which it becomes aware.

5) The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

DEFINITIONS

In this section you will find the definitions for the capitalized words found throughout this Plan. There may be additional words or terms that have a meaning that pertains to a specific section and those definitions will be found in that section. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan. Please refer to the appropriate sections of this Plan for that information.

Accident means a non-occupational sudden and unforeseen event, definite as to time and place or a deliberate act resulting in unforeseen consequences.

Ambulatory Surgical Center means a free-standing surgical center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures; (3) has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located; and (5) does not provide for overnight accommodations.

Assistant Surgeon means a Physician who actively assists the Physician in charge of a case in performing a Surgical Procedure. Depending on the type of Surgery to be performed, an operating surgeon may have one Assistant Surgeon, or 2 Assistant Surgeons if Medically Necessary. The technical aspects of the Surgery involved dictate the need for an Assistant Surgeon.

Autism Spectrum Disorder means any of the pervasive developmental disorders or autism spectrum disorder as defined by the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association available at the time an individual is first evaluated for suspected developmental delay.

Brand Name Drug means a trade name medication.

Calendar Year (Year) means January 1 – December 31.

Child means your natural born son, daughter, stepson, stepdaughter, legally adopted Child (or a Child placed with you in anticipation of adoption), or a Child for whom you are the Legal Guardian. Coverage for a Child for whom you are the Legal Guardian will remain in effect until such Child no longer meets the age requirements of an eligible Dependent under the terms of the Plan, regardless of whether or not such Child has attained age 18 (or any other applicable age of emancipation of minors).

Child Placed with You in Anticipation of Adoption means a Child that you intend to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the Child in anticipation of adoption of the Child. The Child must be available for adoption and the legal process must have commenced.

Close Relative means a Covered Person's Spouse, parent (including step-parents), sibling, Child, grandparent, or in-law.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time.

Coinsurance your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any Deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your Deductible, you would pay the copay, then your coinsurance payment would be 20% of the allowed changes. The health insurance or plan pays the rest of the allowed amount.)

Concurrent Review means the Medical Management Program Administrator will review all Inpatient admissions for a patient's length of stay. The review is based on clinical information received by the Medical Management Program Administrator from the provider or facility.

Congenital Anomaly means a physical developmental defect that is present at birth.

Copay/Copayment a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cosmetic means any procedure which is primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease.

Covered Expense means:

1) An item or service listed in the Plan as an eligible medical expense for which the Plan provides coverage.

2) For Prescription Drug expenses, any Prescription Drugs, or medicines eligible for coverage under the Prescription Drug Card Program.

Covered Person means, individually, a covered Employee and each of his or her Dependents who are covered under the Plan.

Custodial Care means care, or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Deductible an amount you owe during a benefit period for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. Separate deductibles may apply to specific services or groups of services (e.g., dental benefits). For example, if your deductible is $150, your plan won't pay anything until you've met your $150 deductible for covered health care services subject to the deductible.

Dentist means an individual who is duly licensed to practice dentistry or to perform oral Surgery in the state where the service is performed and is operating within the scope of such license. A Physician will be considered a Dentist when performing any covered dental services allowed within such license.

Dependent is a Covered Person, other than the Employee**,** who is covered by the Plan pursuant to the terms and conditions set forth in the "Eligibility for Participation" section of the Plan.

Durable Medical Equipment means equipment and supplies ordered by a health care provider for everyday or extended use that:

1) Can withstand repeated use;

2) Is primarily and customarily used to serve a medical purpose;

3) Generally is not useful to a person in the absence of an Illness or Injury; and

4) Is appropriate for use in the home.

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

1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

2) Serious impairment to bodily functions; or

3) Serious dysfunction of any bodily organ or part.

Emergency Services means treatment for an Emergency Medical Condition in a Hospital emergency room or an Independent Freestanding Emergency Department within the capabilities of the staff and facilities available at the hospital or Independent Freestanding Emergency Department, including ancillary services routinely available in an emergency department to evaluate an Emergency Medical Condition This includes evaluation of, and treatment to Stabilize an Emergency Medical Condition.

Employer means the Appointing Authority under which you are hired.

Experimental and/or Investigational means services, supplies, care, and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Plan Administrator as set forth below.

The Plan must make an independent evaluation of the Experimental or non-Experimental standings of specific technologies. The Plan shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan will be final and binding on the Plan. In addition to the above, the Plan will be guided by the following principles to determine whether a proposed treatment is deemed to be Experimental and/or Investigational:

1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be Experimental and/or Investigational; or

2) If the drug, device, medical treatment or procedure or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed, and approved by the treating facility's Institutional Review Board or other body serving a similar function or if federal law requires such review or approval, then it is deemed to be Experimental and/or Investigational; or

3) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials or is the subject of the research, Experimental, study, Investigational or other arm of on-going Phase III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational; or

4) If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the FDA for general use.

Expenses for drugs, devices, services, medical treatments, or procedures related to an Experimental and/or Investigational treatment (related services) and complications from an Experimental and/or Investigational treatment and their related services are excluded from coverage, even if such complications and related services would be covered in the absence of the Experimental and/or Investigational treatment.

Final determination of Experimental and/or Investigational, Medical Necessity and/or whether a proposed drug, device, medical treatment, or procedure is covered under the Plan will be made by and in the sole discretion of the Plan Sponsor.

FMLA means the Family and Medical Leave Act of 1993, as may be amended from time to time.

Formulary a list of drugs your plan may cover. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

Generic Drug refers to a Prescription Drug which has the equivalency of the Brand Name Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. Genetic Information will not be taken into account for purposes of (1) determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility) and (2) establishing contribution or premium accounts for coverage under the Plan.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended from time to time.

Home Health Care Agency means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions, it: (1) is duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services; (2) qualifies as a Home Health Care Agency under Medicare; (3) meets the standards of the area-wide healthcare planning agency; (4) provides skilled nursing services and other services on a visiting basis in the patient's home; (5) is responsible for administering a home health care program; and (6) supervises the delivery of a home health care program where the services are prescribed and approved in writing by the patient's attending Physician.

Hospice means an agency that provides counseling and incidental medical services and may provide room and board to terminally ill individuals and which meets all of the following requirements: (1) has obtained any required state or governmental Certificate of Need approval; (2) provides 24-hour-a-day, 7 days-a-week service; (3) is under the direct supervision of a duly qualified Physician; (4) has a nurse coordinator who is a registered nurse (R.N.) with 4 years of full-time clinical experience, at least 2 of which involved caring for terminally ill patients; (5) has a social-service coordinator who is licensed in the jurisdiction in which it is located; (6) is an agency that has as its primary purpose the provision of hospice services; (7) has a full-time administrator; (8) maintains written records of services provided to the patient; (9) the employees are bonded and it provides malpractice and malplacement insurance; (10) is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; (11) provides nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed physical therapist, certified occupational therapist, American Speech Language and Hearing Association certified speech therapist or a certified respiratory therapist; and (12) provides a home health aide acting under the direct supervision of one of the above persons while performing services specifically ordered by a Physician.

Hospital means a facility which: (1) is licensed as a Hospital where licensing is required; (2) is open at all times; (3) is operated mainly to diagnose and treat Illnesses or Injuries on an Inpatient basis; (4) has a staff of one or more Physicians on call at all times; (5) has 24-hour-a-day nursing services by registered nurses (R.N.'s); and (6) has organized facilities for major Surgery.

However, an institution specializing in the care and treatment of Mental Disorders or Substance Use Disorders which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall be deemed a Hospital.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, a Skilled Nursing Facility, a convalescent home, or a similar institution.

Hour(s) of Service mean each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer (or a related Employer) and each hour for which an Employee is paid, or entitled to payment by the Employer (or a related Employer) for a period of time during which no duties are performed due to vacation, holiday, Illness, incapacity (including disability), layoff, jury duty, military duty, or Leave of Absence, but excluding Hours of Service to the extent that the compensation for those services constitutes income from sources outside the United States or performed as (1) a bona fide volunteer (as defined in Treas. Reg. Section 54.4980H-1(a)(7)) or (2) part of a federal or state work study program. For purposes of this definition, a related Employer is any entity that must be treated as part of the same "applicable large Employer" as the Employer for purposes of Code Section 4980H, as determined at the time that the applicable Hour of Service is performed or credited.

For Employees paid on an hourly basis, an Employer must calculate actual Hours of Service from records of hours worked and hours for which payment is made or due (the "actual method"). For Employees paid on a non-hourly basis, the Employer must calculate Hours of Service based on the actual method or, provided doing so does not substantially understate the Employee's hours, using an equivalency method where the Employee is credited with either: (1) 8 Hours of Service for each day for which the Employee would be required to be credited with one Hour of Service; or (2) 40 Hours of Service for each week for which the Employee would be required to be credited with at least one Hour of Service.

Illness means a non-occupational bodily disorder, disease, physical sickness, pregnancy (including childbirth and miscarriage), Mental Disorder or Substance Use Disorder.

Incurred means the date the service is rendered, or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Independent Freestanding Emergency Department means a health care facility that is geographically separate and distinct and licensed separately from a Hospital under applicable State law and provides Emergency Services.

Injury means physical damage to the body, caused by an external force and which is due directly and independently of all other causes, to an Accident.

Inpatient means any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for room and board is made by the Hospital.

Intensive Care Unit means a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: (1) facilities for special nursing care not available in regular rooms and wards of the Hospital; (2) special lifesaving equipment which is immediately available at all times; (3) at least 2 beds for the accommodation of the critically ill; and (4) at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 31-day eligibility period. A Special Enrollee is not considered a Late Enrollee.

Leave of Absence means a Leave of Absence of an Employee that has been approved by the Employer, as provided for in the Employer's rules, policies, procedures, and practices.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of an individual that is placed with such person by judgment, decree, or other order of any court of competent jurisdiction.

Lifetime Maximum means the maximum benefit payable during an individual's lifetime while covered under this Plan. Benefits are available only when an individual is eligible for coverage under this Plan. The Plan may provide for a Lifetime Maximum benefit for specific types of medical treatment. Any Lifetime Maximum will be shown in the applicable Schedule of Benefits.

Long-Term Acute Care Facility/Hospital (LTACH) means a facility that provides specialized acute care for medically complex patients who are critically ill; have multi-system complications and/or failures and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour-a-day, 7 days a week basis. The severity of the LTACH patient's condition requires a Hospital stay that provides: (1) interactive Physician direction with daily on-site assessment; (2) significant ancillary services as dictated by complex, acute medical needs - such as full service and laboratory, radiology, respiratory care services, etc.; (3) a patient-centered outcome-focused, interdisciplinary approach requiring a Physician-directed professional team that includes intensive case management to move the patient efficiently through the continuum of care; (4) clinically competent care providers with advanced assessment and intervention skills; and (5) education for the patient and family to manage their present and future healthcare needs.

Maintenance Therapy means medical and non-medical health-related services that do not seek to cure or that are provided during periods when the medical condition of the patient is not changing or does not require continued administration by medical personnel.

Measurement Period refers to the time period that is used to track an employee's hours worked for purposes of eligibility under the Plan.

Medically Necessary/Medical Necessity means treatment is generally accepted by medical professionals in the United States as proven, effective, and appropriate for the condition based on recognized standards of the health care specialty involved.

1) "Proven" means the care is not considered Experimental and/or Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA) for general use.

2) "Effective" means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, Injury, Illness, or a clinical condition.

3) "Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the Plan.

All criteria must be satisfied. When a Physician recommends or approves certain care it does not mean that care is Medically Necessary.

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

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

Morbid Obesity is defined as (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, or musculoskeletal dysfunction.

Non-Participating Provider means a health care practitioner, health care facility, or pharmacy that has not contracted directly with the Plan or an entity contracting on behalf of the Plan to provide services to Plan enrollees.

Non-Preferred Drug refers to any Brand Name Drugs that do not appear on the list of Preferred Drugs.

Orthodontic Treatment means the corrective movement of teeth to treat a handicapping malocclusion of the mouth.

Out-of-Pocket Maximum has the same meaning as set forth in the section of this Plan entitled "General Overview of the Plan".

Participating Provider means a health care practitioner, health care facility, or pharmacy that has contracted directly with the Plan or an entity contracting on behalf of the Plan to provide services to Plan enrollees.

Physician means a legally licensed Physician who is acting within the scope of their license and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of Physician includes but is not limited to: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Nurse Practitioner, Physician's Assistant, Speech Therapist, Speech Pathologist and Licensed Midwife (if covered by the Plan). An employee of a Physician who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan.

Plan means the Wood County Employee Health Benefits Plan.

Plan Administrator means the administrator of the Plan and may include any Third Party Administrators responsible for processing and paying claims on behalf of the Plan Sponsor.

Plan Sponsor means Wood County Board of County Commissioners or any successor thereto.

Plan Year means the period from January 1 - December 31 each year.

Precertification is a requirement for the healthcare provider to obtain approval from the insurance company before a service is rendered. It ensures that the service is medically necessary and covered by the insurance plan.

Predetermination is a process in which the insurance company determines whether a specific treatment or service is covered under the patient's plan before it is provided. It provides detailed coverage information, including the percentage of costs covered.

Preferred Drug refers to a list of Brand Name Drugs that has been developed by a Pharmacy and Therapeutics Committee comprised of Physicians, Pharmacists, and other health care professionals. The list of Brand Name Drugs is subject to periodic review and modification based on a variety of factors such as, but not limited to, Generic Drug availability, Food and Drug Administration (FDA) changes, and clinical information. The Plan will have a list of Preferred Drugs available.

Prescription Drug is any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, "Caution: federal law prohibits dispensing without prescription"; (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

Qualified Medical Child Support Order/QMCSO is defined as a child support decree or order issued by a court (or a state administrative agency that has the force and effect of law under applicable state law) that obligates you to support or provide health care coverage to your Child and includes certain information concerning such coverage. The Plan Administrator will determine whether any child support order it receives constitutes a QMCSO. Except for QMCSO's, no Child is eligible for Plan coverage, even if you are required to provide coverage for that Child under the terms of a separation agreement or court order, unless the Child is an eligible Child under this Plan. Procedures for determining a QMCSO may be obtained, free of charge, by contacting the Plan.

Reconstructive Surgery means Surgery that is incidental to an Injury, Illness or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such Surgery as Cosmetic when a physical impairment exists, and the Surgery restores or improves function. Additionally, the fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Illness or Congenital Anomaly does not classify Surgery to relieve such consequences or behavior as Reconstructive Surgery.

Rehabilitation Facility means a facility must meet all of the following requirements: (1) must be for the treatment of acute Injury or Illness; (2) is licensed as an acute Rehabilitation Facility; (3) the care is under the direct supervision of a Physician; (4) services are Medically Necessary; (5) services are specific to an active written treatment plan; (6) the

patient's condition requires skilled nursing care and interventions which cannot be achieved or managed at a lower level of care; (7) nursing services are available 24 hours a day; and (8) the confinement is not for Custodial Care or maintenance care.

Seasonal Employee means an Employee who is hired into a position that recurs annually at about the same time each year for which the customary annual employment is six months or less.

Semi-Private Room means a Hospital room shared by two or more patients.

Skilled Nursing Facility is a facility that meets all of the following requirements:

1) It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

2) Its services are provided for compensation and under the full-time supervision of a Physician.

3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

4) It maintains a complete medical record on each patient.

5) It has an effective utilization review plan.

6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, developmentally disabled, Custodial, or educational care or care of Mental Disorders.

7) It is approved and licensed by Medicare.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation Hospital, Long-Term Acute Care facility or any other similar nomenclature.

Special Enrollee is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 31-day eligibility period and who later enrolls in the Plan due to a Special Enrollment Event.

Specialty Drug means a scientifically or “bioengineered” oral or injectable medicine that targets and treats a specific or “niche” condition, and includes one (1) or more of the following features:

1) it is usually a complex chemical and/or molecular compound;

2) it is offered by the manufacturer at a premium price that is generally significantly higher than those for traditional medications;

3) it is primarily prescribed and administered by a Specialist, such as an oncologist or pulmonologist;

4) it often requires special or unique storage and handling; and

5) it requires disease management services, such as patient education and monitoring.

The Plan Administrator, in its discretion and in consultation with pharmaceutical experts, will determine if a drug is considered to be a Specialty Drug under this Plan.

Spouse means any person who is lawfully married to you under any state law, who is neither divorced or legally separated. Specifically excluded from this definition is a spouse by reason of common law marriage, whether or not permitted in your state.

Stability Period refers to the period of time in which an employee is determined to be eligible for coverage under the Plan.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment for 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; or with respect to an Emergency Medical Condition of a pregnant woman who is having contractions (1) there is adequate time to effect a safe transfer to another Hospital before delivery; and (2) transfer will not pose a threat to the health or safety of the woman or her unborn child to deliver (including the placenta).

Substance Use Disorder means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

Surgery or **Surgical Procedure** means any of the following:

1) The incision, excision, debridement or cauterization of any organ or part of the body and the suturing of a wound;

2) The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;

3) The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;

4) The induction of artificial pneumothorax and the injection of sclerosing solutions;

5) Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;

6) Obstetrical delivery and dilation and curettage; or

7) Biopsy.

Surprise Bill/Surprise Billing happens when people unknowingly get care from providers that are outside of their health Plan's network and can happen for both emergency and non-emergency care.

Urgent Care Facility means a facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

Usual and Customary Charge (U&C) means, with respect to Non-Participating Providers, charges made for medical or dental services or supplies essential to the care of the individual that will be subject to a Usual and Customary determination. Subject to the rest of this definition, the Usual and Customary Charge means the lesser of the charge by other providers in the same geographic area or billed charges for the same or comparable service or supply. From time to time, the Plan may enter into an agreement with a Non-Participating Provider (directly or indirectly through a third party) which sets the rate the Plan will pay for a service or supply. In these cases the Usual and Customary Charge will be the rate established in such agreement with the Non-Participating Provider.

The Plan may reduce the Usual and Customary Charge by applying reimbursement policies administered by the Plan Administrator. These reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

1) The duration and complexity of a service;

2) Whether multiple procedures are billed at the same time, but no additional overhead is required;

3) Whether an Assistant Surgeon is involved and necessary for the service;

4) If follow up care is included;

5) Whether there are any other characteristics that may modify or make a particular service unique; and

6) When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

The reimbursement policies utilized are based on review of the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which are otherwise consistent with Physician or dental specialty society recommendations; and the views of Physicians and Dentists practicing in the relevant clinical areas.

The Usual and Customary Charge for covered services will be based on the median contract rate when a Covered Person had no control over the services performed by a Non-Participating Provider who is under agreement with a network facility or when the Covered Person seeks Emergency Services for an Emergency Medical Condition from a Non-Participating Provider.

MISCELLANEOUS INFORMATION

Assignment of Benefits

No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements, or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an alternate recipient, in the manner described in the Plan's QMCSO procedures.

Clerical Error

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to you and/or your Dependents have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity with Applicable Laws

This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions, or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of Plan. It is intended that the Plan will conform to the requirements of any applicable federal or state law.

Cost of the Plan

The Plan Sponsor is responsible for funding the Plan and will do so as required by law. The Plan is classified as a Code Section 125 welfare benefits plan by the Department of Labor and is funded by contributions from you and your employer. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan, including, but not limited to, payment of Plan expenses from the Trust. If applicable, a biometric evaluation to determine health risk factors associated with a wellness program will be paid from the Trust. The amount of contribution (if any) for your coverage or coverage for your Dependents will be determined from time to time by the Plan Sponsor, in its sole discretion.

Interpretation of this Document

The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this Plan are used for convenience of reference only. You and your Dependents are advised not to rely on any provision because of the heading.

Minimum Essential Coverage

Refer to the Employer's Summary of Benefits and Coverage (SBC) for determination as to whether the Plan provides "minimum essential coverage" within the meaning of Code Section 5000A(f) and any accompanying regulations or guidance and whether it provides "minimum value" within the meaning of Code Section 36B(c)(2)(C)(ii) and any accompanying regulations or guidance (e.g., the Plan provides at least 60% actuarial value).

No Contract of Employment

This Plan and any amendments constitute the terms and provisions of coverage under this Plan. The Plan shall not be deemed to constitute a contract of any type between the Employer and any person or to be consideration for or an inducement or condition of the employment of any Employee. Nothing in this Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

Release of Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan may, without the consent of or notice to any person, release, or obtain any information necessary to determine the acceptability of any applicant or person covered for benefits under this Plan. In so acting, the Plan shall be free from any liability that may arise with regard to such action; however, the Plan at all times will comply with the applicable privacy standards. Any Covered Person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

Workers' Compensation

This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any Workers' Compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that you received or are eligible to receive Workers' Compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement you receive from Workers' Compensation. The Plan will exercise its right to recover against you. The Plan reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

1) The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2) No final determination is made that the Injury or Illness was sustained in the course of or resulted from your employment;

3) The amount of Workers' Compensation benefits due specifically to health care expense is not agreed upon or defined by you or the Workers' Compensation carrier; or

4) The health care expense is specifically excluded from the Workers' Compensation settlement or compromise.

You are required to notify the Plan immediately when you file a claim for coverage under Workers' Compensation if a claim for the same Injury or Illness is or has been filed with this Plan. Failure to do so or to reimburse the Plan for any expenses it has paid for which coverage is available through Workers' Compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

GENERAL PLAN INFORMATION

Name of Plan:	Wood County Employee Health Benefits Plan
Plan Sponsor: **(Named Fiduciary)**	Wood County Board of County Commissioners 1 Courthouse Square Bowling Green, OH 43402 (419) 354-9100
Plan Administrator:	Wood County Board of County Commissioners 1 Courthouse Square Bowling Green, OH 43402 (419) 354-9100
Plan Sponsor EIN:	34-6401607
Plan Year:	January 1 - December 31
Plan Type:	Welfare benefit plan providing medical and prescription drug benefits. Dental and vision benefits are also available.
Plan Funding:	All benefits are paid through a trust that has been established by the Plan Sponsor for the exclusive benefit of its Employees and their eligible Dependents.
Contributions:	The cost of coverage under the Plan is funded in part by Employer contributions and in part by Employee contributions.
Third Party Administrators and Medical Management Program Administrator:	Refer to the Summary Plan Description for the current plan year administrators.
Agent for Service of Legal Process:	Wood County Board of County Commissioners 1 Courthouse Square Bowling Green, OH 43402 (419) 354-9100
Trustee(s):	Wood County Board of County Commissioners 1 Courthouse Square Bowling Green, OH 43402 (419) 354-9100

The Plan is a legal entity. Legal notice may be filed with and legal process served upon the Plan Sponsor.

APPENDIX

A. Section 125 Premium Only Plan

B. Dental Administrator's Limitations and Exclusions

APPENDIX A: SECTION 125 PLAN (PREMIUM ONLY PLAN) PLAN DOCUMENT

The purpose of the Wood County Employees' Section 125 Cafeteria Plan ("Section 125 Plan") is to provide eligible employees with a choice between receiving their full compensation for any plan year in cash or to have a portion of their compensation applied by the Employer to the payment of Employee Provided Premiums, as the case may be, under the Employer's medical/prescription drug, vision, and/or dental benefits ("Qualified Benefits"). By electing to participate in Qualified Benefit Plans available under this Section 125 Plan, your regular compensation will be reduced on a pre-tax basis by the amount of your premium payment (to the extent applicable) for the coverage selected under such plan(s).

For purposes of this Section 125 Plan, "Employee Provided Premium" means the sum of (i) that portion of the total premium cost of a Qualified Benefit Plan that requires payment of premiums, which is required to be paid by the employee, either by law or by agreement, and depending on what options exist under such plan (e.g., to the extent applicable, individual or family coverage, high or low deductibles, etc.), as adjusted from time to time to reflect changes, if any, in the percentage of such premiums paid by the employee and/or changes in the total amount of such premiums, and (ii) a pro rata share of the costs of the administration of the Section 125 Plan (allocated on a uniform basis) to the extent that the Plan Sponsor determines that such costs will be borne by employees participating in the plan.

While the election to receive benefits under one or more Qualified Benefit Plans in lieu of cash is made under this Section 125 Plan, benefits will be provided under the applicable Qualified Benefit Plan. The options available under each such plan, the requirements for participating in such options, the amount of premiums, deductibles, and co-payments (if any), the amount, timing, and conditions for the receipt of benefits and all other terms and conditions of eligibility, coverage, and benefits under such options are set forth in the Qualified Benefit Plans. Any claim which arises under a Qualified Benefit Plan will be subject to review under the Qualified Benefit Plan and not under this Section 125 Plan.

Eligibility and Enrollment

All employees who are eligible for coverage as defined in the Wood County Employee Health Benefits Plan Document are eligible to participate in the Section 125 Plan, except that employees of the Northwestern Water and Sewer District are not eligible for this Section 125 Plan.

Please note that if you are initially classified as an independent contractor (or any other non-employee designation) by your Employer and are subsequently determined to be a common law employee for any purpose, including without limitation, for wage, labor, or tax purposes by either the Internal Revenue Service, Department of Labor or any other Federal or state agency, administrative body or court, you will still be ineligible to participate in the Section 125 Plan.

You must elect coverage for one or more Qualified Benefits under the Wood County Employee Health Benefits Plan to participate. To enroll in the Section 125 Plan, you must complete an election form during your enrollment period as defined in the Wood County Employee Health Benefits Plan Document; thereafter, if no new election form is filed during the Annual Election Period, the last Election made will be deemed to continue during the new Plan Year. For the purposes of this Plan, "Plan Year" means the twelve-month period commencing January 1 and ending on the subsequent December 31. Generally, you must provide the Plan Sponsor with notice that you do not intend to participate in this Section 125 Plan at least 30 days prior to start of any Plan Year, or within seven days of the date you first participate in the Qualified Benefit Plan, as applicable.

Under the Section 125 Plan, you may choose to receive your entire compensation in cash, or use a portion to pay for any of the nontaxable benefits available under the Plan. The nontaxable benefits in this Section 125 Plan include pre-tax premium contributions provided under the Plan Sponsor's health and welfare plans/Qualified Benefit Plans available under this Section 125 Plan, as designated and announced by the Plan Sponsor from time to time.

While the election to receive benefits under one or more Qualified Benefit Plans in lieu of cash is made under this Section 125 Plan, benefits will be provided under the applicable Qualified Benefit Plan. The options available under each such plan, the requirements for participating in such options, the amount of premiums, deductibles, and co-payments (if any), the amount, timing, and conditions for the receipt of benefits and all other terms and conditions of eligibility, coverage, and benefits under such options are set forth in the Qualified Benefit Plans. Any claim which arises under a Qualified Benefit Plan will be subject to review under the Qualified Benefit Plan and not under this Section 125 Plan. The terms of those Qualified Benefit Plans control for the benefits available under those plans.

Irrevocability of Elections

Generally, you cannot change the elections you have made after the beginning of the Plan Year. However, you are permitted to change certain elections if you experience an IRS defined "change in status" and/or other special events as described below. Examples of status changes include these events:

- Marriage;
- Divorce, legal separation or annulment;
- Death of your spouse or dependent child;
- Birth, adoption, or placement for adoption of a child;
- Termination of the employment of your spouse or dependent child;
- Commencement of the employment of your spouse or dependent child;
- Your or your spouse's or dependent child's commencement or return from an unpaid leave of absence from employment;
- Adjustment to your or your spouse's or dependent child's work schedule, such as a switch between part-time and full-time work, a strike, a lockout, or an increase or reduction in hours of employment, that causes a loss of coverage;
- A change in your or your spouse's or dependent child's worksite or residence that causes a loss of current coverage eligibility;
- Adjustments in dependent status through satisfying or ceasing to satisfy the age, student status or other requirements to qualify as a dependent under the plan;
- Significant change in your or your spouse's health coverage attributable to the spouse's employment; and
- Leave of absence under the Family Medical and Leave Act.

Your election may also be changed if one of these special events occurs:

- The issuance of a judgment, decree, or order that requires accident or health coverage for your dependent child.
- Your or your spouse's or dependent child's entitlement to Medicare or Medicaid that causes a loss of coverage.
- A "significant" increase in the cost of any benefit under the Section 125 Plan. **Note: If the cost of a health and welfare plan increases or decreases during the Plan Year, this Section Plan may, on a reasonable and consistent basis, automatically change your premium contributions in response to the change in cost.*
- Elimination or "significant" cutback in coverage provided by an insurance company or other third party. You may cancel your election and receive coverage under a similar plan, provided both plans agree to make the change.
- Your failure to make the required premium payment. Your election will be canceled but you will not be able to make a new election for the rest of the Plan Year.
- Your separation from service. If you terminate employment, you may cancel your election for any remaining period of coverage.
- Your enrollment in Marketplace coverage. If you enroll or intend to enroll in Marketplace coverage during the Marketplace's annual open enrollment period or during a special enrollment period, the Administrator may permit you to cancel your election for any remaining period of coverage, provided that you (and any related individuals who cease coverage due to the revocation) enroll in a Marketplace plan effective immediately following the revocation. No change is permitted with regard to non-health benefits available under the Section 125 Plan.
- Your enrollment and/or or a related individuals' enrollment, in Marketplace coverage. If you and/or a related individual enroll or intend to enroll in Marketplace coverage during the Marketplace's annual open enrollment period or during a special enrollment period, the Administrator may permit you to cancel your election for any remaining period of coverage, provided that you and/or any related individuals who cease coverage due to the revocation enroll in a Marketplace plan effective immediately following the revocation. If only your related individual(s) enroll or intend to enroll in Marketplace coverage, you will be transitioned to self-only coverage under the Employer's health benefits. No change is permitted with regard to non-health benefits available under the Section 125 Plan.
- Your permanent change to part-time status. If your employment status changes from full-time status to part-time status and is reasonably expected to remain in part-time status, the Administrator may permit you to cancel your election for any remaining period of coverage, provided that you (and any related individuals who cease coverage due to the revocation) enroll or intend to enroll in another plan no later than the first day of

the second full month following the revocation. No change is permitted with regard to non-health benefits available under the Section 125 Plan.

If you have a status change and you want to cancel or modify your election for a Plan Year, you must file a written application with the Plan Administrator within 30 days of the event. Keep in mind that any change to your election must be on account of and consistent with your status change. The Plan Administrator will consider your application and inform you of the decision.

Elections made under this Section 125 Plan automatically terminate on the date on which you cease to be a participant in the Section 125 Plan. In the event you become a participant again within 30 days of the date you stopped being a participant and before the end of the same Plan Year, the elections you previously had in effect shall automatically be reinstated for the balance of the Plan Year.

Automatic Termination of Elections

Elections made or deemed to be made under this Section 125 Plan will automatically terminate on the date on which you (i) terminate employment with the Plan Sponsor or (ii) elect to receive cash in lieu of benefits under the Qualified Benefit Plans, although coverage or benefits under any group health plan that is a Qualified Benefit Plan may continue if and to the extent provided by such plan or as required by law. Despite any other contrary provision of the Section 125 Plan, if your employment with the Plan Sponsor terminates and you return to employment with the Plan Sponsor within thirty (30) days of such termination and within the same Plan Year of your date of termination, then your pre-termination elections under the Section 125 Plan will be automatically reinstated, and no election changes shall be permitted unless otherwise specified in the “Irrevocability of Elections” section of this Section 125 Plan.

In the case of health benefits, you may have a right by law to continue your benefits that would otherwise terminate when (i) you leave employment, (ii) you are no longer eligible under the terms of any group health plan or insurance policy, or (iii) when insurance coverage terminates.

Nondiscrimination

Under the Internal Revenue Code, “highly compensated individuals,” “highly compensated employees,” and “key employees” are employees participating in this plan who are generally highly paid employees. If you are within these categories, the amount of your contributions and benefits may be limited so that the Section 125 Plan as a whole does not unfairly favor those who are highly paid. Section 125 Plan experience will dictate whether contribution limitations on “highly compensated individuals,” “highly compensated employees,” or “key employees” will apply. You will be notified of these limitations if you are affected.

Any action taken by the Plan Administrator shall be pursuant to rules uniformly applicable to similarly situated employees participating in this Section 125 Plan to assure compliance with Internal Revenue requirements. Such action may include, without limitation, a modification of elections by such highly compensated individuals, highly compensated employees, or key employees with or without their consent.

FMLA and USERRA Leave

If you elect to maintain coverage of any Qualified Benefit while on an FMLA Leave or while absent from work for more than 31 days for duty in the Uniformed Services, you must continue to make any required contributions towards the cost of your premiums. During such absence, you may choose to make such contributions by (i) remitting payment to the Plan Sponsor on or before each pay period for which the contributions would have been deducted from the your paycheck if leave had not been taken, provided that any delinquent payments must be made within 30 days of their due date, or (ii) if you elect in writing (on forms furnished by and delivered to the Administrator not less than 30 days prior to prepayment), prepaying the amounts that will become due during such leave out of one or more of your paychecks preceding such leave. The Plan Sponsor, in its sole discretion, may agree to fund your required contributions during the leave of absence, as long as the you agree (on forms furnished by and delivered to the Administrator not less than 30 days prior to commencement of such leave of absence) to commence remitting payment to the Plan Sponsor upon your return to active employment with the Plan Sponsor following the leave of absence of all amounts paid by the Plan Sponsor on your behalf to maintain coverage; provided, however, if you fail to return to active employment with the Plan Sponsor following the leave of absence, then you shall reimburse the Plan Sponsor for such advances made on the your behalf within thirty (30) days following the Plan Sponsor’s written demand for such reimbursement. Despite the foregoing, if you are absent from work for any paid leave of absence, you must continue any and all benefits elected under this Section 125 Plan (unless the same is prohibited by any insurance

policy provision requiring an insured to be actively at work), and your contributions for those benefits that the you choose to continue while on the leave of absence will continue to be deducted from your paycheck in such absence.

Plan Administration

The administration of the Section 125 Plan will be under the supervision of the Plan Administrator. It will be a duty of the Plan Administrator to ensure that the section 125 Plan is carried out, in accordance with its terms and in a nondiscriminatory manner, for the exclusive benefit of all participating employees and their beneficiaries. The Administrator will have the power to administer the Section 125 Plan, subject to applicable requirements of law. The Administrator's powers include, but are not limited to, discretionary authority to:

- Make and enforce such rules and regulations as the Administrator deems necessary or appropriate for the efficient administration of the Section 125 Plan;
- Interpret the Section 125 Plan (such interpretation will be final, binding and conclusive with respect to all claims arising under this Section 125 Plan);
- Decide all questions concerning the eligibility of any person to participate in and to receive benefits under the Section 125 Plan, and to make all factual determinations;
- Provide employees with a reasonable and timely notification of benefit options available under the Section 125 Plan;
- Authorize the payment of benefits, which will be paid only if the Administrator decides in its sole discretion that the employee participating in this Section 125 Plan or applicant is entitled to them; and
- Appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Section 125 Plan.

Payment of Expenses

Administrative expenses will be paid by the Plan Sponsor unless the Plan Sponsor determines that administrative costs will be borne by the any employee participating under the Section 125 Plan. The Administrator may impose reasonable conditions for payments, provided that such conditions do not discriminate in favor of employees who are participating in this Section 125 Plan who are highly compensated employees or key employees.

Examination of Records

The Administrator will make available to each participating employee his or her records under this Section 125 Plan for examination at reasonable times during normal business hours.

Reliance on Tables, Etc.

In administering the Section 125 Plan, the Administrator will be entitled to rely conclusively on all tables, valuations, certificates, opinions, and reports furnished by, or in accordance with the instructions of, any insurer, or by accountants, counsel, or other experts employed or engaged by the Administrator.

Insurance Contracts Control

Despite any other provision of this Section 125 Plan, if the terms of this Section 125 Plan and the terms of an insurance contract which funds a Qualified Benefit Plan (as applicable) conflict, the terms of such insurance contract will control unless contrary to law.

Amendment of Plan

The Plan Sponsor reserves the right to amend this Section 125 Plan at any time without the consent of any employee or employee participating in the Section 125 Plan.

Termination of Plan

It is the expectation of the Plan Sponsor that it will continue this Section 125 Plan indefinitely, but the continuance of this Section 125 Plan is not assumed as a contractual obligation of the Plan Sponsor, and the right is reserved to the Plan Sponsor at any time to terminate this Section 125 Plan without liability. Upon termination of the Section 125 Plan, all elections and reductions in Compensation relating to the Section 125 Plan will terminate.

Claims Procedure

If any claim made under this Section 125 Plan is wholly or partially denied, the Administrator will notify you, or the person making such claim (the "claimant"), of his or her decision in writing. Such notification will be written in a manner

calculated to be understood by the claimant and will contain (i) specific reasons for the denial, (ii) specific reference to pertinent Section 125 Plan provisions, (iii) a description of any additional material or information necessary to perfect such claim and an explanation of why such material or information is necessary, and (iv) information as to the steps to be taken if the claimant wishes to submit a request for review. Such notification will be given within 90 days after the claim is received by the Administrator (or within 180 days, if special circumstances require an extension and if written notice of such extension is given to the claimant within the initial 90-day period). If such notification is not given within such period, the claim will be considered denied as of the last day of such period and the claimant may request review thereof. Despite the foregoing, any claim made in connection with a Qualified Benefit Plan will be subject to review thereunder and will not be subject to review under this section.

Review Procedure

Within 60 days after the date on which the claimant receives a written notice of a denied claim (or, if applicable, within 60 days after the date on which such denial is considered to have occurred) the claimant may (i) file a written request with the Administrator for a review of the denied claim and (ii) submit written comments to the Administrator. The Administrator will notify the claimant of his or her decision in writing. Such notification will be written in a manner calculated to be understood by the claimant and will contain specific reasons for the decision as well as specific references to pertinent Section 125 Plan provisions. The decision on review will be made within 60 days after the request for review is received by the Administrator (or within 120 days, if special circumstances require an extension of time for processing the request, such as an election by the Administrator to hold a hearing, and if written notice of such extension is given to the claimant within the initial 60-day period). If the decision on review is not made within such period, the claim will be considered denied.

Plan Sponsor and Administrator

The Section 125 Plan is sponsored by the Wood County Board of County Commissioners, located at One Courthouse Square, Bowling Green, Ohio 43402 (419) 354-9100. The Wood County Board of County Commissioners also act as Plan Administrator and manage the overall operations of the Section 125 Plan and decides all questions that come to it on a fair and equitable basis for employees participating in this Section 125 Plan and their beneficiaries. The Plan Administrator has appointed the Human Resources and Benefits Manager of the Commissioners' Office, located at One Courthouse Square, Bowling Green, Ohio 43402, to be responsible for the day to day operation of the Section 125 Plan.

Plan Identification Numbers

The Employer Identification Number ("EIN") assigned to the Wood County employees Health Insurance Program by the Internal Revenue Service ("IRS") is 34-6401607. You should refer to this number in any correspondence about the Section 125 Plan.

Service of Legal Process

Wood County Board of County Commissioners has designated the Plan Administrator as its agent for service of the legal process in connection with claims under the Plan. Such process may be served on the Company by directing the process to the Plan Administrator at the Wood County Board of County Commissioners' address.

Classification

This Section 125 Plan is intended to satisfy the requirements of Section 125 of the Internal Revenue Code of 1986, as amended from time to time. The Section 125 Plan was adopted effective January 1, 2003, and is amended and restated effective as of January 1, 2024.

Contributions

Contributions to the Section 125 Plan consist of contributions made by your election to reduce your salary or wages by a certain amount. All contributions to the Section 125 Plan may be used to pay for benefits under the Section 125 Plan in any way that you want (as long as such benefits are covered under the Section 125 Plan). By your election, contributions that you defer are set aside, only to be used to pay the cost of the employee portion of applicable premiums in the health and welfare plans you choose. The maximum amount of the contributions under this Section 125 Plan for any participating employees in any Plan Year will be the sum of their premiums, as amended from time to time, of the most expensive benefits available under each Qualified Benefit Plan for such Plan Year.

Not a Contract of Employment

This Section 125 Plan will not be deemed to constitute an employment contract between the Plan Sponsor and any employee or to be in consideration of or an inducement for the employment of any employee. Nothing contained in this Section 125 Plan will be deemed to give any employee, including employee's participating in the Section 125 Plan, the right to be retained in the service of the Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge any employee participating in the Section 125 Plan at any time regardless of the effect which such discharge will have upon him or her as a participant in this Section 125 Plan.

Communications to Employees

The Plan Sponsor has and/or will notify you of this Section 125 Plan and its terms, and notifies new employees of the availability and terms of this Section 125 Plan as soon as practicable following the date the employee commences his or her employment with the Plan Sponsor. Where applicable, newly eligible employees are notified of the availability and terms of this Section 125 Plan during any applicable open or special enrollment period.

Protective Clauses

- If a an employee participating in this Section 125 Plan fails to obtain coverage under any insured Qualified Benefit Plan (whether as a result of the negligence or gross neglect of the Plan Sponsor or otherwise), such participating employee's sole and exclusive remedy will be the return of the amount of the Employee Provided Premiums actually paid by such participating employee in the Plan Year(s) for which coverage was not obtained.
- If and to the extent payments or reimbursements due under an insured Qualified Benefit Plan are required to be paid to the Plan Sponsor, as agent for an employee participating in this Section 125 Plan (or the spouse, Dependent, or other beneficiary of such employee) or otherwise, the Plan Sponsor's liability for any claim brought by a employee participating in this Section 125 Plan or by their spouse, Dependent, or other beneficiary with respect to such payment or reimbursements will be limited to the amount of the payments or reimbursements, if any, actually received by the Plan Sponsor thereunder in connection with such claim. If payments or reimbursements under an insured Qualified Benefit Plan are not timely received by the Plan Sponsor following the submission of a claim, the Plan Sponsor will so notify the participating employee. Thereafter, the Plan Sponsor will have no obligation to pursue such claim, and the participating employee may pursue, settle, or compromise such claim as the participating employee, in the sole exercise of his or her discretion, sees fit.
- The Plan Sponsor will not be responsible for the validity of any insurance contract which funds an insured Qualified Benefit Plan or for the failure of an insurer to make payments provided for thereunder, or for the action of any person which may cause any such insurance contract to be rendered null and void or unenforceable, in whole or in part.
- Once coverage under an insured Qualified Benefit Plan is applied for and obtained, the Plan Sponsor will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Plan Sponsor. Where premium notices are timely received by the Plan Sponsor, the Plan Sponsor's liability for the payment of premiums corresponding to such notices will be limited to the dollar amount of such premiums and will not include liability for any other loss which may result from the failure to pay such premiums.
- The Plan Sponsor will not be liable for the Employee Provided Premium under a Qualified Benefit Plan or any loss which may result from the failure to pay such premium if the amounts deferred pursuant to the terms of this Section 125 Plan are insufficient to provide for the payment of the employee's share of the applicable premium of a Qualified Benefit Plan at the time such premium is due. The Plan Sponsor will notify an individual participating in this Section 125 Plan if such amounts are insufficient to pay such premiums but will not be liable for any failure to make such notification. Such premiums may be paid (i) if permitted under Code Section 125, pursuant to an amendment to an employees election under Section as set forth in the Eligibility and Enrollment section of this Section 125 Plan, or (ii) otherwise, by a cash contribution of the employee or their beneficiaries.

No Guarantee of Tax Consequences

Neither the Administrator nor the Plan Sponsor makes any representation or warranty that any amount paid as premiums or distributed as benefits under any Qualified Benefit Plan will be excludable from the gross income of an employee participating in this Section 125 Plan for federal or state income tax purposes. It will be the obligation of

each participating employee to determine whether payments are excludable from the employee's gross income for federal and state income tax purposes.

Indemnification of the Plan Sponsor by Participants

If any employee participating in the Section 125 Plan receives payments or reimbursements which does not qualify for exclusion from gross income, the employee will indemnify and reimburse the Plan Sponsor for any liability it may incur for failure to withhold federal or state tax from such payments or reimbursements, provided however that such indemnification and reimbursement will not exceed the amount of additional federal and state tax (together with any interest and penalties) that the employee would have owed if the payments or reimbursements had been made to the employee as regular cash compensation, less any such additional tax actually paid by the employee.

Funding

Unless otherwise required by law, (i) contributions to the Section 125 Plan will be deemed general assets of the Plan Sponsor until the amount thereof has been paid over to or under a Qualified Benefit Plan and (ii) nothing herein contained will be construed to require the Plan Sponsor or the Administrator to maintain any fund or segregate any amount, in trust or otherwise, for the benefit of any employee or their beneficiaries, and no employee or other person will have any claim against, right to, or security or other interest in, any asset of the Plan Sponsor from which any payment under the Section 125 Plan may be made.

Nonassignability of Rights

The right of any participating employee of their beneficiaries to receive any amount under the Section 125 Plan will not be alienable by the Participant by assignment or any other method, and will not be subject to the rights of creditors, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

Limitation of Rights

Neither the establishment of the Section Plan nor any amendment thereof, nor the payment of any benefits under this Section 125 Plan, will be construed as giving to any participating employee or other person any legal or equitable right against the Plan Sponsor or Administrator, except as provided herein.

Governing Law

This Section 125 Plan will be construed, administered and enforced according to the laws of the State of Ohio and the provisions of the Code and any other applicable federal law.

Definitions

For purposes of this Section 125 Plan:

- "Employee" means any individual employed by the Plan Sponsor. However, only those individuals classified as "employees" by the Plan Sponsor shall be eligible to participate, including any leased employees within the meaning of Code Section 414(n)(2). Independent contractors, freelancers, and individuals hired through staffing firms shall not be eligible to participate in the Plan even if they are subsequently determined to be common law employees for any purpose, including without limitation, for wage, labor, or tax purposes by either the Internal Revenue Service, Department of Labor, or any other Federal or state agency, administrative body or court.

- "Dependent" means any person who falls within the definition of dependent under Code Section 152, as modified by Code Section 105(b), and any child of a Participant as defined in Code Section 152(f)(1) until the end of the year in which the child attains age 26

APPENDIX B: DENTAL ADMINISTRATOR'S EXCLUSIONS AND LIMITATIONS

Exclusions

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Services received from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under, Medicaid or Medicare.
2. Services or supplies, as determined by the Dental Administrator, for correction of congenital or developmental malformations, with the exception of congenitally missing teeth.
3. Cosmetic surgery or dentistry for aesthetic reasons, as determined by the Dental Administrator.
4. Services completed or appliances completed before a person became eligible under this Plan. This exclusion does not apply to orthodontic treatment in progress (if a Covered Service).
5. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions, and relative analgesia.
6. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
7. Charges for hospitalization, laboratory tests, histopathological examinations and miscellaneous tests.
8. Charges for failure to keep a scheduled visit with the Dentist.
9. Services or supplies, as determined by the Dental Administrator, for which no valid dental need can be demonstrated.
10. Services or supplies, as determined by the Dental Administrator that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
11. Services or supplies, as determined by the Dental Administrator, which are specialized procedures or techniques.
12. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the supervision of a licensed Dentist. Treatment rendered by any other licensed dental professional may be covered only as solely determined by this Plan and/or the Dental Administrator.
13. Services or supplies for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of the Dental Administrator coverage.
14. Services or supplies received due to an act of war, declared or undeclared, or terrorism.
15. Services or supplies covered under a hospital, surgical/medical, or prescription drug program.
16. Services or supplies that are not within the categories of Benefits selected by this Plan and that are not covered under the terms of the Plan.
17. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
18. Caries preventive medicament.
19. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
20. Space maintainers for maintaining space due to premature loss of anterior primary teeth.
21. Lost, missing, or stolen appliances of any type, or replacement or repair of orthodontic appliances or space maintainers.
22. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
23. Veneers.
24. Prefabricated crowns used as final restorations on permanent teeth.
25. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If Orthodontic Services are Covered Services, this exclusion will not apply to Orthodontic Services as limited by the terms and conditions of the contract between the Dental Administrator and this Plan.
26. Implant/abutment supported interim fixed denture for edentulous arch.
27. Soft occlusal guard appliances.
28. Paste-type root canal fillings on permanent teeth.
29. Replacement, repair, relines, or adjustments of occlusal guards.
30. Chemical curettage.
31. Services associated with overdentures.
32. Metal bases on removable prostheses.
33. The replacement of teeth beyond the normal complement of teeth.
34. Personalization or characterization of any service or appliance.
35. Temporary crowns used for temporization during crown or bridge fabrication.
36. Posterior bridges in conjunction with partial dentures in the same arch, sharing at least one posterior edentulous

space in common.

37. Precision abutments, attachments and stress breakers.

38. Biologic materials to aid in soft and osseous tissue regeneration when submitted on the same day as tooth extraction, periradicular surgery, soft tissue grafting, guided tissue regeneration, implants, ridge augmentation, ridge preservation/extraction sites, periradicular surgery, apicoectomy sites, hemisections, and periodontal or implant bone grafting.

39. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.

40. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint.

41. Diagnostic photographs and cephalometric films, unless done for orthodontics and orthodontics are a Covered Service.

42. 3-D scans and images.

43. Myofunctional therapy.

44. Mounted case analyses.

45. Molecular, antigen or antibody testing for a public health related pathogen.

46. Vaccinations.

47. Bone replacement grafts when performed in conjunction with a hemisection.

48. Fabrication, adjustment, reline, or repair of sleep apnea appliances.

49. Removal of non-resorbable barrier.

50. Intraoral tomosynthesis images.

51. Any and all taxes applicable to the services.

52. Processing policies may otherwise exclude payment by the Dental Administrator for services or supplies.

The Plan will make no payment for the following services or supplies. Participating Dentists may not charge Members for these services or supplies. All charges from Nonparticipating Dentists for the following services or supplies are your responsibility:

1. Services or supplies, as determined by the Dental Administrator, which are not provided in accordance with generally accepted standards of dental practice.

2. The completion of forms or submission of Claims.

3. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.

4. Carries risk assessment performed on a Member age 2 or under.

5. Local anesthesia.

6. Acid etching, cement bases, cavity liners, and bases or temporary fillings.

7. Infection control.

8. Temporary, interim, or provisional crowns.

9. Gingivectomy as an aid to the placement of a restoration.

10. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.

11. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.

12. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the condition.

13. Post-operative X-rays, when done following any completed service or procedure.

14. Periodontal charting.

15. Pins and preformed posts, when done with core buildups.

16. Any substructure when done for inlays, onlays, and veneers.

17. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.

18. A pulpotomy on a permanent tooth, except on a tooth with an open apex.

19. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.

20. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.

21. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.

22. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.

23. Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within 30 days of three or four quadrants of scaling and root planing or other periodontal treatment.

24. Full mouth debridement when done within 30 days of scaling and root planing.

25. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces without flap entry and closure, when performed within 12 months of implant restorations, provisional implant crowns and implant or abutment supported interim dentures.

26. Scaling and debridement in the presence of inflammation or mucositis of a single implant, when done on the same day as a prophylaxis, scaling in the presence of gingival inflammation, periodontal maintenance, full mouth debridement, periodontal scaling and root planing, periodontal surgery or debridement of a peri-implant defect.

27. Full mouth debridement, when done on the same day as a comprehensive periodontal evaluation.

28. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as a sealant, sealant repair, preventive resin restoration or interim caries arresting medicament performed on the same tooth.

29. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.

30. Reline, rebase, or any adjustment or repair within six months of the delivery of a denture.

31. Reline or any adjustment or repair to a sleep apnea appliance within six months of the delivery.

32. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.

33. Adjustments, temporary relines, or tissue conditioning within three months of delivery of an immediate denture.

34. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period of time of performing panoramic and/or full mouth X-rays, as determined solely by the Dental Administrator.

35. Charges or fees for overhead, internet/video connections, software, hardware or other equipment necessary to deliver services, including but not limited to teledentistry services.

36. Capture only images which are not associated with any interpretation or reporting.

37. Frenulectomy when performed on the same day as any other surgical procedure(s) in the same surgical area by the same dentist or dental office.

38. Surgical removal of implant body when performed within three months of an implant/mini implant on the same tooth by the same dentist or dental office.

39. Non-surgical implant removal when performed within six months of an implant/mini-implant on the same tooth by the same dentist or dental office.

40. Scaling and root planing when performed on the same day as surgical root repair or exposures.

41. Surgical repair or exposure of root when performed on the same day as endodontic or periodontal surgical procedures.

42. Intraorifice barriers.

43. Removal of non-resorbable barrier when performed by the same dentist who placed the barrier.

44. Excision of benign or malignant lesions when performed in the same area and on the same day as another surgical procedure by the same dentist or dental office.

45. Processing policies may otherwise exclude payment by the Dental Administrator for services or supplies.

Limitations

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the actual date (i.e., to the day) of the applicable prior dates of services in our records with any the Dental Administrator Member Plan or, at the request of this Plan, any dental plan:

1. Bitewing X-rays are payable once per benefit period, unless a full mouth X-ray which include bitewings has been paid in that same year.

2. Panoramic or full mouth X-rays (which may include bitewing X-rays) are payable once in any five-year period.

3. Any combination of teeth cleanings (prophylaxes, full mouth debridement, scaling in the presence of inflammation, and periodontal maintenance procedures) are payable twice per benefit year. Full mouth debridement is payable once in a lifetime.

4. Oral examinations and evaluations (not including limited problem focused evaluations or patient screenings) are only payable twice per benefit period, regardless of the Dentist's specialty.

5. Patient screening is payable once per benefit period.

6. Preventive fluoride treatments are payable twice per benefit period.

7. Bilateral space maintainers are payable once per arch in a lifetime for people age 13 and under.

8. Unilateral space maintainers are payable once per quadrant in a lifetime for people age 13 and under.

9. A distal shoe space maintainer is payable for first permanent molars once per quadrant for people age 8 and

under.

10. Cast restorations (including jackets, crowns and onlays) and associated procedures (such as core buildups and post substructures) are payable once in any five-year period per tooth. Subsequent minor restorations on the same tooth are also subject to this five-year limitation.

11. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture (lost or mobile tooth structure).

12. Individual crowns over implants are payable at the prosthodontic benefit level once in a five-year period.

13. Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people age 11 and under.

14. Hard full or partial arch occlusal guards are payable once every five years.

15. An interim partial denture is payable only for the replacement of permanent anterior teeth for people age 16 and under or during the healing period for people age 17 and over.

16. Biologic materials to aid in soft and osseous tissue regeneration are payable once per natural tooth in a 36-month period.

17. Prosthodontic Services limitations:

    a. One complete upper and one complete lower denture, and any implant used to support a denture, are payable once in any five-year period.

    b. A removable partial denture, endosteal implant (other than to support a denture), or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.

    c. A removable unilateral partial denture is payable once per quadrant in any five-year period unless the loss of additional teeth requires the construction of a new appliance.

    d. Fixed bridges and removable partial dentures are not payable for people age 15 and under.

    e. Rebase hybrid prostheses are payable once in any five-year period per appliance.

    f. A reline or the complete replacement of denture base material is payable once in any three-year period per appliance.

    g. Implant removal is payable once per tooth or area in a five-year period.

    h. Implant maintenance is payable once per any 12-month period.

    i. Removal of a broken implant retaining screw is payable once in a five-year period.

18. Orthodontic Services limitations, if covered under your Plan pursuant to your Summary of Dental Plan Benefits:

    a. Orthodontic Services are payable for eligible members through the end of the calendar year of age 19.

    b. If the treatment plan terminates before completion for any reason, the Dental Administrator's obligation for payment ends on the last day of the month in which the patient was last treated.

    c. Upon written notification to the Dental Administrator and to the patient, a Dentist may terminate treatment for lack of patient interest and cooperation. In those cases, the Dental Administrator's obligation for payment ends on the last day of the month in which the patient was last treated.

19. The Dental Administrator's obligation for payment of Benefits ends on the last day of coverage. However, the Dental Administrator will make payment for Covered Services provided on or before the last day of coverage, as long as the Dental Administrator receives a Claim for those services within one year of the date of service.

20. When services in progress are interrupted, the Dental Administrator will not issue payment for any incomplete services; however, The Dental Administrator will calculate the Maximum Approved Fee that the dentist may charge you for such incomplete services, and those charges will be your responsibility. In the event the interrupted services are completed later by a Dentist, the Dental Administrator will review the Claim to determine the amount of payment, if any, to the Dentist in accordance with the Dental Administrator's policies at the time services are completed.

21. Care terminated due to the death of a Member will be paid to the limit of the Dental Administrator's liability for the services completed or in progress.

22. Optional treatment: If you select a more expensive service than is customarily provided, the Dental Administrator may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, the Dental Administrator will make the final determination regarding optional treatment and any available allowance.

    Listed below are services for which the Dental Administrator will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment.

    a. Resin, porcelain fused to metal, and porcelain crowns (including implant crowns), bridge retainers, or pontics on posterior teeth – The Dental Administrator will pay only the amount that it would pay for a full metal crown.

    b. Overdentures – The Dental Administrator will pay only the amount that it would pay for a conventional

denture.

c. Resin, or porcelain/ceramic onlays on posterior teeth – The Dental Administrator will pay only the amount that it would pay for a metallic onlay.

d. Inlays, regardless of the material used – The Dental Administrator will pay only the amount that it would pay for an amalgam or composite resin restoration.

e. All-porcelain/ceramic bridges – The Dental Administrator will pay only the amount that it would pay for a conventional fixed bridge.

f. Implant/abutment supported complete or partial dentures – The Dental Administrator will pay only the amount that it would pay for a conventional denture.

g. Gold foil restorations – The Dental Administrator will pay only the amount that it would pay for an amalgam or composite restoration.

h. Posterior stainless steel crowns with esthetic facings, veneers or coatings – The Dental Administrator will pay only the amount that it would pay for a conventional stainless steel crown.

23. Maximum Payment for all benefits available under this Plan are subject to the Maximum Payment limitations set forth in your Summary of Dental Plan Benefits.
24. If a Deductible amount is stated in the Summary of Dental Plan Benefits, the Dental Administrator will not pay for any services or supplies, in whole or in part, to which the Deductible applies until the Deductible amount is met.
25. Caries risk assessments are payable once in any 12-month period for Members age 3-18.
26. Assessments of salivary flow by measurement are payable once in any 36-month period.
27. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period.
28. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restorations involving the occlusal surface.
29. Interim caries arresting medicament is payable twice per tooth per benefit period and is limited to five applications per day.
30. Sealants are covered once per tooth per lifetime on first permanent molars for Members age 9 and under.
31. Sealants are covered once per tooth per lifetime on second permanent molars for Members age 14 and under.
32. One cone beam CT is allowed within a 12-month period except when performed for TMD treatment.
33. Restorations performed within two months of caries arresting medicament.
34. Processing policies may otherwise limit payment by the Dental Administrator for services or supplies.

The Plan will make no payment for services or supplies that exceed the following limitations. All charges from a Non-Participating Dentist are your responsibility. However, Participating Dentists may not charge Members for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the actual date (i.e., to the day) of the applicable prior dates of services in our records with any the Dental Administrator Member Plan or, at the request of this Plan, any dental plan.

1. Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.
2. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
3. Recementation of a crown, onlay, inlay, veneer, space maintainer, or bridge within six months of the seating date.
4. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.
5. Root planing is payable once in any two-year period.
6. Periodontal surgery is payable once in any three-year period.
7. A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
8. Tissue conditioning is payable twice per arch in any three-year period.
9. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
10. Services or supplies, as determined by the Dental Administrator, which are not provided in accordance

with generally accepted standards of dental practice.

11. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period when performed by the same office.

12. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restorations involving the occlusal surface when performed by the same office.

13. A sealant, sealant repair or preventive resin restoration is not payable when performed within 24 months of a sealant, sealant repair or preventive resin restoration performed on the same tooth.

14. One caries risk assessment is allowed on the same date of service.

15. One caries risk assessment is allowed within a 12-month period when done by the same dentist/dental office.

16. One assessment of salivary flow by measurement is allowed within a 12-month period when done by the same dentist/dental office

17. Processing policies may otherwise limit payment by the Dental Administrator for services or supplies.