CITY OF PERRYSBURG
EMPLOYEE HEALTH PLAN

PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

Effective: January 1, 2012
Restated: August 1, 2018

Third Party Administrator:
NFP Benefit Alliance
701 Adams Street
Suite 850
Toledo, OH 43604

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GENERAL PLAN INFORMATION

What is the purpose of the Plan?
The *Plan Sponsor* has established the *Plan* for your benefit, on the terms and conditions described herein. The *Plan Sponsor's* purpose in establishing the *Plan* is to help to offset, for you, the economic effects arising from an *injury* or *illness*. To accomplish this purpose, the *Plan Sponsor* must be cognizant of the necessity of containing health care costs through effective plan design, and the *Plan Administrator* must abide by the terms of the *summary plan description*, to allow the *Plan Sponsor* to allocate the resources available to help those individuals participating in the *Plan* to the maximum feasible extent.

City of Perrysburg 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, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that 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 limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the *Plan Administrator* at (419) 872-8010. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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

The purpose of this *summary plan description* 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 medical expenses. The *summary plan description* is maintained by the *Plan Administrator* and may be inspected at any time during normal working hours by any *covered person*.

General *Plan* Information You Should Know

Name of *Plan*:	**City of Perrysburg Employee Health Plan**
***Plan Sponsor*:**	**City of Perrysburg** **201 Indiana Avenue** **Perrysburg, OH 43551** **(419) 872-8010**
***Plan Administrator*:** **(Named Fiduciary)**	**City of Perrysburg** **201 Indiana Avenue** **Perrysburg, OH 43551** **(419) 872-8010**
***Plan Sponsor* ID No. (EIN):**	**34-6401069**
Fiscal Plan Year:	**January 1 through December 31**
***Plan* Number:**	**501**
***Plan* Type:**	**Medical** **Prescription Drug**

Third Party Administrator:	**NFP Benefit Alliance** **701 Adams St., Ste. 850** **Toledo, OH 43604** **419-244-0135**
Participating Employer(s):	**City of Perrysburg**
Agent for Service of Process:	**City of Perrysburg** **Plan Administrator** **201 Indiana Avenue** **Perrysburg, OH 43551** **(419) 872-8010**

The *Plan* shall take effect for each *participating employer* on the *effective date* shown on the cover, unless a different date is set forth above.

The *Plan* is a legal entity. Legal notice may be filed with, and legal process served upon, the *Plan Administrator*.

ELIGIBILITY FOR PARTICIPATION

Am I eligible to participate in the Plan?
As a full-time *employee* regularly scheduled to work at least 40 hours per week, you are eligible to enroll for coverage following completion of 30 days active employment. Permanent, part-time employees, working more than 30 hours per week are also eligible to enroll, as long as they pay their portion of the cost for the coverage. This class of employee would also be eligible to enroll after completion of 30 days of active employment. Coverage for all participants will begin the first of the month following the waiting period.

You must actually begin work for the *participating employer* in order to be eligible. If you are unable to begin work as scheduled, then your coverage will become effective on the date when you begin work.

If your employment terminates and you later return to full-time *active employment* within 13 weeks following the termination, your coverage will be reinstated as it was in effect prior to the termination, including credit toward satisfaction of your *waiting period*, if any, and any amounts applied to *deductibles*, *out-of-pocket expense* limits and *Plan* maximums will be reinstated. If you return to *active employment* more than 13 weeks following termination, you must satisfy a new *waiting period* and re-enroll under the same terms and conditions as a newly hired *employee*.

You are not eligible to participate if you are an independent contractor. Temporary, leased or seasonal employees eligibility will be determined in compliance with the Affordable Care Act regulations regarding temporary, leased or seasonal employees and the Plan's established measurement periods for eligibility determination.

Are my dependents eligible to participate in the Plan?
Your *dependents* will become eligible for coverage on the latest of the following dates:

- The date you become eligible for coverage;
- The date coverage for *dependents* first becomes available under the *Plan*; and
- The first date upon which you acquire a *dependent*.

You must be covered under the *Plan* in order to cover any *dependents*.

No *dependent child* may be covered as a *dependent* of more than one *employee* who is covered under the *Plan*.

No person may be covered simultaneously under this *Plan* as both an *employee* and a *dependent*.

Please note: The *Plan Administrator* will require such documentation as it deems necessary to establish the eligibility of any dependent for coverage under the *Plan*.

When will we become covered persons in the Plan?
Coverage will become effective at 12:01 A.M. (except for newborn *children*) on the date specified below, subject to the conditions of this section.

- Coverage will become effective on the first day of the month following the date you or your *dependents* are eligible, provided you and your *dependents* have enrolled for coverage on a form satisfactory to the *Plan Administrator* within 31 days following the date of eligibility.
- For a *dependent child* who is born after the date your coverage becomes effective:
    - If you already have coverage for *dependents* at the time of your *child's* birth, your newborn *child* will be covered during the first 31 days from the *child's* birth. In order to continue this coverage

beyond 31 days, you must make written application and agree to any required contributions during the first 31 days from the *child's* birth.

- If you do not yet have any *dependents* covered under the *Plan* at the time of your *child's* birth, you must make written application and agree to any required contributions during the first 31 days from the *child's* birth. Coverage for the newborn *child* will then become effective from the moment of birth.

- If you acquire a *dependent* while you are eligible for coverage for *dependents*, coverage for the newly acquired *dependent* will be effective on the first day following the date the *dependent* becomes eligible, provided you make written application for the *dependent* and agree to make any required contributions, within 31 days of the date of eligibility.

What if I do not enroll during my original eligibility period and later decide to apply for coverage?
You and your *dependents* may enroll for coverage during the *Plan's annual open enrollment period*, which is the month of December in each *plan year*. If you or your *dependents* enroll during an open enrollment period, coverage will be effective at 12:01 A.M. on the first day of January next following the *annual open enrollment period*, unless you have not satisfied the *waiting period*. In that case, coverage for you and your eligible *dependents* will be effective on the first day following your completion of the *waiting period*.

Are there any exceptions for late enrollment?

Special Enrollment Periods
This *Plan* provides two special enrollment periods that allow you to enroll in the *Plan*, even if you declined enrollment during an initial or subsequent eligibility period.

Loss of Other Coverage
If you declined enrollment for yourself or your *dependents* (including your spouse) because of other health coverage, you may enroll for coverage for yourself and/or your *dependents* if the other health coverage is lost. You must make written application for special enrollment within 30 days of the date the other health coverage was lost.

The following conditions apply to any eligible *employee* and *dependents:*

You may enroll during this special enrollment period:

- If you are eligible for coverage under the terms of this *Plan;*

- You are not currently enrolled under the *Plan*;

- When enrollment was previously offered, you declined because of coverage under another group health plan or health insurance coverage. You must have provided a written statement that other health coverage was the reason for declining enrollment under this *Plan,* and

- If the other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

You must make written application for special enrollment within **60 days** of the date of loss of eligibility for coverage under:

- Title XIX of the Social Security Act (Medicaid); or

- A State Child Health Plan under Title XXI of the Social Security Act (CHIP).

Note: You may be eligible for special enrollment if you are eligible for a premium assistance subsidy. You must make written application for special enrollment within 60 days of your eligibility for premium assistance. Please contact your *participating employer* for additional information regarding whether a premium assistance subsidy is available to you.

An *employee* who is already enrolled in a benefit package may enroll in another benefit package under the *Plan* if a *dependent* of that *employee* has a special enrollment right in the *Plan* because the *dependent* lost eligibility for other coverage. You must make written application for special enrollment in the new benefit package within the time limits specified above in this section following the date the other health coverage was lost.
You are not eligible for this special enrollment right if:

- The other coverage was *COBRA* continuation coverage and you did not exhaust the maximum time available to you for that *COBRA* coverage, or

- The other coverage was lost due to non-payment of premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for special enrollment are satisfied, coverage for you and/or your *dependent(s)* will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request is received by the Plan.

New Dependent
If you acquire a new *dependent* as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your *dependents* during a special enrollment period. You must make written application for special enrollment no later than 30 days after you acquire the new *dependent*.

The following conditions apply to any eligible employee and dependents*:*

You may enroll yourself and/or your *eligible dependents* during this special enrollment period if:

- You are eligible for coverage under the terms of this *Plan*, and

- You have acquired a new *dependent* through marriage, birth, adoption or placement for adoption.

If the conditions for special enrollment are satisfied, coverage for you and your *dependent(s)* will be effective at 12:01 A.M.:

- For a marriage, on the date of marriage.

- For a birth, on the date of birth.

- For an adoption or placement for adoption, on the date of the adoption or placement for adoption.

What if a court orders coverage for a child?
Federal law requires the *Plan*, under certain circumstances, to provide coverage for your *children*. The details of these requirements are summarized below. Be sure you read them carefully

The *Plan Administrator* shall enroll for immediate coverage under this *Plan* any *alternate recipient* who is the subject of a "*medical child support order" ("MCSO")* or *"national medical support notice" ("NMSN")* that is a "*qualified medical child support order*" ("*QMCSO*") if the *child* named in the *MCSO* is not already covered by the *Plan* as an eligible *dependent*, once the *Plan Administrator* has determined that the order or notice meets the standards for qualification set forth below.

"A*lternate recipient*" shall mean any *child* of a *covered person* who is recognized under a *MCSO* as having a right to enrollment under this *Plan* as the *covered person's e*ligible *dependent*. *"MCSO"* shall mean any

judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

- Provides for child support with respect to a *covered person's child* or directs the *covered person* to provide coverage under an employee benefit plan pursuant to a state domestic relations law (including a community property law); or

- Enforces a law relating to medical child support described in Social Security Act §1908 with respect to a group health plan.

"*NMSN*" shall mean a notice that contains the following information:

- Name of an issuing state agency;

- Name and mailing address (if any) of an *employee* who is a *covered person* under the *Plan*;

- Name and mailing address of one or more *alternate recipients* (i.e., the *child* or *children* of the *covered person* or the name and address of a substituted official or agency that has been substituted for the mailing address of the *alternate recipients(s)*); and

- Identity of an underlying child support order.

"*QMCSO*" is an *MCSO* that creates or recognizes the existence of an *alternate recipient's* right to, or assigns to an *alternate recipient* the right to, receive benefits for which a *covered person* or eligible *dependent* is entitled under this *Plan*. In order for such order to be a *QMCSO*, it must clearly specify the following:

- The name and last known mailing address (if any) of the *covered person* and the name and mailing address of each *alternate recipient* covered by the order;

- A reasonable description of the type of coverage to be provided by the *Plan* to each *alternate recipient*, or the manner in which such type of coverage is to be determined;

- The period of coverage to which the order pertains; and

- The name of this *Plan*.

In addition, a *NMSN* shall be deemed a *QMCSO* if it:

- Contains the information set forth above in the definition of "*NMSN*";

    - Identifies either the specific type of coverage or all available group health coverage. If the employer receives a *NMSN* that does not designate either specific type(s) of coverage or all available coverage, the employer and the *Plan Administrator* will assume that all are designated; or

    - Informs the *Plan Administrator* that, if a group health plan has multiple options and the *covered person* is not enrolled, the issuing agency will make a selection after the *NMSN* is qualified, and, if the agency does not respond within 20 days, the *child* will be enrolled under the *Plan's* default option (if any); and

- Specifies that the period of coverage may end for the *alternate recipient(s)* only when similarly situated *dependents* are no longer eligible for coverage under the terms of the *Plan*, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the *Plan* to provide any type or form of benefit, or any option, not otherwise provided to *covered persons* without regard to this section, except to the extent necessary to meet the requirements of a state law relating to MCSO's, as described in Social Security Act §1908.

Upon receiving a *MCSO*, the *Plan Administrator* shall, as soon as administratively possible:

- Notify the *covered person* and each *alternate recipient* covered by the order (at the address included in the order) in writing of the receipt of such order and the *Plan's* procedures for determining whether the order qualifies as a *QMCSO*; and

- Make an administrative determination if the order is a *QMCSO* and notify the *covered person* and each affected *alternate recipient* of such determination.

Upon receiving a *NMSN*, the *Plan Administrator* shall:

- Notify the state agency issuing the notice with respect to the child whether coverage of the *child* is available under the terms of the *Plan* and, if so:

  - Whether the *child* is covered under the *Plan*; and

  - Either the *effective date* of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and

- Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the *Plan Administrator* shall:

- Establish reasonable, written procedures for determining the qualified status of a *MCSO* or *NMSN*; and

- Permit any *alternate recipient* to designate a representative for receipt of copies of the notices that are sent to the *alternate recipient* with respect to the order.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 ("GINA")

What is "*genetic information*" under *GINA*?
Under *GINA*, the term "*genetic information*" includes:

> Information about an individual or his/her family member's genetic tests (defined as analyses of the individual's DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations or chromosomal changes);
>
> The manifestation of a disease or disorder in the family members of the individual. Family members are broadly defined under *GINA* to include individuals who are *dependents*, as well as any other first, second, third or fourth degree relative. Further, *genetic information* includes that information of any fetus or embryo carried by a pregnant woman; and
>
> Information obtained through genetic services (that is genetic tests, genetic counseling or genetic education) or participation in clinical research that includes genetic services.

Genetic information does not include the sex or age of an individual.

GINA prohibits the *Plan* from:

> Adjusting premiums or contribution amounts for the group as a whole on the basis of "*genetic information*".
>
> Requesting or requiring an individual or a family member to undergo a genetic test. However, subject to certain conditions, the *Plan* may request that an individual voluntarily undergo a genetic test as part of a research study so long as the results are not used for underwriting purposes.
>
> Requesting, requiring or purchasing *genetic information* for underwriting purposes (which includes eligibility rules or determinations, computation of premium or contribution amounts, and other activities related to the creation, renewal or replacement of coverage). The *Plan* is also prohibited from requesting, requiring or purchasing *genetic information* with respect to any individual prior to such individual's enrollment under the *Plan* or coverage. However, if the *Plan* obtains *genetic information* incidental to the collection of other information prior to enrollment, it will not be in violation of *GINA* so long as it is not used for underwriting purposes.

GINA allows the group health *Plan* to obtain and use the results of genetic tests for purposes of making payment determinations.

SELECTION OF YOUR HEALTH CARE PROVIDER

Overview of PPO/Non-PPO Option
The *Plan Administrator* has entered into an agreement with one or more networks of *hospitals* and *physicians,* called *"PPO networks."* These *PPO networks* offer *covered persons* health care services at discounted rates. Using a *PPO network provider* will normally result in a lower cost to the *Plan* as well as to the *covered person.* There is no requirement for any *covered person* to seek care from a *provider* who participates in the *PPO network*. The choice of *provider* is entirely up to the *covered person*.

If you **reside outside the *PPO network* service area**, which includes the state of Ohio, and use a non-*PPO network provider*, your benefits will be based on the *PPO network provider* level shown in the "Schedule of Medical Benefits." This also applies to *dependent children* who are covered by this *Plan,* and reside outside the *network* service area.

Ancillary and *physician's* services provided through a *PPO network provider hospital* or facility (whether as *inpatient or* outpatient), which are rendered and billed by a non-*PPO network provider* that you did not select, are reimbursed at the *PPO network provider* percentage payable for *usual, customary and reasonable fees*.

Also, services required due to a medical ***emergency*** which are rendered and billed by a non-*PPO network provider*, are reimbursed at the *PPO network provider* percentage payable for *usual, customary and reasonable fees*. The determination regarding whether a condition qualifies as a medical *emergency* will be made by the *Plan Administrator* in its sole discretion.

A current list of *PPO network providers* is available on the *PPO network's* website. You may also contact your *PPO network* at the phone number or web site shown on your *Plan* ID card.

Some *PPO network provider hospital*s have arrangements through which the benefit payable is more than the actual charges, e.g., per diem or diagnosis-related group (DRG) charges. When this occurs, the *Plan* will reimburse the *hospital* based upon the agreed per diem or DRG rates.

Each *covered person* has a free choice of any provider, and the *covered person*, together with his provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the *Plan* will pay for all or a portion of the cost of such care. The *PPO network providers* are independent contractors; neither the *Plan* nor the *Plan Administrator* makes any warranty as to the quality of care that may be rendered by any *PPO network provider*.

Many *PPO network providers* will require that the *Plan* offer incentives, or "steerage," in order to encourage *covered persons* to use their member *providers*. This *Plan* defines "steerage" as lower costs to the *covered person* through reduced charges, resulting in lower out-of-pocket amounts, or higher rates of reimbursement under the *Plan*. The *Plan Administrator* reserves the right to negotiate discounts with *providers* of service, and those discounts will be used to reduce the amount of otherwise *covered expenses* considered for payment by the *Plan*. In certain cases, the *Plan Administrator*, in its sole discretion, may determine that the benefit payable for a discounted claim will be at the *PPO network provider* reimbursement level, and such payments will be considered to be in full compliance with the terms of the *Plan*.

YOUR COSTS

You must pay for a certain portion of the cost of *covered expenses* under the *Plan,* including *deductibles,* copayments and the coinsurance percentage that is not paid by the *Plan.* This is called *"out-of-pocket expense."*

Deductibles and copayments are shown in the "Schedule of Medical Benefits." The *Plan* limits the amount of *deductible* and *out-of-pocket expense* you must pay for your *family unit*, also shown in the "Schedule of Medical Benefits."

Allowable claim limits will never include charges for services or supplies not listed for coverage under the *Plan.* You must pay for these charges and any *deductibles*, copayments or coinsurance *out-of-pocket expenses* which are your responsibility as part of the normal cost-sharing features of the *Plan*. Please refer to the section, "Claim Review and Audit Program" for additional information regarding *allowable claim limits.*

For All Other Expenses
There may be differences in the coinsurance percentage payable by the *Plan* depending upon whether you are using a *PPO network provider* or a non-*PPO network provider.* Or, the *Plan* may not cover certain types of expenses unless they are provided by a *PPO network provider*. The *Plan* also contains a limit for the amount of *out-of-pocket expense* you must pay toward *covered expenses,* as listed in the "Schedule of Medical Benefits," and your *out-of-pocket expense* limit may be higher for non-*PPO network providers* than for *PPO network providers*. **Amounts accrued for *PPO network providers* will also apply to non-PPO *providers* and amounts accrued for non-*PPO network providers* will apply to *PPO network providers*.**

Please note, however, that not all *covered expenses* are eligible to accumulate toward your *out-of-pocket expense* limit. These types of expenses include:

- Amounts applied toward *deductibles;*
- Copayments
- Prescription drug program expenses

In addition, certain types of expenses may be subject to dollar maximums or limited to a certain number of visits in a given year. This information is contained in the "Schedule of Medical Benefits" section. Expenses in excess of these *Plan* limits will not accumulate toward the *out-of-pocket expense* limit.

Once you have paid the *out-of-pocket expense* limit for eligible expenses *incurred* during a *plan year,* the *Plan* will reimburse additional eligible *covered expenses incurred* during that year at 100%.

If you have any questions about whether an expense is a *covered expense*, or whether it is eligible for accumulation toward your *out-of-pocket* expense limit, please contact the *third party administrator* for assistance.

SCHEDULE OF MEDICAL BENEFITS

This schedule is provided as a convenience only and is not all-inclusive. Important information is contained in sections, "Medical Benefits" and "Plan Exclusions and Limitations." You may find the "Definitions" section helpful in understanding some of the italicized terms used throughout this *summary plan description*. In addition, the *Plan* has other requirements and provisions that may affect benefits, such as the "Claim Review and Audit Program" and "Cost Containment Provisions," and it is strongly recommended that you read the entire *summary plan description* to ensure a complete understanding of the *Plan* provisions. You may also contact the *third party administrator* or the *Plan Administrator* for assistance.

Lifetime Maximum Benefits
The following lifetime maximums apply to each *covered person*:

Lifetime Maximum Benefits for:	
Lifetime Maximum for All Benefits	Unlimited

The *plan year* for this *Plan* is the calendar year January 1st through December 31st.

Deductibles, Percentage Payable and Out-of-Pocket Expense Limits
Covered expenses incurred during the last three months of a *plan year* that were applied toward a *deductible* will be allowed as credit toward satisfaction of the *deductible* in the following *plan year*. The following amounts are applied per *plan year*:

	PPO Network Providers	**Non-*PPO Network Providers***
Deductible • Individual • *Family Unit*	 $250 $500	
Percentage Payable (unless otherwise stated)	80%	60%
Out-of-Pocket Expense Limit* • Individual • *Family Unit*	 $1,250 $2,500	 $2,500 $5,000
* Certain types of expenses are not accumulated toward this *out-of-pocket expense* limit. These expenses are identified in the section, "Your Costs."		

If you reside outside the *PPO network* service area, which includes the state of Ohio, and you must use a non-*PPO network provider*, your benefits will be based on the *PPO network provider* level.

Covered expenses for services by *PPO network providers* and non-*PPO network providers* will cross accumulate toward satisfaction of the *out-of-pocket expense* limit.

Payment Levels and Limits
The *deductible* will apply to *covered expenses* unless otherwise noted in this section. Maximums stated apply to the amount of *covered expenses* unless otherwise indicated. **Please refer to the section, "Selection of Your Health Care Provider" for information regarding out-of-area benefits and exceptions for non-*PPO network providers*.**

***Hospital Inpatient* Services**			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Medical/Surgical Room & Board & Ancillary	80% of *PPO* rate for semi-private room and ancillary charges subject to *deductible*	60% of *usual, customary and reasonable fees* for semi-private room and ancillary charges subject to *deductible*	
Intensive Care Unit Room & Board	80% of *PPO intensive care unit* rate subject to *deductible*	60% of *usual, customary and reasonable fees* for *intensive care unit* subject to *deductible*	
Skilled Nursing/ Extended Care and Convalescent Care Facility, Room & Board & Ancillary	80% of *PPO* rate for semi-private room and ancillary charges subject to *deductible*	60% of *usual, customary and reasonable fees* for semi-private room and ancillary charges subject to *deductible*	

***Hospital* Newborn Care**			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Neo-Natal Room & Board & Ancillary	80% of *PPO* rate for room and ancillary charges subject to *deductible*	60% of *usual, customary and reasonable fees* for room and ancillary charges subject to *deductible*	
Routine Newborn Nursery & Ancillary	80% of *PPO* rate for nursery and ancillary charges subject to *deductible*	60% of *usual, customary and reasonable fees* for nursery and ancillary charges subject to *deductible*	

***Hospital Mental or Nervous Disorder* and *Substance Abuse* Services**			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Inpatient - Mental or Nervous Disorder and *Substance Abuse* Room & Board & Ancillary	80% of *PPO* rate for semi-private room & ancillary subject to *deductible*	60% of *usual, customary and reasonable fees* for semi-private room & ancillary subject to *deductible*	

***Physician* In-*Hospital* Services**			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Physician Medical *Hospital* Visit	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Physician Routine Newborn Visit	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Consultant Visit	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Mental or Nervous Disorder and *Substance Abuse* Treatment Visit	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* of *intensive care unit* subject to *deductible*	

Surgical *Inpatient* and Outpatient Services (other than office)			
Percentage Payable For:	***PPO Network Provider and Out of Area Providers***	**Non-*PPO Network Providers***	**Limits**
Anesthesia	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Assistant Surgeon	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	Limited to 25% of the *UCR* fee for the surgical procedure
Second Surgical Opinion	100% of *PPO* rate *deductible* waived	100% of *usual, customary and reasonable fees* *deductible* waived	
Obstetrical	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Surgeon	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	

Professional Interpretation Services *Inpatient* and Outpatient			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Pathologist Fees and Radiologist Fees	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	

***Hospital* Emergency Room Services**			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Emergency Room – for emergency situation	80% of *PPO* rate subject to *deductible*	80% of *usual, customary and reasonable fees* subject to *deductible*	
Emergency Room – non-emergency situation	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Emergency Room *Physician* and all related institutional charges – *Accident* or *Illness*	80% of *PPO* rate subject to *deductible*	80% of *usual, customary and reasonable fees* subject to *deductible*	

Outpatient *Diagnostic Services*			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Pre-admission Testing	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Diagnostic Laboratory and X-Rays	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	

Outpatient Facility Fees			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Ambulatory Surgery Center	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Birthing Center	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Urgent Care Center	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Clinic Visit	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	

Outpatient Therapy Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Chemotherapy	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Cardiac Rehabilitation	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Respiration Therapy	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Radiation Therapy	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Physical Therapy	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Occupational Therapy	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Speech Therapy	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	

Physician's Office Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Office Visit	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Injections, Allergy Care, Surgery, Lab & X-ray – performed in office setting	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	

***Chiropractic Care* and Spinal Manipulation Services**			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Office Visit, Therapies and X-rays	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	

Outpatient *Mental or Nervous Disorder* and *Substance Abuse* Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Office or Clinic Visit	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	

Preventive Care Services			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Preventive Care – Covered persons eight years of age or older • Office Visit and Physical Exams • Pap Smears • Mammograms • Prostate Exam • Routine Colon Cancer Screenings and Colonoscopy (persons age 40 or older) • Routine Endoscopic Services • Routine Testing: Blood Glucose Screening Chest X-Ray Cholesterol Test Complete Blood Count Comprehensive Metabolic Panel Electrocardiogram (EKG) Urinalysis (UA) • Bone Density Tests • Well Child Laboratory Tests (eight years of age or older)	100% of *PPO* rate not subject to *deductible*	80% of *usual, customary and reasonable fees* subject to *deductible*	Refer to section, "Medical Benefits" for frequency limits
Well *Child* Care – Covered Persons younger than eight years of age • Office Visit and Examination • Immunizations • Laboratory Tests	80% of PPO rate *Deductible waived*	80% of usual, customary and reasonable fees Deductible *waived*	

Other *Covered Expenses*			
Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits**
Ambulance — Air or Ground Transportation	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Durable Medical Equipment	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Home Health Services	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Hospice - *Inpatient*	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Hospice - Outpatient	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Blood and Administration	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Oxygen and Administration	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Private Duty Nursing Services – Outpatient	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Prosthetic Devices and Orthotics	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Medical Supplies	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
Transplants	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	
All Other Covered Expenses	80% of *PPO* rate subject to *deductible*	60% of *usual, customary and reasonable fees* subject to *deductible*	

MEDICAL BENEFITS

Please refer to the "Cost Containment Provisions" section for important information concerning any requirements of the *Plan* for prior approval of certain services. The following *covered expenses* must be *incurred* while coverage is in force under this *Plan.* Reimbursement will be made according to the "Schedule of Medical Benefits," and will be subject to all *Plan* maximums, limitations, exclusions and other provisions.

Hospital Inpatient Benefits

Inpatient Care
For medical or surgical care of an *illness* or *injury*, the *Plan* will reimburse *covered expenses* for semi-private *room and board* and necessary ancillary expenses. If the *hospital* does not have semi-private accommodations, the *Plan* will allow coverage for an amount equal to the average semi-private rate for other *hospitals* in that geographic area.

Covered expenses will include *cardiac care units* and *intensive care units*, when appropriate for the *covered person's illness* or *injury.*

Maternity Care
Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn *child* to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending *provider*, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a *provider* obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

When a decision is made to discharge a mother or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, at home post delivery follow up care visits are covered for the *covered person* at their residence by a physician or nurse when performed no later than 72 hours following the *covered person* and newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

- Parent education;
- Physical assessments;
- Assistance and training in breast or bottle feeding; and
- Performance of any maternal or neonatal tests routinely performed during the usual course of inpatient care for the mother or newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

Benefits are payable in the same manner as for medical or surgical care of an *illness*, shown in the "Schedule of Medical Benefits" and this section, and subject to the same maximums.

Newborn Care
Coverage for a newborn *child* will be available only if you have satisfied the requirements for coverage in the "Eligibility for Participation" section.

Covered expenses for newborn *children* include neo-natal intensive care *room and board*, and necessary ancillary expenses. Routine newborn nursery care during the period of *hospital* confinement at birth, including circumcision, is covered

Skilled Nursing (or Extended Care or Convalescent Care) Facilities Benefits
Covered expenses for *inpatient skilled nursing* or (extended care or convalescent care) *facilities* include semi-private *room and board* accommodations, and necessary ancillary charges. Services must be *medically necessary* for treatment of a covered *illness* or *injury*, and may not be for *custodial care*.

Rehabilitation Facilities Benefits
Covered expenses for *inpatient rehabilitation facilities* include semi-private *room and board* accommodations, subject to the maximums listed in the "Schedule of Medical Benefits", and necessary ancillary charges. Services must be *medically necessary* for treatment of a covered *illness* or *injury*, and may not be for *custodial care*.

Mental or Nervous Disorder and Substance Abuse Inpatient Services

Mental or Nervous Disorder Inpatient
Covered expenses for *inpatient* care of a *mental or nervous disorder* include semi-private *room and board* and necessary ancillary charges. Treatment must be rendered in a *hospital* or *psychiatric treatment facility*. If the *hospital* or *psychiatric treatment facility* does not have semi-private accommodations, the *Plan* will allow coverage for an amount equal to the average semi-private rate for other *hospitals* in that geographic area

Substance Abuse Inpatient
Covered expenses for *inpatient* care of *substance abuse* include semi-private *room and board* and necessary ancillary charges. Treatment must be rendered in a *hospital* or *substance abuse treatment facility*. If the *hospital* or *substance abuse treatment facility* does not have semi-private accommodations, the *Plan* will allow coverage for an amount equal to the average semi-private rate for other *hospitals* in that geographic area.

Physicians' In-Hospital Services

In-Hospital Medical Services
Covered expenses include professional services rendered by the attending *physician* while the *covered person* is hospitalized.

In-Hospital Concurrent Medical Care
Covered expenses include services rendered concurrently by a *physician* other than the attending *physician* when the *covered person* is being treated for multiple, unrelated *illnesses* or *injuries,* or which require the skills of a *physician* specialist.

In-Hospital Consultant Services
Covered expenses include the services of a *physician* consultant when required for the diagnosis or treatment of *an illness* or *injury*.

Mental or Nervous Disorder In-Hospital Medical Care Services
Covered expenses include professional services rendered by the attending *physician* while the *covered person* is *hospitalized*.

Substance Abuse In-Hospital Medical Care Services
Covered expenses include professional services rendered by the attending *physician* while the *covered person* is *hospitalized*.

Surgical Inpatient and Outpatient Services

Anesthesia Services
Covered expenses include the administration of spinal, rectal or local anesthesia, or a *drug* or other anesthetic agent by injection or inhalation, rendered by a licensed *provider*. Benefits are also payable for these services when rendered by a Certified Registered Nurse Anesthetist (CRNA)

Surgical Assistants
Covered expenses include services by a licensed *physician* who actively assists the operating surgeon in the performance of *surgical procedures* when the condition of the patient and complexity of the *surgery* warrant such assistance. Benefits are also provided for these services when rendered by a licensed surgical *physician's* assistant.

Obstetrical Services
Covered expenses include obstetrical services rendered by the *physician* in charge of the case, including services customarily rendered as prenatal and postnatal care. Benefits for obstetrical care will be based upon the *Plan* provisions in effect on the date the services are rendered.

Second Surgical Opinions
Covered expenses include a second opinion to determine the *medical necessity* for a recommended *surgical procedure*. The *physician* rendering the second opinion must not be affiliated with the *physician* who recommended the *surgical procedure*. A third opinion will be covered if the two opinions differ, and if it is performed by a *physician* who is not affiliated with the *physicians* who have rendered opinions.

Surgical Services
Covered expenses include *surgical procedures*, including treatment for fractures and dislocations and routine pre- and post-operative care.

When more than one *surgical procedure* is performed through a single incision you are covered only for the most complex procedure. However, if each *surgical procedure* is mutually exclusive of the other, you will be covered for each *surgical procedure*. **Incidental Surgery is not covered.**

When more than one *surgical procedure* is performed during the same operative session through a separate incision, the allowed expense is calculated as follows:

- 100% of the *PPO* rate or the *UCR fee,* as appropriate for the *provider*, for the most complex procedure;
- 50% of the *PPO* rate or the *UCR fee,* as appropriate for the *provider*, for the second procedure; and
- 25% of the *PPO* rate or the *UCR fee,* as appropriate for the *provider*, for the third and subsequent procedures.

If two or more foot surgeries (podiatric surgical procedures) are performed, you are covered for 100% of the *PPO* rate or the *UCR fee,* as appropriate for the *provider,* for the most complex procedure and 50% of the *PPO* rate or the *UCR fee*, as appropriate for the *provider*, for the next two complex procedures. For all other procedures you are covered for 25% of the *PPO* rate or the *UCR fee,* as appropriate for the *provider* for that procedure.

Professional Interpretation Services Inpatient and Outpatient
Covered expenses include interpretation and reporting by a licensed radiologist or pathologist for covered *diagnostic services*. Benefits are provided only for testing required for the diagnosis or treatment of an *illness* or *injury*, unless otherwise provided under "Preventive Care"

Hospital Emergency Room Services
Covered expenses include:

- *Emergency* treatment of an accidental *injury*.
- *Emergency* treatment of an *illness.*

Covered expenses also include *physician's* charges, and charges for radiology and pathology, for *emergency* surgical or medical care rendered in the *hospital* emergency room.

Outpatient Facility Fees
Covered expenses include the following services when provided in an outpatient department of a *hospital* or other *institution*:

Outpatient Diagnostic Examinations
Benefits are provided for *diagnostic services* such as X-ray and laboratory examinations, electrocardiograms (EKG), venous Doppler studies, magnetic resonance imaging (MRI, computerized axial tomography (CAT scan), basal metabolism tests, and electroencephalograms (EEG) when the study is directed toward the diagnosis of an *illness* or *injury,* except as otherwise provided for Preventive Care.

Pre-Admission Testing
Benefits are provided for *pre-admissions' testing for* expenses *incurred* within seven days prior to the scheduled *hospital* admission only when:

- The tests are related to the performance of the scheduled *surgery* or treatment;
- The tests have been ordered by a *physician* after a condition requiring *surgery* or treatment has been diagnosed and *hospital* admission has been requested by the *physician* and confirmed by the *hospital*;
- The *covered person* is subsequently admitted to the *hospital*, or confinement is cancelled or postponed because a *hospital* bed is unavailable or if, after the tests are reviewed, the *physician* determines that the confinement is unnecessary; and
- The tests are performed in the *hospital* where the confinement will take place and are in lieu of duplicate tests which would be rendered during confinement.

Outpatient Surgery/Ambulatory Surgery Center
Benefits are provided for charges by a *hospital*, *ambulatory surgical center*, or in a *physician's* office, for services required for a *surgical procedure*. The facility fees may include services and supplies required for the *surgery*.

Birthing Center
Benefits are provided for charges by a *birthing center* for *medically necessary* services and supplies for obstetrical delivery for a covered *pregnancy*.

Urgent Care Center
Benefits are provided for charges by an *urgent care center* for *medically necessary* services and supplies for treatment of a covered *illness* or *injury*.

Outpatient Therapy Services
Covered expenses include the following services when provided in the home, an office, and outpatient department of a *hospital* or other *institution*:

Cardiac Rehabilitation
Benefits are provided for cardiac rehabilitation program services when certified as *medically necessary* by the attending *physician* in a treatment program that is appropriate for the *covered person's illness*.

Chemotherapy Services
Benefits are provided for administration of chemotherapy treatment, including the *usual, customary and reasonable fee* for *drugs* and supplies used during the treatment.

Respiration Therapy
Benefits are provided for administration of respiration therapy, including the *usual, customary and reasonable fee* for drugs and supplies used during the treatment.

Occupational Therapy
Benefits are provided for occupation therapy to restore a *covered person* to health, or to social or economic independence when rendered following an *inpatient* course of acute care for a covered *illness* or *injury*. These services must be performed by a licensed occupational therapist, who evaluates the performance skills of well and disabled persons of all ages, and who plans and implements programs designed to restore, develop, and maintain the *covered person's* ability to accomplish satisfactorily normal daily tasks. Occupational therapy must be ordered by the attending *physician* as part of a treatment plan that is appropriate for the *covered person's illness* or *injury*.

Physical Therapy
Benefits are provided for rehabilitation concerned with restoration of function and prevention of disability following *illness*, *injury* or loss of a body part. The services must be performed by a licensed physical therapist as part of a treatment program which is appropriate for the *illness* or *injury*, and which is ordered by the attending *physician*.

Radiation Therapy
Benefits are provided for treatment by X-rayradium, external radiation, or radioactive isotopes, including the *usual, customary and reasonable fee* for materials.

Speech Therapy
Benefits are provided for the evaluation and treatment of *covered persons* who have voice, speech, language, swallowing, cognitive or hearing disorders when rendered for a covered *illness* or *injury*. These services must be performed by a licensed and certified speech therapist as part of a treatment program which is appropriate for the *illness* or *injury*, and which is ordered by the attending *physician*.

Physician's Office Services
Covered expenses include the following services rendered in a *physician's* office:

Office Visits
Benefits are provided for services given in a *physician's* office which are required for the diagnosis or treatment of an *illness* or *injury.* Covered services include the services of a *physician's* assistant ("P.A.") rendered under the supervision of the *physician*, and billed by the *physician*.

Allergy Care
Benefits are provided for allergy care, including injections, serums and extracts, given in a *physician's* office. Covered services include the services of a *physician's* assistant ("P.A.") rendered under the supervision of the *physician*, and billed by the *physician*.

Injections
Benefits are provided for therapeutic injections given in a *physician's* office which are required for the treatment of an *illness* or *injury.* Immunizations and other injections which are not for the treatment of an *illness* or *injury* are not covered unless specified under "Preventive Care." Covered services include the services of a *physician's* assistant ("P.A.") rendered under the supervision of the *physician*, and billed by the *physician*.

Diagnostic X-ray and Laboratory Services
Benefits are provided for diagnostic x-ray and laboratory services given in a *physician's* office which are required for the diagnosis or treatment of an *illness* or *injury.* Covered services include the services of a *physician's* assistant ("P.A.") rendered under the supervision of the *physician*, and billed by the *physician*.

Chiropractic Care and Spinal Manipulation Services
Covered expenses include spinal manipulation and other related therapy treatments, and X-rays. *Chiropractic care* must be rendered for the active treatment of an *illness* or *injury*. Maintenance care is not covered.

Outpatient Mental or Nervous Disorder and Substance Abuse Services

Outpatient Mental or Nervous Disorder Care
Covered expenses include outpatient *mental or nervous disorder* care by a licensed psychologist or psychiatrist, including family, individual and group therapy, and psychological testing.

Outpatient Substance Abuse Care
Covered expenses include outpatient *substance ab*use care by a licensed psychologist or psychiatrist, including family, individual and group therapy, and psychological testing.

Preventive Care Benefits

Covered employees and spouses:
Covered expenses include, but are not limited to, these listed services for preventive care for each covered person ages eight and older:

- Routine physical exams - one per *plan year*;
- Mammograms – one per *plan year*,
- Pap smears - one per *plan year*,
- Prostate exams,
- Routine colon cancer screenings and colonoscopy,
- Routine endoscopic procedures,
- Routine bone density tests,
- Routine EKG, chest x-ray, complete blood count, comprehensive metabolic panel and urinalysis – one each per *plan year*, and
- Routine cholesterol screenings.

The preventive care services must be provided in keeping with prevailing medical standards, be furnished or supervised by a *physician* and comply with all other *Plan* provisions. All services must be provided or ordered in one visit, with the charge for the visit payable to one *physician*.

Well child care:
Covered expenses include these listed services for preventive care for each covered *dependent child* under age eight:

- Office visit and examination;
- Routine lab tests and screenings; and
- Routine immunizations.

Other Covered Expenses

Ambulance Service
Covered expenses include local professional ambulance service from your home to a *hospital*, or from the scene of an *accident* or medical *emergency*, to the nearest *institution* able to treat the condition.

Air ambulance services will be covered when *medically necessary* to transport the *covered person* to the nearest *institution* capable of treating the *illness* or *injury*.

Transportation services provided by an ambulette or a wheelchair van are not *covered expenses*

Durable Medical Equipment
Covered expenses include rental of *durable medical equipment* The *Plan* may approve purchase of the equipment at the *Plan Administrator's* discretion. Benefits for rental will not exceed the *usual, customary and reasonable fee* for purchase.

Home Health Care

Covered expenses include home health services when rendered by a licensed and accredited *home health care agency*. These services must be provided through a formal, written home health care treatment plan, certified as *medically necessary* by the attending *physician,* and approved by the *Plan*. Benefits are provided for:

- Skilled nursing care as provided by a licensed practical nurse or registered nurse who does not ordinarily live in your home and who is not a member of your immediate family.
- Physical occupational, and speech therapy.
- Services provided by a certified home health aide under the supervision of a registered nurse.
- Physician visits.
- Services, drugs and medical supplies which are *medically necessary* for the treatment of the *covered person* that would have been provided in a *hospital*.

Custodial care is not covered. On-going home health services will require re-certification by the attending *physician* and approval by the *Plan,* at the *Plan Administrator's* discretion, in order to qualify for continued coverage.

Hospice Care

Covered expenses include hospice care services for a terminally ill *covered person* who has a life expectancy of six months or less when provided by a *hospice care agency*. The services must be provided through a formal, written hospice care treatment program and certified by the attending *physician* as *medically necessary*. Benefits are provided for:

- *Room and board* for confinement in a licensed, accredited hospice facility.
- Services and supplies furnished by the hospice while the patient is confined.
- Home care furnished by a *hospital* or *home health care agency*, under the direction of a *hospice care agency*, including *custodial care* if it is provided during a regular visit by a registered nurse, a licensed practical nurse or a home health aide.
- Medical supplies, drugs and medicines prescribed by the attending *physician*, but only to the extent such items are necessary for pain control and management of the terminal condition.
- *Physician* services and nursing care by a registered nurse (R.N.), licensed practical nurse (L.P.N.) or a licensed vocational nurse (L.V.N.).
- Nutrition services and/or special meals.
- Respite services.
- Medical social services by licensed or trained social workers, psychologists or counselors.
- Home health aide services.
- Bereavement counseling for members of the *family unit* of the deceased *covered person* for charges *incurred* within six months following death.

Other *Covered Expenses* Also Include:

- **Abortion** and related expenses regardless of whether it is elective or whether the life of the mother is threatened should the pregnancy be allowed to continue to full term.

- **Blood transfusions and blood products,** to the extent not replaced. The Plan will not cover expenses in connection with autologous blood acquisition and storage.

- **Clinical Trial Programs** for routine patient care administered to a *covered person* participating in any stage of an eligible cancer clinical trial, if that care would be covered under the *plan* if the *covered person* was not participating in a clinical trial.

  "Eligible cancer clinical trial" means a cancer clinical trial that meets all the following criteria:

  - A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes;
  - The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcome;
  - The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology; and
  - The trial does one of the following:

    - Tests how to administer a health care service, item, or drug for the treatment of cancer;
    - Tests responses to a health care service, item, or drug for the treatment of cancer;
    - Compares the effectiveness of a health care service, item or drug for the treatment of cancer with that of other health care services, items or drugs for the treatment of cancer;
    - Studies new uses of a health care service, item or drug for the treatment of cancer;
    - The trial is approved by one of the following entities:

      - The national institutes of health or one of its cooperative groups or centers under the United States Department of Health and Human Services;
      - The United States Food and Drug Administration;
      - The United States Department of Defense; or
      - The United States Department of Veteran's Affairs.

"Routine patient care" means all health care services consistent with the coverage provided under the *Plan* for the treatment of cancer, including the type and frequency of any diagnostic modality that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial, and that was not necessitated solely because of the trial.

"Subject of a cancer clinical trial" means the health care service, item or drug that is being evaluated in the clinical trial and that is not routine patient care.

No benefits are payable for the following:

- A health care service, item or drug that is the subject of the cancer clinical trial
- A health care service, item or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
- An Experimental or Investigational drug or device that has not been approved for market by the United States Food and Drug Administration;
- Transportation, lodging, food or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
- An item or drug provided by the cancer clinical trial sponsors free of charge for any patient; and
- A service, item or drug that is eligible for reimbursement by a person other than this *Plan*, including the sponsor of the cancer clinical trial.

- **Health Education Services.** Benefits are provided for educational, vocational and training services while an inpatient of a hospital or other facility provider. Diabetic educational services are covered under this *plan,* whether rendered on an inpatient or outpatient basis.

- **Oxygen** and its administration.

- **R.N. and L.P.N.** private duty nursing services for outpatient care when *medically necessary*.

- **Medical supplies,** including:

  - **Diabetic supplies,** including insulin, syringes, needles, alcohol swabs, blood glucose test strips, ketone test strips and tablets, lancets and devices, and ostomy supplies and other similar items that serve only a medical purpose, excluding items usually stocked in the home, or that have a value in the absence of an *illness* or *injury.*

  - **Prosthetic devices and supplies**, including initial purchase price, fitting, adjustment and repairs. Replacements of prosthetic devices are not covered unless due to a significant change in the *covered person's* physical structure and the current device cannot be made serviceable.

  - **Surgical dressings, splints, casts, braces, orthotics and** other devices used in the reduction of fractures and dislocations, as well as other similar items that serve only a medical purpose, excluding items usually stocked in the home, or that have a value in the absence of an *illness* or *injury*. Replacements for braces will not be covered unless due to a significant change in the *covered person's* physical structure and the current device cannot be made serviceable.

- **One set of lenses** (contact or frame-type) following *surgery* for cataracts, aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

- **Reconstruction of a breast** following a *mastectomy*, reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications from all stages of a *mastectomy*, including lymphademas, in a manner determined in consultation with the attending *physician* and the *covered person*. Reimbursement will be made according to the "Schedule of Medical Benefits" section by type of service.

- **Prescription contraceptives** and contraception-related services, including the initial visit to the prescribing *physician* and any follow-up visits or office and outpatient services.

- **Oral surgical procedures**, including:

  - Surgical extraction of impacted teeth.

  - Excision of malignant tumors and cysts of the jaws, cheeks, lips, tongues, roof and floor of the mouth.

  - *Surgery* needed to correct accidental *injuries* (other than as a result of biting or chewing) to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

  - Treatment of an injury to sound natural teeth (other than as a result of biting or chewing) rendered within 12 months following the date of the *accident*.

- **Chelation therapy** for a diagnosis of lead poisoning, or a diagnosis of anemia for a *child*.

Replacement of Organs/Tissues and Related Services

The *Plan Administrator* strongly recommends that any *covered person* who is a candidate for any transplant procedure contact the claims administrator before making arrangements for the procedure. This communication process may identify certain types of procedures, or expenses associated with the procedures, which will not be covered under the *Plan,* before the actual services are rendered.

The *Plan* will cover the following organ and tissue transplants:

- Bone marrow;
- Heart;
- Lung;
- Heart and lung;
- Liver;
- Pancreas;
- Kidney; and
- Cornea.

Covered expenses include:

- Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part;
- *Medically necessary* and non-*experimental* services and supplies furnished by a *provider*; and
- Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

Surgical, storage and transportation costs, not including donor medical expenses, directly related to the procurement of an organ or tissue used in a transplant, will be covered. If an organ or tissue is sold rather than donated, no benefits will be available for the purchase price of such organ or tissue.

The *Plan* covers expenses *incurred* by the *covered person* who is the recipient of the transplant. Coverage is not provided for expenses incurred by a live donor unless the live donor is also covered under this plan.

COST CONTAINMENT PROVISIONS

Pre-certification Program for Hospital Inpatient Services
Inpatient care is normally the greatest part of the *Plan's* expenses and can be the most critical part of your treatment. Through the *Plan's* Pre-certification Program, it is possible to work with your attending *physician* to arrange for care in a setting that is more comfortable for you, such as your home, and to save both you and the *Plan* unnecessary expense.

The program works by establishing a communication among you, your attending *physician* and the Pre-certification Program administrator to discuss the proposed course of treatment and any options that may be available for your treatment. The Pre-certification Program does not establish your eligibility for coverage under the *Plan*, nor does it approve the services for coverage or reimbursement under the *Plan*. Those responsibilities rest with the *Plan Administrator*.

Because communication is the basis for the program, the *Plan* requires that you contact the Pre-certification Program administrator 10 days or more before a non-*emergency hospital* admission. The contact may be made by you, a friend or family member, or your *physician* or facility; however, it is important that you understand that it is your responsibility to make sure that the contact has been made. **Failure to contact the Program administrator within the time limits specified in this section will result in a penalty reducing the benefits otherwise payable.** The *Plan* will provide coverage only for *inpatient* stays which are determined to be *medically necessary* for treatment of a covered *illness* or *injury*.

The Pre-certification Program administrator for this plan is HealthCare Strategies. The Pre-certification Program administrator's hours of operations are 24/7 and can be reached at 1-800-582-1535.

Urgent Care or Emergency Admissions
Do not delay seeking medical care for any *covered person* who has a serious condition that may jeopardize his life or health because of the requirements of this Program. For urgent, *emergency* admissions, follow your *physician's* instructions carefully, and contact the Pre-certification Program administrator within 48 hours following the admission. For *emergency* admissions after 5:00 p.m. on Friday, on a weekend or over a holiday weekend, the call must be made within 72 hours of admission but no later than the first business day following admission. No penalty will be applied to your benefits if contact is made within this time period.

Since the *Plan* does not require a *covered person* to obtain approval of a medical service prior to getting treatment for an urgent care or *emergency* situation, there are no *"pre-service urgent care claims"* under the *Plan*. In an urgent care or *emergency* situation, you or a covered *dependent* simply follow the *Plan*'s procedures following the treatment and file the claim as a *"post-service claim."*

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn *child* to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending *provider*, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a *provider* obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). **Notification is still encouraged at the time of admission, and is required for any *hospital* stay that is in excess of the minimum length of stay**. Failure to notify the Pre-certification Program administrator within 48 hours of any stay that is in excess of the minimum length of stay will result in application of a penalty to the benefits otherwise payable for *hospital* expenses. For a *hospital* stay that exceeds the time limits specified under federal law on a holiday or after 5:00 p.m. on Friday, contact must be made on the next regular business day. No penalty will be applied to your benefits if contact is made within this time period.

Concurrent Inpatient Review

Once the *inpatient* setting has been pre-certified, the on-going review of the course of treatment becomes the focus of the Program. Working directly with your *physician*, the Pre-certification Program administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses. The *Plan* will provide coverage only for continuing *inpatient* stays which are determined to be *medically necessary* for treatment of a covered *illness* or *injury*.

The Pre-certification Program administrator will not interfere with your course of treatment or the physician-patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this Program.

The Pre-certification Program administrator for this *Plan* is:

HealthCare Strategies
(800) 582-1535

Penalty
If you fail to notify the Pre-certification Program administrator within the time periods described in this section for *emergency* and non-*emergency* care, and receive treatment at a non-network facility, you will be responsible for the full amount of the billed charges from the facility and all charges from providers relating to this admission. This amount will not apply to any *deductibles* or *out-of-pocket expenses.*

A pre-certification or concurrent review determination under this section will not be a guarantee of eligibility, coverage or benefits. All benefit determinations will be based upon the provisions of this *Plan* and the decision of the *Plan Administrator* in its sole discretion.

Voluntary Second Surgical Opinions
Second surgical opinions are designed to assist you in making an informed decision about your treatment. If your *physician* recommends one of the elective *surgical procedures* listed in this section, you may obtain a second opinion from a *physician* who is not associated or affiliated with the *physician* who is recommending the *surgery*.

Do not delay seeking medical care for any *covered person* who has a serious condition that may jeopardize his life or health because of this provision. Second surgical opinions are not recommended under these circumstances.

Procedures that require pre-certification include inpatient hospital stays, outpatient surgeries, all biopsies, blepharoplasty, chemotherapy/infusion therapy, durable medical equipment in excess of $1,500 (purchase or rental), home health services, hospice care, skilled nursing facility stays, hyperbaric oxygen treatment, radiation therapy, renal dialysis and human organ evaluation and transplantation. For a complete list please contact your claims administrator.

The *Plan Administrator* recommends that a second opinion be obtained before you decide to undergo one of the following non-*emergency surgical procedures*:

- Adenoidectomy;
- Bunionectomy;
- Cataract removal;
- Coronary bypass;
- Cholecystectomy (removal of gallbladder);
- Dilation and curettage;
- Hammer toe repair;
- Hemorrhoidectomy;
- Herniography;
- Hysterectomy;
- Laminectomy (removal of spinal disk);
- Mastectomy;

- Meniscectomy (removal of knee cartilage, including arthroscopic approach);
- Nasal surgery (repair of deviated nasal septum, bone or cartilage);
- Prostatectomy (removal of all or part of prostate);
- Release for entrapment of medial nerve (Carpal Tunnel Syndrome);
- Tonsillectomy; and
- Varicose veins (tying off and stripping).

When a second opinion is requested, the *Plan* will pay the benefits shown in the "Schedule of Medical Benefits" for the opinion, including laboratory, X-ray and other *medically necessary* services ordered by the second *physician*. Second opinions for *cosmetic surgery*, normal obstetrical delivery and procedures that require only local anesthesia are not covered. If the second opinion does not concur with the first, the *Plan* will pay for a third opinion in the same manner as the second opinion. The second and/or third opinion must be given within 90 days of the original recommendation for surgery.

The *physician* consulted for the second and/or third opinion must be licensed in the appropriate medical specialty and may not be a partner of, or in association with, the *physician* who originally recommended the procedure.

The decision to undergo the proposed *surgical procedure* is yours alone. The *Plan Administrator* will not interfere with the proposed treatment or the *physician*-patient relationship.

Pre-surgery Approval
The *Plan Administrator* strongly recommends that you obtain prior approval for the types of surgical procedures listed below in this section. These procedures may be considered *cosmetic* or not *medically necessary*, and prior approval can help you to avoid incurring unexpected costs for denied expenses.

However, do not delay seeking medical care for any *covered person* who has a serious condition that may jeopardize his life or health because of this provision. Prior approval is not required or recommended under these circumstances. Since the *Plan* does not require you or a covered *dependent* to obtain approval of any *surgical procedure* prior to getting treatment for an urgent care or *emergency* situation, there are no "Pre-service Urgent Care Claims" under the *Plan*. In an urgent care or *emergency* situation, you or a covered *dependent* simply follow the *Plan*'s procedures following the treatment, and file the claim as a "Post-service Claim."

These are examples of *surgical procedures* which may be limited or excluded under the *Plan*:

- Abdominoplasty;
- Blepharoplasty;
- Breast reduction or enlargement (except following a mastectomy as required under the Women's Health and Cancer Rights Act);
- Dermabrasion;
- Facial or nasal reconstruction;
- Gastric bypass;
- Limpectomy;
- Penile implant;
- Scar revision;
- Sex alteration; or
- Any *experimental* or research procedures which are not generally accepted medical practice.

Because of the broad range of *surgical procedures* available and under development, you should contact the *third party administrator* for further information regarding any proposed procedure that may be limited or excluded from coverage under the *Plan*.

The decision to undergo the proposed *surgical procedure* is yours alone. The *Plan Administrator* will not interfere with the proposed treatment or the *physician*-patient relationship.

A pre-surgery approval under this section will not be a guarantee of eligibility, coverage or benefits. All benefit determinations will be based upon the provisions of this *Plan* and the decision of the *Plan Administrator* in its sole discretion.

Case Management Program
In certain circumstances, especially in the case of a very serious *illness* or *injury*, the *Plan* may make available its Case Management Program services to the *covered person*. This is strictly a voluntary program; no *covered person* is obligated to participate and benefits will not be adversely affected.

The Case Management Program is administered by Health Design Plus. Case managers are medical professionals who will work with your attending *physician* to identify alternate courses of treatment and the best way to use your benefit dollars. They can be of invaluable assistance in locating resources to assist in your recovery.

If you are selected as a candidate for case management, you will be contacted by a case manager who will then work with you and your *physician* throughout the course of treatment. If you have any questions about the Case Management Program, please feel free to contact **HealthCare Strategies 1-800-582-1535.**

Prescription Drug Benefits

Prescription Drug Schedule of Benefits

Prescription Drug Card Program Pharmacy Option	
Prescription Drug Card Program — *Generic*	20% copayment per prescription or refill
Prescription Drug Card Program — Preferred *Brand Name*	20% copayment per prescription or refill
Prescription Drug Card Program — Non-Preferred *Brand Name*	20% copayment per prescription or refill
Pharmacy Option drug card purchases are subject to a maximum 30-day supply	
Prescription Drug Program Mail Order Option	
Prescription Drug Program: Mail Service — *Generic*	20% copayment per prescription or refill
Prescription Drug Program: Mail Service — Preferred *Brand Name*	20% copayment per prescription or refill
Prescription Drug Program: Mail Service — Non-Preferred *Brand Name*	20% copayment per prescription or refill
Mail Order Option drug purchases are subject to a maximum 90-day supply	
Important note effective January 1, 2014 and thereafter: Pharmacy Option and Mail Order Option 20% out-of-pocket copayment expense is limited to $1,500 per individual and no more than $3,000 per family with additional copayment expense paid in full for the remainder of the current Plan year.	

Benefits are provided for the purchase of drugs through the *Plan's* Prescription Drug Benefit. You may choose to purchase covered drugs from a participating pharmacy (the "Pharmacy Option"), or, for certain maintenance drugs that must be taken over long periods of time, you may save money by using the "Mail Order Option", which is explained below.

The *Plan's* Prescription Drug Card Program is administered by National Script. National Script has a network of pharmacies which can identify *covered persons* and the *Plan's* coverage provisions. To find out which pharmacies participate, contact National Script at (855)-628-2100 or the web site at www.nationalscript.com. Participating pharmacies have agreed to provide covered drugs at discounted rates to the *Plan* and to *covered persons*. You may contact your pharmacy or National Script to find out which copayment applies to your prescription drug.

The Prescription Drug Schedule of Benefits shown above contains the copayment amounts for *generic drugs* and for *brand name drugs*. This is the amount you must pay for each prescription or refill. If you do not use a participating pharmacy, or you do not use your *Plan* ID card at the time of purchase, you must pay the full cost of the prescription and the Plan will not reimburse you for this expense.

Also, unless your *physician* has ordered that the prescription be "dispensed as written" (or a similar indication) or there is no *generic* equivalent for your prescription, you must also pay for the cost difference between the *brand name drug* and its *generic* equivalent.

Copayments and cost differentials are not eligible for credit toward your *deductibles* or *out-of-pocket expense* limits.

How the Program Works
There are two ways to purchase drugs through the *Plan's* Prescription Drug Program. You may save money by using the "Mail Order Option" if you have prescription drug(s) that you must take on an on-going basis.

- To fill a prescription at a participating pharmacy (the "Pharmacy Option"), simply present your *Plan* ID card and pay your portion of the cost (shown in the "Prescription Drug Schedule of Benefits"). The pharmacist will file the claim for you.

- To fill a prescription at a non-participating pharmacy, you must pay for the full cost of the prescription. No coverage is provided under the *Plan* for these purchases.

- To fill a prescription through the Drug Card Program's "Mail Order Option":

  - Obtain a copy of the Mail Order Form from your Human Resources department or from National Script Mail Order Service, online at www.nationalscript.com

  - Complete the Mail Order Form and the Patient Profile Questionnaire (for your first order only), and enclose your prescription and your copayment.

  - If you are presently taking medication, you will need a new prescription.

  - If you need the medication immediately but will be taking it on an on-going basis**,** ask your *physician* for two prescriptions: one for a 30-day supply that you can have filled at a local pharmacy, and one for the balance of the prescription, up to a 90-day supply, that you can submit through the "mail order option."

  - Send the completed forms to the address on the Mail Order Form.

  You should receive your medication via First Class Mail. To obtain a refill, follow the instructions that will accompany your first order.

Covered Prescription Drug Expenses
The following are covered under the *Plan*:

- **Compounded prescriptions.** All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity;

- **Diabetes.** Insulin, insulin syringes and needles, diabetic supplies and insulin-related chemical strips, when prescribed by a *physician*;

- **Prescription Contraceptives.** Prescription contraceptives, prescribed by a physician. Contraceptive devices (such as an IUD or implants) are not covered under this benefit; and

- **Required by Federal or State Law.** Drugs prescribed by a *physician* that require a prescription either by federal or state law.

Excluded Prescription Drug Expenses
These expenses are not covered under the Prescription Drug Benefits:

- **Administration.** Any charge for the administration of a covered drug;

- **Consumed Where Dispensed.** Any drug or medicine that is consumed or administered at the place where it is dispensed;

- **Devices.** Devices of any type, even though such devices may require a prescription, including, but not limited to, therapeutic devices, artificial appliances, braces, support garments or any similar device;

- **Excluded Items.** Any charge excluded under the Medical Benefits of the *Plan*;

- ***Experimental* Drugs.** *Experimental* drugs and medicines, even though a charge is made to the *covered person*;

- **Gleevec.** Charges for the prescription drug, Gleevec;

- **Immunizations.** Immunization agents or biological sera;

- **Institutional Medication.** A drug or medicine that is to be taken by a *covered person*, in whole or in part, while confined in an *institution*, including any *institution* that has a facility for dispensing drugs and medicines on its premises;

- **Investigational Use Drugs.** A drug or medicine labeled "Caution – limited by federal law to investigational use;"

- **Job-Related.** Prescriptions which an eligible person is entitled to receive without charge under any workers' compensation or similar law;

- **Legend Drugs**. Fertility drugs; isotretinoin; nutritional supplements; and Rogaine;

- **No Charge.** A charge for drugs which may be properly received without charge under local, state or federal programs;

- **Non-Prescription Drug or Medicine.** A drug or medicine that can legally be bought without a prescription, except for injectable insulin or diabetic supplies; and

- **Vitamins.** Vitamins, except pre-natal vitamins.

PLAN EXCLUSIONS AND LIMITATIONS

This *Plan* will not reimburse any expense that is not a *covered expense*. This *Plan* does not cover any charge for the following services or supplies:

- **Absence of coverage.** That would not have been made in the absence of coverage.
    - This includes charges that are submitted to the *Plan* equal to any amount for which the *provider* has discounted fees or has "written off" amounts due.
- **Acupuncture, biofeedback and hypnosis.** For charges related to acupuncture, biofeedback or hypnosis.
- **Civil insurrection or riot.** Resulting from *injuries* incurred or exacerbated while participating in a civil insurrection or riot**.**
- **Cochlear implants.** For cochlear implants.
- **Complications.** That result from complications arising from a non-covered *illness* or *injury*, or from a non-covered procedure.
- ***Cosmetic.*** For *cosmetic surgery* or procedures, or aesthetic services (including complications arising therefrom).
    - This exclusion does not apply to procedures required as the result of an *injury,* with treatment started by a *physician* within 6 months after the accident; or if approved as *medically necessary* for a covered *illness*.
    - This exclusion does not apply to procedures required to correct a congenital birth defect or abnormality for functional repair or restoration of any body part when necessary to achieve normal body functioning.
    - This exclusion does not apply to reconstruction of a breast following a *mastectomy*, reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications from all stages of a *mastectomy*, including lymphademas, in a manner determined in consultation with the attending *physician* and the *covered person*.
- **Corrective shoes.** For corrective shoes and orthopedic shoes. This exclusion will not apply to orthopedic shoes when they are an integral part of a leg brace and the cost is included in the orthopedic surgeons charge.
- **Counseling.** For counseling, except as specifically the result of a *mental or nervous disorder* or *substance abuse* disorder, for:
    - Marital difficulties
    - Social maladjustment
    - Pastoral issues
    - Financial issues
    - Behavioral issues

- Lack of discipline or other antisocial action.

- **Court-ordered services.** That are ordered by a court, unless determined by the *Plan Administrator*, in its discretion, to otherwise be appropriate and covered.

- ***Custodial care.*** For *custodial care*, except as specified.

- ***Deductibles*, copayments and coinsurance.** That are not payable due to the application of any specified *deductible*, copayment or coinsurance provisions of the *Plan.*

- **Dental *hospital* admissions.** Related to dental *hospital* admissions, unless determined to be *medically necessary* because of a concomitant condition.

- **Dental.** That are related to dental treatment, except as specifically provided in this *Plan*.

- **Educational.** That are related to education or vocational training, except as provided in this *Plan*.

  - This exclusion does not apply to educational services rendered for diabetic counseling, peritoneal dialysis, or any other educational service deemed to be *medically necessary* by the *Plan*.

- **Excess.** That are not payable under the *Plan* due to application of any *Plan* maximum or limit, or because the charges are in excess of the *Plan Administrator's* determination of the *usual, customary and reasonable fee* for the particular service or supply.**Excess over semi-private rate.** That are in excess of the semi-private room rate, except as otherwise noted.

- ***Experimental.*** That are *experimental.*

  - In some cases, the application of an established procedure, as a course of treatment for a specific condition, may be considered *experimental*, and hence, not covered by this *Plan*.

- **Excluded providers and facilities.** That are rendered or provided by the following excluded providers or facilities:

  - Hypnotists;

  - Naturopaths;

  - Rolfers; and

  - Marriage counselors.

- **Exercise programs.** For exercise programs and exercise equipment except as a part of an approved rehabilitation therapy program.

- **Eye exercises or training and orthoptics.** For eye exercises or training and orthoptics.

- **Eyeglasses, contact lenses, refractions.** For eyeglasses, contact lenses and refractions, except one pair of lenses following surgery for cataracts. This exclusion does not apply to aphakic patients, or to soft lenses or sclera shells intended for use as corneal bandages.

- **Food supplements.** Related to food supplements or augmentation, in any form (unless *medically necessary* to sustain life in a critically ill person).

- **Foot care services routine.** For routine foot care, including, but not limited to, cutting or removal of corns or calluses, the trimming of nails and other hygienic and preventive and maintenance care, performed in the absence of localized *illness*, *injury* or symptoms involving the foot.

- **Forms.** For the completion of medical reports, claim forms or itemized billings.

- **Genetic testing and/or counseling.** For genetic testing or counseling.

- **Gleevec.** For the drug, Gleevec.

- **Government services.** To the extent paid, or which the *covered person* is entitled to have paid or obtain without cost, by or through any government, or division thereof, except a program for civilian employees of a government.

- **Hazardous hobby.** For any condition, *illness* or *injury*, or complication thereof, arising out of engaging in a hazardous hobby or activity, which is an unusual activity characterized by a constant threat of danger, such as skydiving, auto racing, hang gliding and bungee jumping. This does not include common recreational activities, such as water or snow skiing, jet ski operating, horseback riding, boating, motorcycling, snowmobiling, all-terrain vehicle riding and team sports.

- **Hearing aids.** For hearing aids or devices, or the examination for their prescription and fitting.

- **Illegal act.** Related to *injuries* sustained, or an *illness* contracted, during the commission, or attempted commission, of a felony. This exclusion will only apply if the *covered person*:

  - has been found guilty of a felony by a court of competent jurisdiction;
  - has pled guilty or no contest to a felony charge; or
  - is under a formal felony charge on the date that a claim for benefits under the *Plan* is adjudicated.

  This exclusion will not apply if a felony charge has been dropped or reduced to a misdemeanor prior to the date the claim for benefits under the *Plan* is adjudicated. If a claim is denied under this exclusion and the felony charge is subsequently dropped or reduced to a misdemeanor, the claim may be reconsidered only on formal appeal. Any such appeal must be filed in accordance with the time limits and conditions for filing appeals as described under the section, "Claim Procedures". The *Plan* will deny consideration of appeals not filed in accordance with the time limits and conditions of the procedures set forth in this *Plan*.

- **Immediate relative.** Provided by an *immediate relative* or an individual residing in your home including your spouse, your children or your spouse's children, brothers, sisters, parents or grandparents.

- **Impotence; sexual dysfunction.** For impotence and sexual dysfunction treatment including, but not limited to, penile implants or sexual devices pertaining to sexual dysfunction or impotence.

- ***Infertility treatment.*** For *infertility treatment*, including, but not limited to, in vitro fertilization, gamete intrafallopian transfer (GIFT), fertility drugs, artificial insemination, zygote intrafallopian transfer (ZIFT), and reversal of a sterilization procedure, surrogate mother or donor eggs.

- **Late claims.** For which the claim is received by the *Plan* after the maximum period allowed under this *Plan* for filing claims has expired.

- **Marital counseling.** For marital counseling or family counseling.

- **Medically unnecessary.** That is not *medically necessary* for the care and treatment of an *injury* or *illness*, except where otherwise specified, or are not accepted as standard practice by the American Medical Association or the Food and Drug Administration.

- **Military service.** Resulting from, or prolonged as a result of, performing a duty as a member of the military service of any state or country.

- **Missed appointments.** Related to missed appointments.

- **No legal obligation.** That are provided to a *covered person* for which the *provider* customarily makes no direct charge or for which the *covered person* is not legally obligated to pay.

- **Non-prescription medicines and supplies.** That can be purchased without a prescription from a licensed *physician*.

- **Not actually rendered.** That are not actually rendered.

- **Not eligible.** That were rendered or received prior to or after any period of coverage under this *Plan,* except as specifically provided for in this *summary plan description*.

- **Not specifically covered.** That are not specifically covered under the *Plan.*

- **Obesity treatment.** For the purpose of weight loss, including food supplements, exercise programs, exercise equipment, weight control programs, injections, drugs and medications, *surgery* of any kind, equipment or educational programs. This exclusion will not apply to treatment of morbid obesity, which is defined on page 73.

- **Orthognathic *surgery*** (jaw realignment *surgery*) to correct retrognathia, apertognathia, prognathism, open bite malocclusion, or transverse skeletal deformities.

- **Outside of the U.S.A.** For any care, services, drugs or supplies *incurred* outside of the U.S.A. if the *covered person* traveled to such a location for the purpose of obtaining the care, services, drugs or supplies. This exclusion may not apply to a *covered person* receiving urgent or *emergency* care for a covered *illness* or *injury* which became necessary while traveling outside of the U.S.A.

- **Patient convenience.** Related to the modification of homes, vehicles or personal property to accommodate patient convenience. This includes, but is not limited to, the installation of ramps, elevators, air conditioners, air purifiers, TDD/TTY communication devices, personal safety alert systems, exercise equipment and cervical pillows. This exclusion also applies to any services or supplies that are provided during a course of treatment for an *illness* or *injury* that are solely for the personal comfort and convenience of the patient.

- **Penalties.** That are related to failure to comply with any requirements for coverage under this *Plan*, or for any copayment amounts identified as a "penalty" in this *summary plan description*.

- **Personal hygiene.** For personal hygiene or convenience items.

- **Preventive care.** For physical examinations, routine and preventive care, except as specifically provided under this *Plan*. This will include but not be limited to physical examinations or services required by an insurance company to obtain insurance, physical examinations or services required by a governmental agency such as the FAA and DOT, physical examinations or services required by an employer in order to begin or continue working, premarital examinations, screening examinations, except as provided or x-ray examinations with no preserved film image or digital record.

- **Prohibited by law.** For which the *Plan* is prohibited by law or regulation from providing benefits.
- **Sex change.** Expenses for all services and supplies in connection with sex change operations or procedures.
- **Sterilization reversal procedures**. Voluntary sterilization charges are *covered expenses* under this *plan.*
- **Subrogation.** That are not payable under the *Plan* by virtue of its subrogation provisions.
- **Telephone consultations.** For telephone consultations**.**
- **Therapy.** That are related to aversion therapy, hypnosis therapy, primal therapy, rolfing, psychodrama, recreational therapy, educational therapy, milieu therapy or megavitamin therapy.
- **Travel.** For travel, even though prescribed by a *physician*.
- **Vision correction.** For radial keratotomy, keratomileusis or other vision correction procedures.
- **Vitamins.** For vitamins.
- **War.** Resulting from war or an act of war, whether declared or undeclared, or any act of aggression, and any complication therefrom. This exclusion does not apply to *covered persons* who are not members of the *uniformed services*.
- **Without approval.** Furnished without recommendation and approval of a *physician* acting within the scope of his or her license.
- **Work-related *illness* or *injury.*** Related to an *illness* or *injury* arising out of, or in the course of, any employment for wage or profit, including that of previous employers or while self-employed, without regard to whether such *illness* or *injury* entitles the *covered person* to workers' compensation or similar benefits.

With respect to any *injury* which is otherwise covered by the *Plan*, the *Plan* will not deny benefits provided for treatment of the *injury* if the *injury* results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

TERMINATION OF COVERAGE

When does my participation end?
Your participation will end at 11:59 P.M. on the earliest of the following dates:

- The date the *Plan* terminates;
- The date of the month on which you request that your coverage be terminated, provided your request is made on or before that date;
- If you fail to make any contribution when it is due, the last date of the period for which you made a contribution;
- The end of the month on which you cease to be eligible for coverage under the *Plan*;
- The end of the month on which your employment is terminated; or
- The date on which an *employee* or his *dependent* submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the *Plan*, including enrollment information.

When does participation end for my dependents?
The coverage for your *dependents* will end at 11:59 P.M. on the earliest of the following dates:

- The date the *Plan* terminates;
- The date the *Plan* discontinues coverage for *dependents*;
- The date your *dependent* becomes covered as an *employee* under the *Plan*;
- The date your coverage terminates;
- If you fail to make any contribution when it is due, the last date of the period for which you made a contribution for your *dependents*;
- In the case of a *child* for whom coverage is being continued beyond the limiting age of 28 due to mental or physical inability to earn his own living, on the date on which the earliest of the following events occurs:
  - Cessation of the inability;
  - Failure to furnish any required proof of the uninterrupted continuance of the inability or to submit to any required examination; or
  - Upon the *child*'s no longer being *dependent* on you for his support;
- In the case of a *child* other than a *child* for whom coverage is continued due to mental or physical inability to earn his own living, on the date on which the *child* reaches age 28;
- The date on which person ceases to be a *dependent*; or
- The date on which an *employee* or his *dependent* submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the *Plan*, including enrollment information.

Will the Plan provide evidence of coverage?
The *Plan* generally will automatically provide a *certificate of coverage* to anyone who loses coverage in the *Plan*. In addition, a *certificate of coverage* will be provided upon request at any time while the individual is covered under a plan and up to 24 months after the individual loses coverage under the *Plan*.

The *Plan* will make reasonable efforts to collect information applicable to any *dependents* and to include that information on the *certificate of coverage*, but the *Plan* will not issue an automatic *certificate of coverage* for *dependents* until the *Plan* has reason to know that a *dependent* has lost coverage under the *Plan*.

Will my participating employer continue our coverage?
Coverage will be continued for you and your *dependents* should the following occur:

- In the event of layoff, coverage will continue for up to two months following the layoff provided that the *employee* pays for the full cost of the coverage. This benefit does not apply if the employee elects COBRA continuation coverage.

The period of continued coverage under this section will not reduce the maximum time for which you may elect to continue coverage under *COBRA*.

May I continue participation during FMLA leave?
The *Plan* will at all times comply with *FMLA*. During any leave taken under *FMLA*, you may maintain coverage under this *Plan* on the same conditions as if you had been continuously employed during the entire leave period. To continue your coverage, you must comply with the terms of the *Plan*, including election during the *Plan's annual enrollment period*, and pay your contributions, if any. Contact your *participating employer* for information concerning your eligibility for *FMLA* and any requirements of the *Plan*.

May I continue participation while I am absent under USERRA? Will my coverage be reinstated on return from USERRA leave?
If you are absent from employment because you are in the *uniformed services*, you may elect to continue your coverage under this *Plan* for up to 24 months. To continue your coverage, you must comply with the terms of the *Plan*, including election during the *Plan's annual enrollment period*, and pay your contributions, if any. In addition, *USERRA* also requires that, regardless of whether you elected to continue your coverage under the *Plan,* your coverage and your *dependents'* coverage be reinstated immediately upon your return to employment, so long as you meet certain requirements contained in *USERRA.* Contact your *participating employer* for information concerning your eligibility for *USERRA* and any requirements of the *Plan*.

COBRA Continuation Coverage
The right to *COBRA continuation coverage* was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("*COBRA*"). *COBRA continuation coverage* can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the *Plan* when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if you or your *dependents* fail to make timely payment of premiums. You should check with your *participating employer* to see if *COBRA* applies to you and your *dependents*.

What is COBRA continuation coverage?
"*COBRA continuation coverage*" is a continuation of *Plan* coverage when coverage otherwise would end because of a life event known as a "*qualifying event*." Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your *participating employer's* plan) are not considered for continuation under *COBRA*.

What is a Qualifying Event?
Specific *qualifying event*s are listed below. After a *qualifying event*, *COBRA continuation coverage* must be offered to each person who is a "*qualified beneficiary*." You, your spouse, and your *dependent children* could become *qualified beneficiaries* if coverage under the *Plan* is lost because of the *qualifying event*.

If you are a *covered employee* (meaning that you are an employee and are covered under the *Plan*), you will become a *qualified beneficiary* if you lose your coverage under the *Plan* because either one of the following *qualifying event*s happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a *covered employee*, you will become a *qualified beneficiary* if you lose your coverage under the *Plan* because any of the following *qualifying event*s happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to *Medicare* benefits (under Part A, Part B, or both); or
- You become legally separated or divorced from your spouse.

Your *dependent children* will become *qualified beneficiaries* if they lose coverage under the *Plan* because any of the following *qualifying event*s happens:

- The parent-*covered employee* dies;
- The parent-*covered employee*'s hours of employment are reduced;
- The parent-*covered employee*'s employment ends for any reason other than his or her gross misconduct;
- The parent-*covered employee* becomes entitled to *Medicare* benefits (Part A, Part B, or both);
- The parents become legally separated or divorced; or
- The child stops being eligible for coverage under the plan as a "*dependent child*."

The participating employer must give notice of some qualifying events

When the *qualifying event* is the end of employment, reduction of hours of employment, death of the *covered employee*, or the *covered employee*'s becoming entitled to *Medicare* benefits (under Part A, Part B, or both), the *participating employer* must notify the *Plan Administrator* of the *qualifying event*.

You must give notice of some qualifying events

Each *covered employee* or *qualified beneficiary* is responsible for providing the *Plan Administrator* with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

- Notice of the occurrence of a *qualifying event* that is a divorce of a *covered employee* (or former employee) from his or her spouse;

- Notice of the occurrence of a *qualifying event* that is an individual's ceasing to be eligible as a *dependent* under the terms of the *Plan*;

- Notice of the occurrence of a second *qualifying event* after a *qualified beneficiary* has become entitled to *COBRA continuation coverage* with a maximum duration of 18 (or 29) months;

- Notice that a *qualified beneficiary* entitled to receive *COBRA continuation coverage* with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of *COBRA continuation coverage*; and

- Notice that a *qualified beneficiary*, with respect to whom a notice described in the bulleted item above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The *Plan Administrator* is:

City of Perrysburg
Plan Administrator
201 Indiana Avenue
Perrysburg, OH 43551
(419) 872-8010

A form of notice is available, free of charge, from the *Plan Administrator* and must be used when providing the notice.

Deadline for providing the notice

For *qualifying event*s described in (1), (2) or (3) above, the notice must be furnished by the date that is 60 days after the latest of:

- The date on which the relevant *qualifying event* occurs;

- The date on which the *qualified beneficiary* loses (or would lose) coverage under the *Plan* as a result of the *qualifying event*; or

- The date on which the *qualified beneficiary* is informed, through the furnishing of the *Plan*'s *summary plan description* or the general notice, of both the responsibility to provide the notice and the *Plan*'s procedures for providing such notice to the *Plan Administrator*.

For the disability determination described in (4) above, the notice must be furnished by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;

- The date on which a *qualifying event* occurs;

- The date on which the *qualified beneficiary* loses (or would lose) coverage under the *Plan* as a result of the *qualifying event*; or

- The date on which the *qualified beneficiary* is informed, through the furnishing of the *Plan*'s *summary plan description* or the general notice, of both the responsibility to provide the notice and the *Plan*'s procedures for providing such notice to the *Plan Administrator*.

In any event, this notice must be furnished before the end of the first 18 months of *COBRA continuation coverage*.

For a change in disability status described in (5) above, the notice must be furnished by the date that is 30 days after the later of:

- The date of the final determination by the SSA that the *qualified beneficiary* is no longer disabled; or

- The date on which the *qualified beneficiary* is informed, through the furnishing of the *Plan*'s *summary plan description* or the general notice, of both the responsibility to provide the notice and the *Plan*'s procedures for providing such notice to the *Plan Administrator*.

The notice must be postmarked (if mailed), or received by the *Plan Administrator* (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 extending *COBRA continuation coverage*, such coverage will end on the last day of the initial 18-month *COBRA continuation coverage* period.

Who can provide the notice?
Any individual who is the *covered employee* (or former employee), a *qualified beneficiary* with respect to the *qualifying event*, or any representative acting on behalf of the *covered employee* (or former employee) or *qualified beneficiary*, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related *qualified beneficiaries* with respect to the *qualifying event*.

Required contents of the notice
The notice must contain the following information:

- Name and address of the *covered employee* or former employee;

- If you already are receiving *COBRA continuation coverage* and wish to extend the maximum coverage period, identification of the initial *qualifying event* and its date of occurrence;

- A description of the *qualifying event* (for example, divorce, cessation of dependent status, entitlement to *Medicare* by the *covered employee* or former employee, death of the *covered employee* or former employee, disability of a *qualified beneficiary* or loss of disability status);

- In the case of a *qualifying event* that is divorce, name(s) and address(es) of spouse and *dependent child(ren)* covered under the *Plan*, date of divorce, and a copy of the decree of divorce;

- In the case of a *qualifying event* that is *Medicare* entitlement of the *covered employee* or former employee, date of entitlement, and name(s) and address(es) of spouse and *dependent child(ren)* covered under the *Plan*;

- In the case of a *qualifying event* that is a dependent child's cessation of dependent status under the *Plan*, name and address of the child, reason the child ceased to be an eligible *dependent* (for example, attained limiting age, lost student status, married or other);

- In the case of a *qualifying event* that is the death of the *covered employee* or former employee, the date of death, and name(s) and address(es) of spouse and *dependent child(ren)* covered under the *Plan*;

- In the case of a *qualifying event* that is disability of a *qualified beneficiary*, name and address of the disabled *qualified beneficiary*, name(s) and address(es) of other family members covered under the *Plan*, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;

- In the case of a *qualifying event* that is loss of disability status, name and address of the *qualified beneficiary* who is no longer disabled, name(s) and address(es) of other family members covered under the *Plan*, the date the disability ended and the date of the SSA's determination; and

- A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline 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 decree of divorce or the SSA's determination is provided.

If the notice does not contain all of the required information, the *Plan Administrator* may request additional information. If the individual fails to provide such information within the time period specified by the *Plan Administrator* in the request, the *Plan Administrator* may reject the notice if it does not contain enough information for the *Plan Administrator* to identify the plan, the *covered employee* (or former employee), the *qualified beneficiaries*, the *qualifying event* or disability, and the date on which the *qualifying event*, if any, occurred.

Electing COBRA continuation coverage

Complete instructions on how to elect *COBRA continuation coverage* will be provided by the *Plan Administrator* within 14 days of receiving the notice of your *qualifying event*. You then have 60 days in which to elect *COBRA continuation coverage*. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. If *COBRA continuation coverage* is not elected in that 60-day period, then the right to elect it ceases.

Each *qualified beneficiary* will have an independent right to elect *COBRA continuation coverage*. *Covered employee*s may elect *COBRA continuation coverage* on behalf of their spouses, and parents may elect *COBRA continuation coverage* on behalf of their *children*.

In the event that the *Plan Administrator* determines that the individual is not entitled to *COBRA continuation coverage*, the *Plan Administrator* will provide to the individual an explanation as to why he or she is not entitled to *COBRA continuation coverage*.

How long does COBRA continuation coverage last?

COBRA continuation coverage will be available up to the maximum time period shown below. Multiple *qualifying event*s which may be combined under *COBRA* will not continue coverage for more than 36 months beyond the date of the original *qualifying event*. When the *qualifying event* is "entitlement to *Medicare*," the 36-month continuation period is measured from the date of the original *qualifying event*. For all other *qualifying event*s, the continuation period is measured from the date of the *qualifying event*, not the date of loss of coverage.

When the *qualifying event* is the death of the *covered employee* (or former employee), the *covered employee*'s (or former employee's) becoming entitled to *Medicare* benefits (under Part A, Part B, or both), your divorce or a dependent child's losing eligibility as a *dependent child*, *COBRA continuation coverage* lasts for up to a total of 36 months.

When the *qualifying event* is the end of employment or reduction of the *covered employee*'s hours of employment, and the *covered employee* became entitled to *Medicare* benefits less than 18 months before the *qualifying event*, *COBRA continuation coverage* for *qualified beneficiaries* other than the *covered employee* lasts until 36 months after the date of *Medicare* entitlement. For example, if a *covered employee* becomes entitled to *Medicare* 8 months before the date on which his employment terminates, *COBRA continuation*

coverage for his spouse and children can last up to 36 months after the date of *Medicare* entitlement, which is equal to 28 months after the date of the *qualifying event* (36 months minus 8 months).

Otherwise, when the *qualifying event* is the end of employment (for reasons other than gross misconduct) or reduction of the *covered employee*'s hours of employment, *COBRA continuation coverage* generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of *COBRA continuation coverage* can be extended.

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the *Plan* is determined by the SSA to be disabled and you notify the *Plan Administrator* as set forth above, you and your entire family 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 60th day of *COBRA continuation coverage* and must last at least until the end of the 18-month period of *COBRA continuation coverage*. An extra fee will be charged for this extended *COBRA continuation coverage*.

Second qualifying event extension of 18-month period of COBRA continuation coverage
If your family experiences another *qualifying event* while receiving 18 months of *COBRA continuation coverage*, the spouse and *dependent* children in your family can get up to 18 additional months of *COBRA continuation coverage*, for a maximum of 36 months, if notice of the second *qualifying event* properly is given to the *Plan* as set forth above. This extension may be available to the spouse and any *dependent children* receiving *COBRA continuation coverage* if the *covered employee* or former employee dies, becomes entitled to *Medicare* benefits (under Part A, Part B, or both), or gets divorced, or if the dependent child stops being eligible under the *Plan* as a *dependent child*, but only if the event would have caused the spouse or dependent child to lose coverage under the *Plan* had the first *qualifying event* not occurred.

Does COBRA continuation coverage ever end earlier than the maximum periods above?
COBRA continuation coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your *participating employer* ceases to provide a group health plan to any employee;
- The date on which coverage ceases by reason of the *qualified beneficiary*'s failure to make timely payment of any required premium;
- 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
- 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.

Certain provisions under the *Trade Act* affect the benefits received under *COBRA*. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a tax credit for premiums paid for certain types of health insurance, including *COBRA* premiums. Second, eligible individuals under the *Trade Act* who do not elect *COBRA continuation coverage* within the election period will be allowed an additional 60-day period to elect *COBRA continuation coverage*. If the *qualified beneficiary* elects *COBRA continuation coverage* during this second election period, the coverage period will run from the beginning

date of the second election period. Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. ARRA made several amendments to these provisions, including an increase in the amount of the credit to 80% of premiums for coverage before January 1, 2011 and temporary extensions of the maximum period of *COBRA continuation coverage* for PBGC recipients (covered employees who have a nonforfeitable right to a benefit any portion of which is to be paid by the PBGC) and *Trade Act* assistance-eligible individuals.

If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Additional Information

Additional information about the *Plan* and *COBRA continuation coverage* is available from the *Plan Administrator*, who is:

City of Perrysburg
Plan Administrator
201 Indiana Avenue
Perrysburg, OH 43551
(419) 872-8010

Current Addresses

In order to protect your family's rights, you should keep the *Plan Administrator* (who is identified above) informed of any changes in the addresses of family members.

CLAIM PROCEDURES

You will receive a *Plan* identification (ID) card which will contain important information, including claim filing directions and contact information. Your ID card will show your *PPO network*, and your Cost Containment Program administrator.

At the time you receive treatment, show your ID card to your *provider* of service. In most cases, your *provider* will file your claim for you. You may file the claim yourself by submitting the required information to:

NFP Benefit Alliance
701 Adams Suite 850
Toledo OH 43604-6600
LOCAL (419)244-0135

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

A Form HCFA or Form UB completed by the *provider* of service, including:

- The date of service;
- The name, address, telephone number and tax identification number of the *provider* of the services or supplies;
- The place where the services were rendered;
- The diagnosis and procedure codes;
- The amount of charges (including *PPO network* repricing information);
- The name of the *Plan*;
- The name of the covered *employee*; and
- The name of the patient.

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 claim for benefits is not being filed with the *Plan*. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Procedures for All Claims
The procedures outlined below must be followed by *covered persons* ("claimants") to obtain payment of health benefits under this *Plan*.

Health Claims
All claims and questions regarding health claims should be directed to the *third party administrator.* The *Plan Administrator* shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the *Plan* will be paid only if the *Plan Administrator* decides in its discretion that the *covered person* is entitled to them. The responsibility to process claims in accordance with the *summary plan description* may be delegated to the *third party administrator*; provided, however, that the *third party administrator* is not a fiduciary of the *Plan* and does not have the authority to make decisions involving the use of discretion.

Each *covered person* claiming benefits under the *Plan* shall be responsible for supplying, at such times and in such manner as the *Plan Administrator* in its sole discretion may require, written proof that the expenses were *incurred* or that the benefit is covered under the *Plan*. If the *Plan Administrator* in its sole discretion shall determine that the *covered person* has not *incurred* a *covered expense* or that the benefit is not covered under the *Plan*, or if the *covered person* shall fail to furnish such proof as is requested, no benefits shall be payable under the *Plan*.

The procedures outlined below must be followed by *covered persons* to obtain payment of health or disability benefits under this *Plan*.

Under the *Plan*, there are three types of claims: Pre-service (Non-urgent), Concurrent Care and Post-service.

- Pre-service Claims. A *"pre-service claim"* is a claim for a benefit under the *Plan* where the *Plan* conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

  A *"pre-service urgent care claim"* is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the *covered person* or the *covered person's* ability to regain maximum function, or, in the opinion of a physician with knowledge of the *covered person's* medical condition, would subject the *covered person* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

  It is important to remember that, if a *covered person* needs medical care for a condition which could seriously jeopardize his life, there is no need to contact the *Plan* for prior approval. The *covered person* should obtain such care without delay.

  Further, if the *Plan* does not require the *covered person* to obtain approval of a specific medical service prior to getting treatment, then there is no *pre-service claim.* The *covered person* simply follows the *Plan's* procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a *post-service claim.*

- Concurrent Claims. A "Concurrent Claim" arises when the *Plan* has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

  - The *Plan* determines that the course of treatment should be reduced or terminated; or

  - The claimant requests extension of the course of treatment beyond that which the *Plan* has approved.

  Since the *Plan* does not require the *covered person* to obtain approval of a medical service in an urgent care situation prior to getting treatment, then there is no need to contact the *Plan Administrator* to request an extension of a course of treatment in an urgent care situation. The *covered person* simply follows the *Plan's* procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a *post-service claim.*

- Post-service Claims. A "Post-service Claim" is a claim for a benefit under the *Plan* after the services have been rendered.

When Claims Must Be Filed
Post-service claims must be filed with the *third party administrator* within 90 days of the date charges for the services were *incurred*. Claims must be filed as soon as reasonably possible but, except in the case of legal incapacity, no later than six months after the charges were *incurred*. Benefits are based upon the *Plan's* provisions at the time the charges were *incurred*. **Claims filed later than that date shall be denied.**

A *pre-service claim* (including a *concurrent claim* that also is a *pre-service claim*) is considered to be filed when the request for approval of treatment or services is made and received by the *third party administrator* in accordance with the *Plan's* procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the *Plan*. The *third party administrator* will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the *third party administrator* within 45 days from receipt by the *covered person* of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The *Plan Administrator* shall notify the *covered person,* in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of *pre-service claims* and *concurrent claims,* of decisions that a claim is payable in full) within the following timeframes:

- *Pre-service Non-urgent Care Claims:*
  - If the *covered person* has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
  - If the *covered person* has not provided all of the information needed to process the claim, then the *covered person* will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The *covered person* will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the *Plan Administrator* and the *covered person* (if additional information was requested during the extension period).
- *Concurrent Claims:*
  - *Plan* Notice of Reduction or Termination. If the *Plan Administrator* is notifying the *covered person* of a reduction or termination of a course of treatment (other than by *Plan* amendment or termination), before the end of such period of time or number of treatments. The *covered person* will be notified sufficiently in advance of the reduction or termination to allow the *covered person* to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
  - Request by *Covered Person* Involving Non-urgent Care. If the *Plan Administrator* receives a request from the *covered person* to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a *pre-service non-urgent claim* or a *post-service claim*).
- *Post-service Claims:*
  - If the *covered person* has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
  - If the *covered person* has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the *covered person* will be notified of a determination of benefits prior to the end of the extension period, unless additional

information is requested during the extension period, then the *covered person* will be notified of the determination by a date agreed to by the *Plan Administrator* and the *covered person.*

- Extensions – *Pre-service Non-urgent Care Claims*. This period may be extended by the *Plan* for up to 15 days, provided that the *Plan Administrator* both determines that such an extension is necessary due to matters beyond the control of the *Plan* and notifies the *covered person,* prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the *Plan* expects to render a decision.

- Extensions – *Post-service Claims*. This period may be extended by the *Plan* for up to 15 days, provided that the *Plan Administrator* both determines that such an extension is necessary due to matters beyond the control of the *Plan* and notifies the *covered person,* prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the *Plan* expects to render a decision.

- Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the *Plan*.

Notification of an Adverse Benefit Determination

The *Plan Administrator* shall provide a *covered person* with a notice, either in writing or electronically, containing the following information:

- A reference to the specific portion(s) of the *summary plan description* upon which a denial is based;

- Specific reason(s) for a denial;

- A description of any additional information necessary for the *covered person* to perfect the claim and an explanation of why such information is necessary;

- A description of the *Plan's* review procedures and the time limits applicable to the procedures, including a statement of the *covered person's* right to bring a civil action following an adverse benefit determination on final review;

- A statement that the *covered person* is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the *covered person's* claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the *Plan* did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the *covered person,* free of charge, upon request); and

- In the case of denials based upon a medical judgment (such as whether the treatment is *medically necessary* or *experimental*), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *covered person's* medical circumstances, or a statement that such explanation will be provided to the *covered person,* free of charge, upon request.

Appeals of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the *covered person* believes the claim has been denied wrongly, the *covered person* may appeal the denial and review pertinent documents. The

claims procedures of this *Plan* provide a *covered person* with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the *Plan* provides:

- *Covered persons* at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and 60 days to appeal a second adverse benefit determination;

- *Covered persons* the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the *Plan*, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- For a review that takes into account all comments, documents, records, and other information submitted by the *covered person* relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

- That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the *Plan* fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

- For the identification of medical or vocational experts whose advice was obtained on behalf of the *Plan* in connection with a claim, even if the Plan did not rely upon their advice; and

- That a *covered person* will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *covered person's* claim for benefits in possession of the *Plan Administrator* or the *third party administrator*; information regarding any voluntary appeals procedures offered by the *Plan*; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *covered person's* medical circumstances.

First Appeal Level

Requirements for First Appeal

The *covered person* must file the first appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the *covered person's* appeal must be addressed as follows and mailed or faxed as follows:

NFP Benefit Alliance
ATTENTION: Appeals Department
701 Adams St, Suite 850
Toledo OH 43604-6600
Fax (419)244-5743

It shall be the responsibility of the *covered person* to submit proof that the claim for benefits is covered and payable under the provisions of the *Plan*. Any appeal must include:

- The name of the *employee*/*covered person*;

- The *employee/covered person's* social security number;

- The group name or identification number;

- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the *covered person* will lose the right to raise factual arguments and theories which support this claim if the *covered person* fails to include them in the appeal**;

- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

- Any material or information that the *covered person* has which indicates that the *covered person* is entitled to benefits under the *Plan*.

If the *covered person* provides all of the required information, it may be that the expenses will be eligible for payment under the *Plan*.

Timing of Notification of Benefit Determination on First Appeal
The *Plan Administrator* shall notify the *covered person* of the *Plan's* benefit determination on review within the following timeframes:

- *Pre-service Non-urgent Care Claims:* Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.

- *Concurrent Claims:* The response will be made in the appropriate time period based upon the type of claim – *pre-service non-urgent* or *post-service*.

- *Post-service Claims:* Within a reasonable period of time, but not later than 30 days after receipt of the appeal.

- Calculating Time Periods. The period of time within which the *Plan's* determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this *Plan*, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on First Appeal
The *Plan Administrator* shall provide a *covered person* with notification, in writing or electronically, of a *Plan's* adverse benefit determination on review, setting forth:

- The specific reason or reasons for the denial;

Reference to the specific portion(s) of the *summary plan description* on which the denial is based;
The identity of any medical or vocational experts consulted in connection with the claim, even if the *Plan* did not rely upon their advice;

- A statement that the *covered person* is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *covered person's* claim for benefits;

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the *covered person* upon request;

- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *covered person's* medical circumstances, will be provided free of charge upon request;

- A description of any additional information necessary for the *covered person* to perfect the claim and an explanation of why such information is necessary;

- A description of the *Plan's* review procedures and the time limits applicable to the procedures;

- A statement of the *covered person's* right to bring an action following an adverse benefit determination on final review; and

- The following statement: "You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination
In the case of an adverse benefit determination on review, the *Plan Administrator* shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal
Upon receipt of notice of the *Plan's* adverse decision regarding the first appeal, the *covered person* has 60 days to file a second appeal of the denial of benefits. The *covered person* again is entitled to a "full and fair review" of any denial made at the first appeal, which means the *covered person* has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the *covered person's* second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal
The *Plan Administrator* shall notify the *covered person* of the *Plan's* benefit determination on review within the following timeframes:

- *Pre-service Non-urgent Care Claims:* Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.

- *Concurrent Claims:* The response will be made in the appropriate time period based upon the type of claim – *pre-service non-urgent* or *post-service*.

- *Post-service Claims:* Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.

- Calculating Time Periods. The period of time within which the *Plan's* determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this *Plan*, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal
The same information must be included in the *Plan's* response to a second appeal as a first appeal, except for:

- A description of any additional information necessary for the *covered person* to perfect the claim and an explanation of why such information is needed; and

- A description of the *Plan's* review procedures and the time limits applicable to the procedures. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination
In the case of an adverse benefit determination on the second appeal, the *Plan Administrator* shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

Decision on Second Appeal to be Final
If, for any reason, the *covered person* does not receive a written response to the appeal within the appropriate time period set forth above, the *covered person* may assume that the appeal has been denied. The decision by the *Plan Administrator* or other appropriate named fiduciary of the *Plan* on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the *Plan* must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the *Plan's* claim review procedures have been exhausted.**

Appointment of Authorized Representative
A *covered person* is permitted to appoint an authorized representative to act on his 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 Administrator* or the *third party administrator.* However, in connection with a claim involving urgent care, 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 Administrator,* in writing, to the contrary.

Provider of Service Appeal Rights – Medical Benefits
A *covered person* may appoint the provider of service as the authorized representative with full authority to act on his or her behalf in the appeal of a denied claim. An assignment of benefits by a *covered person* to a provider of service will not constitute appointment of that provider as an authorized representative. However, in an effort to ensure a full and fair review of the denied claim, and as a courtesy to a provider of service that is not an authorized representative, the *Plan* will consider an appeal received from the provider in the same manner as a *covered person*'s appeal, and will respond to the provider and the *covered person* with the results of the review accordingly. Any such appeal from a provider of service must be made within the time limits and under the conditions for filing an appeal specified under the section, "Appeals of Adverse Benefit Determinations", above. **Providers requesting such appeal rights under the *Plan* must agree to pursue reimbursement for denied expenses directly from the *Plan*, waiving any right to recover such expenses from the *covered person*, and comply with the conditions of the section, "Appeals of Adverse Benefit Determinations", above.**

For purposes of this section, the provider's waiver to pursue denied expenses from the *covered person* does not include the following amounts, which are the responsibility of the *covered person*:

- *Deductibles*;
- Copayments;
- Coinsurance;
- Penalties for failure to comply with the terms of the *Plan*;
- Charges for services and supplies which are not included for coverage under the *Plan*, and
- Amounts which are in excess of any stated Plan maximums or limits.

Also, for purposes of this section, if a provider indicates on a Form UB or on a Form HCFA (or similar claim form) that the provider has an assignment of benefits, then the *Plan* will require no further evidence that benefits are legally assigned to that provider.

Contact the *third party administrator* or the *Plan Administrator* for additional information regarding provider of service appeals.

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 shall be at the expense of the *Plan*. This right may be exercised when and as often as the *Plan Administrator* may reasonably require during the pendency of a claim. The *covered person* must comply with this requirement as a necessary condition to coverage.

Autopsy
The *Plan* reserves the right to have an autopsy performed upon any deceased *covered person* whose *illness* or *injury* is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits
All benefits under this *Plan* are payable, in U.S. Dollars, to the covered *employee* whose *illness* or *injury*, or whose covered *dependent's illness* or *injury*, is the basis of a claim. In the event of the death or incapacity of a covered *employee* and in the absence of written evidence to this *Plan* of the qualification of a guardian for his estate, the *Plan Administrator* may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the *Plan Administrator,* is or was providing the care and support of such *employee*.

Assignments
Benefits for medical expenses covered under this *Plan* may be assigned by a *covered person* to the *provider;* however, if those benefits are paid directly to the *employee*, the *Plan* shall be deemed to have fulfilled its obligations with respect to such benefits. The *Plan* will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered *employee* and the assignee, has been received before the proof of loss is submitted.

Non-U.S. Providers
Medical expenses for care, supplies or services which are rendered by a *provider* whose principal place of business or address for payment is located outside the United States (a *"non-U.S. provider"*) are payable under the *Plan*, subject to all *Plan* exclusions, limitations, maximums and other provisions, under the following conditions:

- Benefits may not be assigned to a *non-U.S. provider;*
- The *covered person* is responsible for making all payments to *non-U.S. providers,* and submitting proof of services to the *Plan* for reimbursement;
- Benefit payments will be determined by the *Plan* based upon the exchange rate in effect on the *incurred* date;
- The *non-U.S. provider* shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
- Claims for benefits must be submitted to the *Plan* in English.

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, or are not paid according to the *Plan's* terms, conditions, limitations or exclusions. Whenever the *Plan* pays benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the *covered person* or *dependent* on whose behalf such payment was made.

A *covered person, dependent, 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 the amount of such erroneous payment to the *Plan* within 30 days of discovery or demand.

The *Plan Administrator* shall have no obligation to secure 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 Administrator* 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 Administrator* 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 other *injuries* or *illnesses*) under the *Plan* by the amount due as reimbursement to the *Plan*. The *Plan Administrator* may also, in its sole discretion, deny or reduce future benefits (including future benefits for other *injuries* or *illnesses*) 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*, in consideration of such payments, 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, ICD-9 or CPT standards, *Medicare* guidelines, HCPCS standards, or other standards approved by the *Plan Administrator* 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.

Medicaid Coverage
A *covered person'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 such *covered person*. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the *covered 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

Benefits Subject to This Provision
This provision applies to all benefits provided under any section of this *Plan*.

"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:

- Group, blanket, or franchise insurance coverage;
- Blue Cross, Blue Shield, group practice, and other group prepayment coverage;
- Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, school insurance, or employee benefit organization plans;
- Any coverage under governmental programs, and any coverage required or provided by statute; and
- 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.

"Allowable Expenses"
"Allowable expenses" shall mean any *medically necessary*, *usual, reasonable and customary* 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 will be deemed to be the benefit.

It is important that you fulfill any requirements of *other plan(s)* for payment of benefits. If you fail to properly file for, and receive payment by, any *other plan(s)*, this *Plan* will estimate the benefits that would otherwise have been payable and apply that amount, as though actually paid, to the "Application to Benefit Determinations" calculation explained in this section.

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.

Effect on Benefits

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. If this Plan is the secondary or subsequent plan, this Plan will pay the balance due up to 100% of the total cumulative *allowable expenses* for a single claim submission. When there is a conflict in the order of benefit determination, this *Plan* will never pay more than 50% of *allowable expenses.*

When medical payments are available under automobile insurance, this *Plan* will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the *other plan* will be ignored for the purposes of determining the benefits under this *Plan*. This is the case when:

- The *other plan* would, according to its rules, determine its benefits after the benefits of this *Plan* have been determined; and

- The rules in the section entitled "Order of Benefit Determination" would require this *Plan* to determine its benefits before the *other plan*.

Order of Benefit Determination
For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are listed below. The *Plan* will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim.

- A plan without a coordinating provision will always be the primary plan;

- The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, will be determined before the benefits of a plan which covers such person as a dependent. If the person on whose expenses the claim is based is an inactive employee (e.g. retired or on layoff, or through COBRA) or the dependent of an inactive employee, the benefits of the plan covering the person in an active status will be determined before the benefits of a plan covering the person in an inactive status;

- If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

  - When the parents are separated (whether or not ever legally married) or divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or

  - When the parents are separated (whether or not ever legally married) or divorced and, the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

  Notwithstanding the above provisions, if there is a court decree which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any *other plan* which covers the child as a dependent child; and

- When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information
For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any *other plan*, this *Plan* may, without the consent of or 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* shall 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 Administrator* 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*.

Coordination of Benefits with Medicare
If you are eligible for *Medicare*, and you are eligible for coverage under this *Plan*, you may choose to continue coverage under this *Plan*, and any *Medicare* benefits to which you are entitled may be used to supplement the benefits of this *Plan*. If, however, you choose to make *Medicare* your primary plan, you may not supplement your *Medicare* coverage with the benefits of this *Plan*.

In all cases, coordination of benefits with *Medicare* will conform with Federal law. **When coordination of benefits with *Medicare* is permitted, each individual who is eligible for *Medicare* will be assumed to have full *Medicare* coverage (parts A and B) whether or not the individual has enrolled for full coverage.** Your benefits under this *Plan* will be secondary to *Medicare* to the extent allowed by Federal law.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Beneficiaries Who Are Covered Under This Plan
If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement, unless applicable federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

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*.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

Benefits Subject to this Provision
This provision shall apply to all benefits provided under any section of this *Plan*.

When this Provision Applies
A *covered person* may *incur* medical or other charges related to *injuries* or *illness* caused by the act or omission of another person; or *another party* may be liable or legally responsible for payment of charges *incurred* in connection with the *injuries* or *illness*. If so, the *covered person* may have a claim against that other person or *another party* for payment of the medical or other charges. In that event, the *Plan* will be secondary, not primary, and the *Plan* will be *subrogated* to all rights the *covered person* may have against that other person or *another party* and will be entitled to *reimbursement*. In addition, the *Plan* shall have the first lien against any *recovery* to the extent of benefits paid or to be paid and expenses *incurred* by the *Plan* in enforcing this provision. The *Plan's* first lien supersedes any right that the *covered person* may have to be "made whole." In other words, the *Plan* is entitled to the right of first *reimbursement* out of any *recovery* the *covered person* procures or may be entitled to procure regardless of whether the *covered person* has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the *Plan's* right of first *reimbursement* will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the *Plan*, the *covered person* agrees that acceptance of benefits is constructive notice of this provision.

The *covered person* must:

- Execute and deliver a subrogation and reimbursement agreement;
- Authorize the *Plan* to sue, compromise and settle in the *covered person's* name to the extent of the amount of medical or other benefits paid for the *injuries* or *illness* under the *Plan* and the expenses *incurred* by the *Plan* in collecting this amount, and assign to the *Plan* the *covered person's* rights to *recovery* when this provision applies;
- Immediately reimburse the *Plan*, out of any *recovery* made from *another party*, 100% of the amount of medical or other benefits paid for the *injuries* or *illness* under the *Plan* and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) *incurred* by the *Plan* in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);
- Notify the *Plan* in writing of any proposed settlement and obtain the *Plan's* written consent before signing any release or agreeing to any settlement; and
- Cooperate fully with the *Plan* in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the *Plan*.

When a right of recovery exists, and as a condition to any payment by the *Plan* (including payment of future benefits for other *illnesses* or *injuries*), the *covered person* will execute and deliver all required instruments and papers, including a subrogation and reimbursement agreement provided by the *Plan*, as well as doing and providing whatever else is needed, to secure the *Plan's* rights of *subrogation* and *reimbursement*, before any medical or other benefits will be paid by the *Plan* for the *injuries* or *illness*. The *Plan Administrator* may determine, in its sole discretion, that it is in the *Plan's* best interests to pay medical or other benefits for the *injuries* or *illness* before these papers are signed and things are done (for example, to obtain a prompt payment discount); however, in that event, the *Plan* still will be entitled to *subrogation* and *reimbursement*. In addition, the *covered person* will do nothing to prejudice the *Plan's* right to *subrogation* and *reimbursement* and acknowledges that the *Plan* precludes operation of the made-whole and common-fund doctrines. A *covered person* who receives any *recovery* (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the *recovery* to the *Plan* under the terms of this provision. A *covered person* who receives any such *recovery* and does not immediately tender the *recovery* to the *Plan* will be deemed to hold the *recovery* in constructive trust for

the *Plan*, because the *covered person* is not the rightful owner of the *recovery* and should not be in possession of the *recovery* until the *Plan* has been fully reimbursed.

The *Plan Administrator* has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

Amount Subject to Subrogation or Reimbursement
Any amounts recovered will be subject to *subrogation* or *reimbursement.* In no case will the amount subject to *subrogation* or *reimbursement* exceed the amount of medical or other benefits paid for the *injuries* or *illness* under the *Plan* and the expenses *incurred* by the *Plan* in collecting this amount. The *Plan* has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the *covered person* does not receive full compensation for all of his charges and expenses.

When Recovery Includes the Cost of Past or Future Expenses
In certain circumstances, a *covered person* may receive a *recovery* that includes amounts intended to be compensation for past and/or future expenses for treatment of the *illness* or *injury* that is the subject of the *recovery.* This *Plan* will not cover any expenses for which compensation was provided through a previous *recovery*. This exclusion will apply to the full extent of such *recovery* or the amount of the expenses submitted to the *Plan* for payment, whichever is less. The *Plan* also precludes operation of the made-whole and common-fund doctrines in applying this provision.

It is the responsibility of the *covered person* to inform the *Plan Administrator* when expenses are related to an *illness* or *injury* for which a *recovery* has been made. Acceptance of benefits under this *Plan* for which the *covered person* has received a *recovery* will be considered fraud, and the *covered person* will be subject to any sanctions determined by the *Plan Administrator,* in its sole discretion, to be appropriate. The *covered person* is required to submit full and complete documentation of any such *recovery* in order for the *Plan* to consider eligible expenses that exceed the *recovery.*

"Another Party"
"A*nother party*" shall mean any individual or entity, other than the *Plan*, who is liable or legally responsible to pay expenses, compensation or damages in connection with a *covered person's injuries* or *illness*.

"*Another party*" shall include the party or parties who caused the *injuries* or *illness*; the insurer, guarantor or other indemnifier of the party or parties who caused the *injuries* or *illness*; a *covered person's* own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or entity that is liable or legally responsible for payment in connection with the *injuries* or *illness*.

"Recovery"
"*Recovery*" shall mean any and all monies paid to the *covered person* by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the *injuries* or *illness*. Any *recovery* shall be deemed to apply, first, for *reimbursement*.

"Subrogation"
"*Subrogation*" shall mean the *Plan's* right to pursue the *covered person's* claims for medical or other charges paid by the *Plan* against *another party*.

"Reimbursement"
"*Reimbursement*" shall mean repayment to the *Plan* for medical or other benefits that it has paid toward care and treatment of the *injury* or *illness* and for the expenses incurred by the *Plan* in collecting this benefit amount.

When a Covered Person retains an Attorney
If the *covered person* retains an attorney, that attorney must sign the subrogation and reimbursement agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other *illnesses* or *injuries*. Additionally, the *covered person's* attorney must recognize and consent to the fact that the *Plan* precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine

in his pursuit of *recovery*. The *Plan* will not pay the *covered person's* attorneys' fees and costs associated with the recovery of funds, nor will it reduce its reimbursement pro rata for the payment of the *covered person's* attorneys' fees and costs. Attorneys' fees will be payable from the *recovery* only after the *Plan* has received full *reimbursement*.

An attorney who receives any *recovery* (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the *recovery* to the *Plan* under the terms of this provision. A *covered person's* attorney who receives any such *recovery* and does not immediately tender the *recovery* to the *Plan* will be deemed to hold the *recovery* in constructive trust for the *Plan*, because neither the *covered person* nor his attorney is the rightful owner of the *recovery* and should not be in possession of the *recovery* until the *Plan* has been fully reimbursed.

When the Covered Person is a Minor or is deceased
The provisions of this section apply to the parents, trustee, guardian or other representative of a minor *covered person* and to the heir or personal representative of the estate of a deceased *covered person*, regardless of applicable law and whether or not the representative has access or control of the *recovery*.

When a Covered Person Does Not Comply
When a *covered person* does not comply with the provisions of this section, the *Plan Administrator* 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 other *injuries* or *illnesses*) under the *Plan* by the amount due as *reimbursement* to the *Plan*. The *Plan Administrator* may also, in its sole discretion, deny or reduce future benefits (including future benefits for other *injuries* or *illnesses*) under any other group benefits plan maintained by the *Plan Sponsor*. The reductions will equal the amount of the required *reimbursement*. If the *Plan* must bring an action against a *covered person* to enforce the provisions of this section, then that *covered person* agrees to pay the *Plan's* attorneys' fees and costs, regardless of the action's outcome.

DEFINITIONS

In this section you will find the definitions for the italicized words found throughout this *summary plan description*. 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 *summary plan description* for that information.**

"*Accident*" means a sudden and unforeseen event, definite as to time and place, or a deliberate act resulting in unforeseen consequences.

"*Actively at work*" or "*active employment*" means performance by the *employee* of all the regular duties of his occupation at an established business location of the *participating employer*, or at another location to which he may be required to travel to perform the duties of his employment. An *employee* will be deemed *actively at work* if the *employee* is absent from work due to a health factor. In no event will an *employee* be considered *actively at work* if employment has been terminated.

"*ADA*" means the American Dental Association.

"AHA" means the American Hospital Association.

"*Allowable claim limits*" means the charges for services and supplies, listed and included as *covered expenses* under the *Plan*, which are *medically necessary* for the care and treatment of *illness* or *injury*, but only to the extent that such fees are within the *allowable claim limits*.

"AMA" means the American Medical Association.

"Ambulatory surgical center" means any public or private state licensed and approved (whenever required by law) establishment with an organized medical staff of *physicians*, with permanent facilities that are equipped and operated primarily for the purpose of performing *surgical procedures*, with continuous *physician* services and registered professional nursing service whenever a patient is in the *institution*, and which does not provide service or other accommodations for patients to stay overnight.

"Birthing center" means an independent, licensed facility which is certified under the statutory requirements of the given state in which it is located, and provides 24 hour nursing services by registered graduate nurses and certified nurse midwives. An obstetrician or a *physician* qualified to practice obstetrics with *hospital* admitting privileges must be available for consultation and referral and on call during labor and delivery. A birthing center must be equipped, staffed, and operating for the purpose of providing:

- Family centered obstetrical care for patients during uncomplicated *pregnancy*, delivery, and immediate postpartum periods;
- Care for infants born in the center who are either normal or who have abnormalities which do not impair functions or threaten life; and
- Care for obstetrical patients and infants born in the center who require emergency and immediate life support measures to sustain life pending transfer to a hospital.

A birthing center must have an agreement with an ambulance service and a *hospital* to accept transfer.

"Cardiac care unit" means a separate, clearly designated service area which is maintained within a *hospital* and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical condition;

- It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the *hospital*;

- It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;

- It contains at least two beds for the accommodation of critically ill patients; and

- It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

"Certificate of coverage" means a written certification provided by any source that offers medical care coverage, including the *Plan*, for the purpose of confirming the duration and type of an individual's previous coverage.

"Child(ren means, in addition to the *employee's* own blood descendant of the first degree or lawfully adopted child, a child placed with the *employee* in anticipation of adoption, a child who is an *alternate recipient* under a QMCSO as required by the federal Omnibus Budget Reconciliation Act of 1993, a stepchild, an eligible foster child who is placed with the *employee* by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction, or any other child for whom the *employee* has obtained legal guardianship. In order for a child to meet the Plan's definition of a *dependent*, the child must qualify as a child pursuant to *Code* §152(f)(1).

"Chiropractic care" means office visits, x-rays, manipulations, supplies, heat treatment, cold treatment and massages.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Company" means City of Perrysburg.

"Complications of pregnancy" means:

- Conditions whose diagnoses are distinct from *pregnancy*, but adversely affected by *pregnancy* or caused by *pregnancy*. Such conditions include acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, and eclampsia;

- A non-elective cesarean section *surgical procedure*; or

- A terminated ectopic *pregnancy.*

Complication of pregnancy does not mean:

- False labor;

- Occasional spotting;

- Prescribed rest during the period of *pregnancy*; or

- Similar conditions associated with the management of a difficult *pregnancy*, but not constituting a distinct complication of *pregnancy*.

"Cosmetic" or "cosmetic surgery" means any *surgery*, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an *injury*.

"*Covered expense* means a *medically necessary* service or supply which is *usual, customary and reasonable,* or within the *allowable claim limit* and which is listed for coverage in this *Plan.*

"Covered person" means a covered *employee* and his covered *dependents* who are enrolled and eligible for benefits under the *Plan*.

"Creditable coverage" shall mean coverage of an individual under any of the following: a group health plan, health insurance coverage, Medicare, Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines), medical and dental care for members and certain former members of the uniformed services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, a health plan offered under the Federal Employee*s* Health Benefits Program, a public health plan, a Employee Health Plan under Section 5(e) of the Peace Corps Act, or Title XXI of the Social Security Act (State Children's Health Insurance Program). To the extent that further clarification is needed with respect to the sources of Creditable Coverage listed in the prior sentence, please see the complete definition of Creditable Coverage that is set forth in 45 C.F.R. § 146.113(a).

"Custodial care" means care or confinement provided primarily for the maintenance of the *covered person*, essentially designed to assist the c*overed 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" means an amount of money that must be paid by a *covered person* for *covered expenses* before the *Plan* will reimburse additional *covered expenses incurred* during that *plan year.*

"Dentist" means an individual holding a D.D.S. or D.M.D. degree, who is licensed to practice dentistry in the jurisdiction where such services are provided.

"Dependent" means one or more of the following person(s):

- An e*mployee*'s lawfully married spouse of the opposite sex possessing a marriage license who is not divorced from the e*mployee*;

- An *employee's* common law spouse, based upon a common law marriage which is legally recognized in the jurisdiction in which the *employee* has his principal residence;

- A child who otherwise meets the eligibility requirements of the Plan, and who is not eligible for coverage under another group health plan (other than a group health plan of a parent) and is less than 28 years of age is eligible for coverage under this Plan.

- An e*mployee*'s *child,* regardless of age, who was covered prior to attaining the limiting age under the bullet above, who is mentally or physically incapable of sustaining his own living. Such *child* must have been mentally or physically incapable of earning his own living prior to attaining the limiting age under the bullets above. Written proof of such incapacity and dependency satisfactory to the *Plan* must be furnished and approved by the *Plan* within 31 days following the date on which the *child* attains the limiting age under the bullets above. The *Plan* may annually require subsequent proof of incapacity satisfactory to the *Plan* thereafter.

"*Dependent*" does not include any person who is a member of the armed forces of any country or who is a resident of a country outside the United States.

The *Plan* reserves the right to require documentation, satisfactory to the *Plan Administrator*, which establishes a *dependent* relationship.

"Detoxification" means the process whereby an alcohol-intoxicated person, or person experiencing the symptoms of *substance abuse,* is assisted in a facility licensed by the Department of Health through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency factors or alcohol in combination with drugs as determined by a licensed *physician*, while keeping the physiological risk to the patient to a minimum.

"Diagnostic service" means a test or procedure performed for specified symptoms to detect or to monitor an *illness* or *injury*. It must be ordered by a *physician* or other professional *provider*.

"Drug" means insulin and prescription legend drugs. A prescription legend drug is a Federal legend drug (any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription") or a state restricted drug (any medicinal substance which may be dispensed only by prescription, according to state law) and which, in either case, is legally obtained from a licensed drug dispenser only upon a prescription of a currently licensed *physician*.

"Durable medical equipment" means equipment which:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of an *illness* or *injury*; and
- Is appropriate for use in the home.

"Effective date" means January 1, 2012, the original effective date of the *Plan*.

"Emergency" means a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An emergency includes poisoning, shock, hemorrhage, severe chest pain, difficulty in breathing, sudden onset of weakness or paralysis of a body part, severe burns, unconsciousness, partial or complete severing of a limb, and convulsions.

Other emergencies and acute conditions may be considered on receipt of proof, satisfactory to the *Plan*, that an *emergency* did exist.

"Employee" means a person who is a regular employee of the *participating employer*, regularly scheduled to work at least 40 hours per week for the *participating employer* in an employer-employee relationship. *Employee* also means a part-time employee, working more than 30 hours per week, who pays the required contribution for coverage. An employee is not a seasonal, temporary or leased employee, or an independent contractor.

"Experimental" means services, supplies, care, procedures, treatments or courses of treatment, which:

- Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
- Are rendered on a research basis as determined by the United States Food and Drug Administration and the *AMA*'s Council on Medical Specialty Societies. Phase I, II and III clinical trials shall be considered experimental.

Drugs are considered *experimental* if they are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

"Family unit" means the *employee*, his or her spouse and his or her *dependent children*.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"FMLA leave" means a *leave of absence*, which the *company* is required to extend to an *employee* under the provisions of the *FMLA*.

"Generic drug" means drugs not protected by a trademark, usually descriptive of drug's chemical structure.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"Home health care" means certain services and supplies required for treatment of an *illness* or *injury* in the *covered person's* home as part of a formal treatment plan certified by the attending *physician* and approved by the *Plan Administrator*.

"Home health care agency" means an agency or organization which provides a program of *home health care* and which:

- Is approved as a home health agency under *Medicare*;
- 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 the responsibility for licensing; or
- Meets all of the following requirements:
  - It is an agency which holds itself forth to the public as having the primary purpose of providing a *home health care* delivery system bringing supportive services to the home;
  - It has a full-time administrator;
  - It maintains written records of services provided to the patient;
  - Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and
  - Its employees are bonded and it provides malpractice insurance.

"Hospice care agency" means an agency which has the primary purpose of providing hospice services to hospice patients. It must be licensed and operated according to the laws of the state in which it is located and meet all of the following requirements:

- Has obtained any required certificate of need;
- Provides 24 hour a day, seven days a week service, supervised by a Qualified Practitioner;
- Has a full-time coordinator;
- Keeps written records of services provided to each patient;
- Has a nurse coordinator who is a registered nurse (RN) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients; and
- Has a licensed social service coordinator.

A *hospice care agenc*y will establish policies for the provision of hospice care, assess the patient's medical and social needs and develop a program to meet those needs. It will provide an ongoing quality assurance program, permit area

medical personnel to use its services for their patients and use volunteers trained in care of and services for non-medical needs.

"Hospital" means an *institution* that meets all of the following requirements:

- It provides medical and surgical facilities for the treatment and care of injured or sick persons on an *inpatient* basis;
- It is under the supervision of a staff of *physicians*;
- It provides 24-hour-a-day nursing service by registered nurses;
- It is duly licensed as a *hospital*, except that this requirement will not apply in the case of a state tax-supported *institution*;
- It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type institution, or an institution which is supported in whole or in part by a federal government fund; and
- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations sponsored by the *AMA* and the *AHA*.

The requirement of surgical facilities shall not apply to a *hospital* specializing in the care and treatment of mentally ill patients, provided such *institution* is accredited as such an *institution* by the Joint Commission on Accreditation of Healthcare Organizations sponsored by the *AMA* and the *AHA*.

"Illness" means a condition, sickness or disease not resulting from trauma.

"Immediate relative" means spouse, *child*, brother, sister or parent of the *covered person*, whether by birth, adoption or marriage

"Impregnation" **and** ***"infertility treatment"*** mean artificial insemination, fertility *drugs*, G.I.F.T. (Gamete Intrafallopian Transfer), in-vitro fertilization, reversal of a sterilization operation, surrogate mother, donor eggs, or any type of artificial impregnation procedure, whether or not such procedure is successful.

"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.

"*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*.

"Institution" means a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a *hospital*, *ambulatory surgical center*, *psychiatric hospital*, community mental health center, residential treatment facility, *psychiatric hospital*, *substance abuse treatment center*, alternative *birthing center*, *home health care* center, or any other such facility that the *Plan* approves.

"Intensive care unit" means a separate, clearly designated service area which is maintained within a *hospital* and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical condition;

- It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the *hospital*;

- It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;

- It contains at least two beds for the accommodation of critically ill patients; and

- It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

"Leave of absence" means a leave of absence of an *employee* that has been approved by his *participating employer*, as provided for in the *participating employer's* rules, policies, procedures and practices.

"Mastectomy" means the *surgical* removal of all or part of a breast.

"Medically necessary" means services or supplies which are determined by the *Plan Administrator* to be:

- Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the medical condition, *injury* or *illness*;

- Provided for the diagnosis or direct care and treatment of the medical condition, *injury* or *illness*;

- Within standards of good medical practice within the organized medical community;

- Not primarily for the convenience of the *covered person*, the *covered person's physician* or another *provider*; and

- The most appropriate supply or level of service which can safely be provided.

For *hospital* stays, this means that acute care as an *inpatient* is necessary due to the kind of services the *covered person* is receiving or the severity of the *covered person's* condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a *physician* does not mean that it is "*medically necessary*." In addition, the fact that certain services are excluded from coverage under this *Plan* because they are not "*medically necessary*" does not mean that any other services are deemed to be "*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 or nervous disorder" means any *illness* or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services; or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

"Morbid Obesity" Patient has one or more of the following are present:

Patient has a Body Mass Index. BMI of 40 or greater

Patient has a BMI of 35 or greater and a clinically serious condition related to obesity (e.g. Obesity, hypoventilation, obstructive sleep apnea, diabetes, hypertension, cardiomyopathy, musculosketal dysfunction)

Surgical Intervention appropriate as indicated by ALL of the following:

Failure to achieve and maintain significant weight loss by other means

Adherence to a multidisciplinary nonsurgical program that includes ALL of the following:

- Low-calorie or very-low- calorie diet
- Supervised exercise
- Behavior modification

No specific correctable cause for obesity identified (e.g. Endocrine disorder)

Full Growth

- Patient is receiving treatment in a multidisciplinary program experienced in obesity surgery than can provide ALL of the following:

  - Surgeons experienced with the procedure
  - Preoperative medical consultation and approval
  - Preoperative psychiatric consultation and approval
  - Nutritional Counseling
  - Exercise counseling
  - Psychological counseling
  - Support group meetings

"Out-of-pocket expense" means the cost to the *covered person* for *deductibles*, coinsurance, copayments, penalties and non-*covered expenses*.

"Participating employer(s)" means City of Perrysburg.

"Physician" means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental *Surgery* (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.).

"Plan" means the City of Perrysburg Employee Health Plan.

"Plan Administrator" means City of Perrysburg.

"Plan document" means this plan document and *summary plan description*.

"Plan Sponsor" means City of Perrysburg.

"Plan year" means the period commencing January 1st and continuing until the next succeeding anniversary.

"Pregnancy" means carrying a child, resulting childbirth, miscarriage and non-elective abortion, including *complications of pregnancy*. The *Plan* considers *pregnancy* as an *illness* for the purpose of determining benefits.

*"**Privacy Standards**"* means the standards for privacy of individually identifiable health information, as enacted pursuant to *HIPAA*.

"Provider" means a *physician*, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, psychiatrist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, certified midwife, or other practitioner or facility defined or listed herein, or approved by the *Plan Administrator*.

"Psychiatric hospital" means an *institution* constituted, licensed, and operated as set forth in the laws that apply to *hospital*s, which meets all of the following requirements:

- It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a *physician*;
- It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
- It is licensed as a *psychiatric hospital*;
- It requires that every patient be under the care of a *physician*; and
- It provides 24-hour-a-day nursing service.

It does not include an *institution*, or that part of an *institution*, used mainly for nursing care, rest care, convalescent care, care of the aged, *custodial care* or educational care.

*"**Rehabilitation hospital"*** means an *institution* which mainly provides therapeutic and restorative services to sick or injured people. It is recognized as such if:

- It carries out its stated purpose under all relevant federal, state and local laws;
- It is accredited for its stated purpose by either the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation for Rehabilitation Facilities; or
- It is approved for its stated purpose by *Medicare*.

"Room and board" means an *institution*'s charge for:

- Room and linen service;
- Dietary service, including meals, special diets and nourishment;
- General nursing service; and
- Other conditions of occupancy which are *medically necessary*.

"Security standards" mean the final rule implementing *HIPAA's* Security Standards for the Protection of *Electronic PHI,* as amended.

"Significant break in coverage" means a period of 63 consecutive days during each of which an individual does not have any *creditable coverage*.

"Skilled nursing facility" means a lawfully operated *institution* or that part of such an *institution* that meets all of the following conditions:

- It is licensed to provide, and is engaged in providing, on an *inpatient* basis, for a person convalescing from *injury* or *illness*, professional nursing services rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily activities;

- Its services are provided for compensation from its patients and under the full-time supervision of a *physician* or Registered Nurse;

- It maintains a complete medical record on each patient;

- It has an effective utilization review plan; and

- It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care, or care of *mental or nervous disorders*.

The term shall also apply to expenses incurred in an *institution* referring to itself as an extended care facility, convalescent nursing facility or any other similar designation.

"Substance abuse" means any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

"Substance abuse treatment center" means an *institution* which provides a program for the treatment of *substance abuse* by means of a written treatment plan approved and monitored by a *physician*. This *institution* must be:

- Affiliated with a *hospital* under a contractual agreement with an established system for patient referral;

- Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or

- Licensed, certified or approved as an alcohol or *substance abuse* treatment program or center by a state agency having legal authority to do so.

"Summary plan description" means this *plan document* and summary plan description.

"Surgery" **or** ***"surgical procedure"*** means any of the following:

- The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;

- The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;

- 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;

- The induction of artificial pneumothorax and the injection of sclerosing solutions;

- Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;

- Obstetrical delivery and dilation and curettage; or

- Biopsy.

"*Third party administrator*" means NFP Benefit Alliance

"Total disability" or "totally disabled" means the inability of an employee to perform substantially all of the duties of his occupation due to an illness or injury. The *Plan Administrator* may, in its sole discretion, require satisfactory evidence of total disability.

"Trade Act" means the Trade Act of 2002, as amended.

"Uniformed services" means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or *emergency*.

"Urgent care center" means a licensed health care facility, other than a *hospital,* that provides urgent care for *emergencies* and *injuries*.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

"Usual, customary and reasonable" or "usual, customary and reasonable fees" *("UCR")* means services and supplies which are *medically necessary* for the care and treatment of *illness* or *injury*, but only to the extent that such fees are reasonable.

Determination that a fee is reasonable will be made by the *Plan Administrator*, taking into consideration:

- The fee which the *provider* most frequently accepts or charges the majority of patients for the service or supply;

- The prevailing range of fees charged in the same Area by *providers* of similar training and experience for the service or supply; and

- Unusual circumstances or complications requiring additional time, skill and experience in connection with the particular service or supply.

*"**Waiting period"*** means an interval of time during which the *employee* is in the continuous, *active employment* of his *participating employer* before he becomes eligible to participate in the *Plan*.

PLAN ADMINISTRATION

Who has the authority to make decisions in connection with the Plan?

Plan Administrator and Designated Decision Maker
An individual or entity may be appointed by the *Plan Sponsor* to be *Plan Administrator* and serve at the convenience of the *Plan Sponsor*. If the *Plan Administrator* resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the *Plan Sponsor* shall appoint a new *Plan Administrator* as soon as reasonably possible.

Notwithstanding any provisions of this *Plan Document* and *Summary Plan Description* to the contrary, the *Plan Sponsor* has the authority to, and hereby does, allocate certain fiduciary responsibility to NFP Benefit Alliance *(the "Designated Decision Maker" or "DDM")*. The fiduciary responsibility allocated to the *DDM* is limited to discretionary authority and ultimate decision-making authority with respect to any appeals of denied claims, which shall be referred to the *DDM* by the *Plan Administrator* (the "*referred appeals*"). The *Plan Sponsor* has allocated additional fiduciary responsibility to the *DDM*, limited to discretionary authority and ultimate decision-making authority with respect to the review and audit of certain claims in accordance with the applicable *Plan* provisions under the section, "Claim Review and Audit Program". Such claims selected as eligible for review and audit shall be identified according to guidelines to which the *Plan Sponsor* has agreed, and shall be referred to the *DDM* by the *Plan Administrator*. The *DDM* shall have no authority, responsibility or liability other than with respect to the *referred appeals* and its duties under the Claim Review and Audit Program.

The *Plan Administrator* shall establish the policies, practices and procedures of this *Plan*. The *Plan Administrator* and the *Designated Decision Maker* shall administer this *Plan* in accordance with its terms. It is the express intent of this *Plan* that the *Plan Administrator* and the *Designated Decision Maker* shall 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*), to decide disputes which may arise relative to a *Plan* participant's rights, and to decide questions of *Plan* interpretation and those of fact relating to the *Plan*. The decisions of the *Plan Administrator* and/or the *Designated Decision Maker* 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* or the *Designated Decision Maker* decides, in its discretion, that the *Plan* participant is entitled to them.

Duties of the Plan Administrator
The duties of the *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 *Plan* participant's rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the *Plan* documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To perform all necessary reporting;
10. To establish and communicate procedures to determine whether a medical child support order or national medical support notice 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.

May changes be made to the Plan?
The *Plan Sponsor* expects to maintain this *Plan* indefinitely; however, the *Plan Sponsor* may, in its sole discretion, at any time, amend, suspend or terminate the *Plan* in whole or in part. This includes amending the benefits under the *Plan*.

Any such amendment, suspension or termination shall be enacted, if the *Plan Sponsor* is a corporation, by resolution of the *Plan Sponsor's* directors and officers, which shall be acted upon as provided in the *Plan Sponsor's* articles of incorporation or bylaws, as applicable, and in accordance with applicable federal and state law. In the event that the *Plan Sponsor* is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the *Plan Sponsor* is a sole proprietorship, then such action shall be taken by the sole proprietor, in his own discretion.

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

MISCELLANEOUS INFORMATION

Who pays the cost of the Plan?
The *Plan Sponsor* is responsible for funding the *Plan* and will do so as required by law. To the extent permitted by law, the *Plan Sponsor* is free to determine the manner and means of funding the *Plan*. The amount of the *covered person's* contribution (if any) will be determined from time to time by the *Plan Sponsor*, in its sole discretion.

Will the Plan release my information to anyone?
For the purpose of determining the applicability of and implementing the terms of these benefits, the *Plan Administrator* may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or *covered person* for benefits under this *Plan*. In so acting, the *Plan Administrator* shall be free from any liability that may arise with regard to such action; however, the *Plan Administrator* at all times will comply with the *privacy standards*. Any *covered person* claiming benefits under this *Plan* shall furnish to the *Plan Administrator* such information as may be necessary to implement this provision.

What if the Plan makes an 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 *covered persons* 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.

Will the Plan conform with applicable laws?
This *Plan* shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this *Plan*, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the *Plan Administrator* to pay claims that are otherwise limited or excluded under this *Plan*, such payments will be considered as being in accordance with the terms of this *summary plan description*. It is intended that the *Plan* will conform to the requirements of any applicable law.

What constitutes a fraudulent claim?
The following actions by you, or your knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this *Plan* for the entire *family unit* of which you are a member:

- Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a *covered person* in the *Plan*;

- Attempting to file a claim for a *covered person* for services that were not rendered or drugs or other items that were not provided;

- Providing false or misleading information in connection with enrollment in the *Plan*; or

- Providing any false or misleading information to the *Plan*.

How will this document be interpreted?
The use of masculine pronouns in this *summary plan description* shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this *summary plan description* are used for convenience of reference only. *Covered persons* are advised not to rely on any provision because of the heading.

The use of the words, "you" and "your" throughout this *summary plan description* applies to eligible or covered *employees* and, where appropriate in context, their covered *dependents*.

How may a Plan provision be waived?
No term, condition or provision of this *Plan* shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this *Plan*, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Is this summary plan description a contract between the employer and covered persons?
This *summary plan description* and any amendments constitute the terms and provisions of coverage under this *Plan*. The *summary plan description* shall not be deemed to constitute a contract of any type between the *employer* and any *covered person* or to be consideration for, or an inducement or condition of, the employment of any *employee*. Nothing in this *summary plan description* 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.

What if there is coverage through workers' compensation?
This *Plan* excludes coverage for any i*njury* 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:

- The workers' compensation benefits are in dispute or are made by means of settlement or compromise;

- No final determination is made that the *injury* or *illness* was sustained in the course of or resulted from your employment;

- 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

- The health care expense is specifically excluded from the workers' compensation settlement or compromise.

You are required to notify the *Plan Administrator* 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.

Will the Plan cover an alternate course of treatment?
The *Plan Administrator* may, in its sole discretion, determine that a service or supply, including prescription drugs, not otherwise listed for coverage under this *Plan,* be included for coverage, if the service or supply is deemed

appropriate and necessary, and is in lieu of a more expensive, listed covered service or supply. Such payments will be considered as being in accordance with the terms of this *summary plan description*.

Does the Plan limit my choice of providers?
Each *covered person* has a free choice of any provider, and the *covered person*, together with his provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the *Plan* will pay for all or a portion of the cost of such care.

HIPAA PRIVACY PRACTICES

The following is a description of certain uses and disclosures that may be made by the *Plan* 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:

- Obtaining premium bids from health plans for providing health insurance coverage under this *Plan;* or
- Modifying, amending or terminating the *Plan*.

"Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the *Plan,* but it 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 five-digit zip code.

Disclosure of Protected Health Information *("PHI")* to the Plan Sponsor for Plan Administration Purposes
In order that the *Plan Sponsor* may receive and use *PHI* for *plan administration* purposes, the *Plan Sponsor* agrees to:

- Not use or further disclose *PHI* other than as permitted or required by the *Plan* documents or as *required by law* (as defined in the *privacy standards*);
- Ensure that any agents, including a subcontractor, to whom the *Plan Sponsor* provides *PHI* received from the *Plan* agree to the same restrictions and conditions that apply to the *Plan Sponsor* with respect to such *PHI*;
- 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,* except pursuant to an authorization which meets the requirements of the *privacy standards;*
- 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;
- Make available *PHI* in accordance with section 164.524 of the *privacy standards* (45 CFR 164.524);
- Make available *PHI* for amendment and incorporate any amendments to *PHI* in accordance with section 164.526 of the *privacy standards* (45 CFR 164.526);
- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the *privacy standards* (45 CFR 164.528);
- Make its internal practices, books and records relating to the use and disclosure of *PHI* received from the *Plan* available to the Secretary of the U.S. Department of Health and Human Services *("HHS"),* or any other officer or employee of *HHS* to whom the authority involved has been delegated, for purposes of determining compliance by the *Plan* with part 164, subpart E, of the *privacy standards* (45 CFR 164.500 *et seq*);
- 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

- Ensure that adequate separation between the *Plan* and the *Plan Sponsor,* as required in section 164.504(f)(2)(iii) of the *privacy standards* (45 CFR 164.504(f)(2)(iii)), is established as follows:

  - The following employees, or classes of employees, or other persons under control of the *Plan Sponsor,* shall be given access to the *PHI* to be disclosed:

    - Plan Administrator and designated Human Resources personnel

  - The access to and use of *PHI* by the individuals described above shall be restricted to the *plan administration* functions that the *Plan Sponsor* performs for the *Plan*.

  - In the event any of the individuals described in 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, to ensure that no further non-compliance occurs. 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:

- The *Plan* documents have been amended to incorporate the above provisions; and

- The *Plan Sponsor* agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the *privacy standards* (45 CFR 164.504(f)(1)(iii)), 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 by the *Plan* to the *Plan Sponsor.*

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The *Plan Sponsor* hereby authorizes and directs the *Plan*, through the *Plan Administrator* or the *third party 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*.

Other Disclosures and Uses of PHI
With respect to all other uses and disclosures of *PHI*, the *Plan* shall comply with the *privacy standards.*

Breach of Privacy or Security Standards
Agents and *"business associates"* of the *Plan* are required to notify and report to the *Plan* any use or disclosure of *PHI* not permitted by *HIPAA* which compromises the privacy or security of *PHI*. Such notice will be made following discovery and without unreasonable delay, but in no event later than sixty (60) calendar days following discovery of a "*breach*" of "*unsecured protected health information*".

- "*Business associate*" shall mean a person who performs functions or activities on behalf of, or certain services for, a *Plan* that involve the use or disclosure of individually identifiable health information.

- "*Breach*" shall mean the unauthorized acquisition, access, use or disclosure of *PHI w*hich compromises the security or privacy of such information. "*Breach*" does not include:

    - Any unintentional acquisition, access, or use of *PHI* by a workforce member or person acting under the authority of a *Plan* or a *business associate*, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under *HIPAA*.

    - Any inadvertent disclosure by a person who is authorized to access *PHI* for this *Plan* or a *business associate* to another person authorized to access *PHI* for the *Plan* or *business associate*, or organized health care arrangement in which the *Plan* participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under *HIPAA*.

- "*Compromises the privacy or security of PHI*" shall mean posing a significant risk of financial, reputational or other harm to an individual.

- "*Unsecured protected health information*" shall mean *PHI* that is not secured through the use of technology or methodology specified by the Secretary of the Department of Health and Human Services ("DHHS") that renders *PHI* unusable, unreadable or indecipherable to unauthorized individuals.

Any terms not otherwise defined in this section shall have the meanings set forth in the *privacy standards* and the *security standards*.

Agents and *business associates* shall cooperate with the *Plan* in investigating any *breach* and in meeting the *Plan's* obligations to you and DHHS and any other security *breach* notification laws.

The *Plan* will notify you (in the manner required by law) of any use or disclosure of *PHI* not permitted by *HIPAA* which compromises the privacy or security of *PHI*. If your *unsecured protected health information* has been, or is reasonably believed by the *Plan*, to have been accessed, acquired, or disclosed during a *breach*, you will be notified, including;

- A brief description of what happened, including the date of the *breach* and the date of the discovery of the *breach*, if known;

- A description of the types of *unsecured protected health information* that were involved in the *breach* (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

- Any steps you should take to protect yourself from potential harm resulting from the *breach*;

- A brief description of what the *Plan* involved is doing to investigate the *breach*, to mitigate harm to individuals, and to protect against any further *breaches*; and

- Contact procedures for you to ask questions or learn additional information, which shall include a toll free telephone number, an e-mail address, Web site, or postal address.

Notice of a discovery of a *breach* by a *business associate* to the *Plan* shall include:

- The identification, to the extent possible, of each individual whose *unsecured protected health information* has been, or is reasonably believed to have been, acquired, used, or disclosed during the *breach*; and

- Any other available information that the *Plan* is required to include in the notification to you, as described above, at the time notification is required or as promptly thereafter as information becomes available.

The *Plan* has the right to terminate any contract with any agents and *business associates*, if the other party has engaged in a pattern of activity or practice that constitutes a material breach or violation of agents and *business associates,* or the *Plan's* respective obligations regarding *PHI*, and, on notice of such material breach or violation from the *Plan*, fails to take reasonable steps to cure the material breach or violation.

This *Plan* will at all times comply with the *HIPAA privacy standards* and *security standards*.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

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:

- Implement 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*;

- 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;

- Ensure that any agent, including a 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; and

- Report to the *Plan* any Security Incident of which it becomes aware.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

ADOPTION OF PLAN DOCUMENT

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

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

City of Perrysburg

By: _____
Title: _____
Date: _____

EMPLOYEE ACKNOWLEDGMENT

By signing this form, I agree that I have received a copy of my *plan document* and *summary plan description* on the date listed below.

Date Received	Employee's Signature
	Employee's Printed Name