The University of Akron Employee Medical Benefit Plan

PLAN DOCUMENT AND SUMMARY (PPO)

Effective: January 1, 2011
Restated: January 1, 2014
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ESTABLISHMENT OF THE PLAN
ADOPTION OF THE PLAN SUMMARY

THIS PLAN SUMMARY made by The University of Akron, as the Plan Sponsor, as of January 1, 2014, hereby amends and restates the Plan, which was originally adopted by The University of Akron, effective January 1, 2011.

Effective Date
This Plan Summary is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein (the “Effective Date”).

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

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

The University of Akron
(PPO for Active Employees)

By: ________________________________
Name: ________________________________
Date: ________________________________
Title: ________________________________
Introduction and Purpose
The Plan Sponsor has established the Plan for the benefit of eligible Employees, on the terms and conditions described herein. Plan benefits may be self-funded through a benefit fund or a trust established by the Plan Sponsor or may be funded solely from the general assets of the Plan Sponsor. Employees in the Plan may be required to contribute toward their and their Dependents’ benefits.

The Plan Sponsor’s purpose in establishing the Plan is to help to offset, for eligible Employees, the economic effects arising from a non-occupational 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 of abiding by the terms of the Plan Summary, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Summary 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 expenses for medical benefits.

General Plan Information

<table>
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<th>Name and Type of Plan:</th>
<th>The University of Akron Employee Medical Benefit Plan</th>
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<td>Plan Type:</td>
<td>Preferred Provider Organization (PPO) Medical</td>
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| Plan Sponsor and Administrator: | The University of Akron  
185 E. Mill  
Akron, OH 44325-0602  
330-972-5146 |
| Type of Plan Administration: | The Plan is managed by the Plan Administrator, with certain ministerial services being provided by the Third Party Administrator. |
| Third Party Administrator and Claims Adjudicator: | Apex Health Solutions.  
P.O. Box 3620  
Akron, OH 44309-3620  
(330) 996-8515 or (800) 753-8429 |
| Funding and Source of Contributions: | The Plan is a self-funded plan, with funds provided by the Plan Sponsor. |
| Plan Year: | January 1st through December 31st |
| Plan Sponsor Employer Identification Number (EIN): | 34-6002924 |
Agent for Service of Process: The University of Akron
Plan Administrator
185 E. Mill
Akron, OH 44325-0602
330-972-5146

Participating Employers: The University of Akron

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer’s name.

Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract
This Plan Summary and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Summary 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 Plan Summary 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.
DEFINITIONS

The definitions provided below may make it easier for you to understand the words used in this Plan Summary. The terms listed, if used, will have the following meanings. 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 the Plan Summary for that information.

**Accident**
Accident shall mean a sudden, unforeseen and unexpected event caused by external trauma to the body.

**Actively at Work or Active Employment**
Actively at Work or Active Employment shall mean 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.

**Activities of Daily Living**
Activities of Daily Living shall mean the skill and performance of physical and psychological/emotional self-care, work and play/leisure activities to a level of independence appropriate to age, life-space and disability.

**Acute Medical Condition**
Acute Medical Condition shall mean a condition or symptom that is of such severity that it does in fact constitute an extremely hazardous medical condition that would result in jeopardy to the Covered Person’s life or cause serious harm to his health if not treated immediately by a Provider.

**Adverse Benefit Determination**
Adverse Benefit Determination shall mean any of the following: a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant’s or beneficiary’s eligibility to participate in a plan, and includes, with respect to group health plans, a denial, reduction, termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. An adverse benefit determination includes a rescission of coverage determination and a declination of individual health insurance.

**Annual Open Enrollment Period**
Annual Open Enrollment Period shall mean the annual period during which an Eligible Employee may enroll himself and his Eligible Dependents in the Plan.

**Annual Benefit Maximum**
Annual Benefit Maximum shall mean the day, visits or dollar limits per benefit as listed in the annual benefit maximum section of the Schedule of Benefits.
**Annual Out-of-Pocket Maximum**
Annual Out-of-Pocket Maximum shall mean your share in the cost of Eligible Expenses is limited to the annual out-of-pocket maximum listed in the Schedule of Benefits. Out-of-pocket expenses paid for In-Network care will apply toward the In-Network and Out-of-Network annual out-of-pocket maximum and vice versa. Any amounts paid by you over the Reasonable and Customary Charge, Non Covered services, prior authorization penalties and services that have exceeded the annual benefit maximum do not apply toward any out-of-pocket maximums associated with this Plan. Medical Co-payments, Deductibles and Coinsurance amounts paid by you do apply toward the annual out-of-pocket maximum.

**Benefit Year**
Benefit Year shall mean a period of one year beginning January 1\textsuperscript{st} and ending December 31\textsuperscript{st}.

**Calendar Year**
Calendar Year shall mean a period of one year beginning with January 1\textsuperscript{st} and ending December 31\textsuperscript{st}.

**Case Management**
Case Management shall mean an economical, common sense approach to managing health care benefits. Apex Health Solutions’s case management staff evaluates opportunities to cover cost-effective alternatives to the patient’s current health care needs. Case management has proven to be very effective with catastrophic cases, long-term care, and psychiatric and substance abuse treatment.

**Certificate of Creditable Coverage**
Certificate of Creditable Coverage shall mean 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.

**Chiropractic Services (Musculoskeletal Care)**
Chiropractic Services (Musculoskeletal Care) shall mean the actual services provided by a chiropractor for examinations, laboratory and X-rays, spinal manipulation therapy (defined as the manual manipulation of the spine to restore mobility to the joints and to allow vertebrae to assume their normal position), and other modalities of treatment.

**Coinsurance**
Coinsurance shall mean the percentage of Eligible Expenses which you must pay. For example, if the Coinsurance is 90% under the Plan, it means that you will pay 10% of the Eligible Expense and the Plan will pay 90%.

**Co-payment**
Co-payment shall mean the amount that you must pay for Eligible Expenses. For example, if the Co-payment is $20 under the Plan, this means that the Plan will cover the cost at 100%, after you pay $20.

**Covered Person**
Covered Person shall mean an Employee or Eligible Dependent who enrolls, becomes covered and remains covered under this Plan, continuing to meet the Plan’s eligibility requirements.
Custodial Care
Custodial Care shall mean care or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, and 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 Amount
Deductible Amount shall mean the amount of Eligible Expenses you must pay out-of-pocket each Calendar Year, before the Plan’s coverage begins for services subject to such Deductible Amount. In the case of family coverage, each covered person would not be required to satisfy more than the individual deductible amount. Deductible amounts for In-Network services will also apply to the Out-of-Network services and vice versa.

Eligible Cancer Clinical Trial
Eligible Cancer Clinical Trial shall mean a cancer clinical trial that meets all of the following criteria:

1. A purpose of the trial is to test whether the intervention potentially improves the trial participant’s health outcomes;
2. The treatment provided as part of the trial is given with the intention of improving the trial participant’s health outcomes;
3. The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology;
4. The trial does one of the following:
   a. Tests how to administer a health care service, item, or drug for the treatment of cancer;
   b. Tests responses to a health care service, item, or drug for the treatment of cancer;
   c. 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; or
   d. Studies new uses of a health care service, item, or drug for the treatment of cancer.
5. The trial is approved by one of the following entities:
   a. The national institutes of health or one of its cooperative groups or centers under the United States department of health and human services;
   b. The United States food and drug administration;
   c. The United States department of defense; or
   d. The United States Department of Veterans’ Affairs.

Eligible Dependent
Eligible Dependent shall mean:

1. Your wife or husband to whom you are lawfully wed and with respect to whom you possess a valid marriage license;
2. Your same gender domestic partner;
3. Your child(ren) under age 26 regardless of marital status;
4. Your unmarried child(ren) age 26 and up to age 28; if all of the following requirements are met:
   a. Your unmarried child must be under the age of 28;
   b. Your unmarried child must be your natural child, your stepchild, or your adopted child;
   c. Your unmarried child is a resident of the state of Ohio or is a full-time student at an accredited college or university;
   d. Your unmarried child must not be employed by an employer that offers any health benefit plan in which your unmarried child is eligible to enroll; and
   e. Your unmarried child must not be eligible for coverage under the Medicaid program or the Medicare program.
5. Your unmarried child (ren) 26 years or older, provided they are dependent upon you and, upon attainment of age 26, are mentally or physically incapable of self-support as determined by the Plan Administrator. Eligibility terminates when the individual is no longer mentally or physically incapable of self-support;
6. A child placed with you for adoption when you have a legal obligation for support. Placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.

The word “child(ren)” in addition to your natural children includes stepchildren, legally adopted children, and children for whom you have legal guardianship.

**Eligible Expense**
Eligible Expense shall mean a charge less than or equal to the Maximum Allowable Charge (with respect to charges by Network Providers) or the Plan’s Usual and Customary Charge (with respect to Out-of-Network Providers) that is incurred by a Covered Person for services and supplies that are:

1. Recommended by a Physician;
2. Medically necessary for the treatment of an Illness or Injury;
3. Provided after the effective date of coverage under the Plan and prior to the termination of coverage under this Plan; and
4. Are not otherwise excluded from coverage in this Plan Summary.

**Emergency**
Emergency shall mean a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect any of the following: placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or body part.

**Emergency Care Center**
Emergency Care Center shall mean a public or private establishment with an organized staff of Physicians and with permanent facilities equipped primarily to provide immediate Emergency Accident care and non-acute medical care.
**Employee**
Employee shall mean a person who is an Employee of the Participating Plan Sponsor, regularly scheduled to work for the Participating Plan Sponsor in an employer-employee relationship. A full-time person must be scheduled to work at least 40 hours per week in order to be eligible for benefits.

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

**Experimental**
Experimental shall mean services, supplies, care, procedures, treatments or courses of treatment which:

1. 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
2. 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.

All phases of clinical trials, except routine basic care, 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 Coverage**
Family Coverage shall mean coverage for you and one or more of your Eligible Dependents.

**Health Services Management Program**
Health Services Management Program shall mean a Physician-directed program whose goal is to work with Providers and Covered Persons to achieve efficient and appropriate utilization of health care resources.

**HIPAA**
HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

**Home Health Aide**
Home Health Aide shall mean a person who provides care of a medical or therapeutic nature and reports to and is under the direct supervision of a Home Health Care Agency.

**Home Health Care Agency**
Home Health Care Agency shall mean a public or private agency or organization, or part of one, that primarily provides skilled nursing and other therapeutic services. It must be legally qualified in the state or locality in which it operates. It must keep clinical records on all Covered Persons. The services must be supervised by a Physician or registered nurse, and they must be based on policies set by associated professionals, which include at least one Physician and one registered nurse.
Home Health Care Plan
Home Health Care Plan shall mean a plan for continued care and treatment of a Covered Person in his home. To qualify, the plan must be established in writing by a Physician who certifies that the Covered Person would require confinement in a Hospital if he did not have the care and treatment stated in the plan.

Hospice Care Agency
Hospice Care Agency shall mean an agency or organization that is properly licensed in the state in which it operates, has hospice care available 24 hours a day, 7 days a week, and provides or arranges for hospice care services or supplies.

Hospice Care Plan
Hospice Care Plan shall mean a plan that is supervised by a Physician and involves a team consisting of:

1. A Physician who provides hospice care;
2. Licensed nurses;
3. A licensed mental health specialist; and
4. A licensed social worker.

The Hospice Care Plan must provide for:

1. The Covered Person's plan of care;
2. Regular reviews of the Covered Person's care;
3. Informing the proper persons of any change in the Covered Person's condition; and
4. Complying with governmental regulations.

Hospice Facility
Hospice Facility shall mean a facility that is properly licensed in the state in which it operates and is engaged primarily in providing palliative care to terminally ill Covered Persons.

Hospital
Hospital shall mean an acute care medical facility equipped to handle all regular medical and surgical cases. U.S. Veteran’s Hospitals are included when the veteran is treated for non-military service-related medical conditions and is legally responsible for charges incurred. It does not include a psychiatric Hospital unless specifically approved by the Plan Administrator. Further, the term does not include an institution which is principally a rest home, nursing home or home for the aged, or an institution primarily engaged in rehabilitation or the care and treatment of drug addicts or alcoholics.

Illness
Illness shall mean any physical or mental sickness or disease that manifests treatable symptoms and that requires treatment of a Physician or other Provider. This definition also includes pregnancy.

Incurred
Incurred shall mean that an Eligible Expense is incurred on 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, Eligible 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,
Eligible 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. However, a period of inpatient hospital confinement is incurred as of the date of admission.

**Injury**
Injury shall mean an Accidental bodily injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

**Inpatient**
Inpatient shall mean a Covered Person is treated in a Hospital as a registered bed patient, incurring a charge for Room and Board, upon the recommendation of a Physician.

**Mastectomy**
Mastectomy shall mean the surgical removal of all or part of a breast.

**Maximum Allowable Charge**
Maximum Allowable Charge shall mean, with respect to a charge by a Network Provider, the charge that is established by an agreement between the Plan and the Network Providers.

**Maximum Lifetime Benefit Amount**
Maximum Lifetime Benefit Amount shall mean the maximum benefits that the Plan will pay for all services received during a Covered Person’s lifetime.

**Medically Necessary**
Medically Necessary shall mean services or supplies received while a Covered Person, which are determined by the Plan to be:

1. Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the Illness or Injury;
2. Provided for the diagnosis or direct care and treatment of the Illness or Injury;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for the convenience of the Covered Person, the Covered Person’s Physician or another Provider; and
5. 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.”

**Network**
Network shall mean the CommunityChoice Network within the defined “Network Service Area” below, Ohio Health Choice (OHC) within the state of Ohio, but outside of the “Network Service Area” and PHCSHD/MultiPlan outside of the state of Ohio. To find a listing of providers visit...
NOTE: If your residence is outside the state of Ohio; PHCS Primary will be your primary network. If you are traveling in the state of Ohio your primary network will be Community Choice within the Network Service Area and PHCS Primary in all other counties within the state of Ohio. To find a listing of PCHS Primary providers visit www.phcs.com.

**Network Facility**

Network Facility shall mean any facility listed in the Network Provider Directory.

**In-Network Provider**

In-Network Provider shall mean a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility listed in the Network Provider Directory or approved by the Plan Administrator.

**Network Service Area**

Network Service Area shall mean Ashtabula, Carroll, Cuyahoga, Erie, Geauga, Holmes, Huron, Lake, Lorain, Mahoning, Medina, Ottawa, Portage, Sandusky, Stark, Summit, Trumbull, Tuscarawas and Wayne counties for the Community Choice Network.

**Out-of-Network Provider**

Out-of-Network Provider shall mean any Physician or other Provider who has not contracted with the above listed Networks to provide services.

**Outpatient**

Outpatient shall mean a Covered Person is treated on a basis other than as an Inpatient in a Hospital or other covered facility. Outpatient care includes services, supplies and medicines provided and used at a Hospital or other covered facility under the direction of a Physician to a person not admitted as an Inpatient.

**Outpatient Day Treatment**

Outpatient Day Treatment shall mean care received at an approved behavioral health center which is less than four hours in duration within a 24-hour period. Care longer than four hours in duration in a 24-hour period will be considered Inpatient treatment.

**Physician**

Physician shall mean a legally qualified person acting within the scope of his license and holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Chiropractic (D.C.) or Doctor of Podiatric Medicine (D.P.M.).

**Plan**

Plan shall mean The University of Akron Employee Medical Benefit Plan.

**Plan Sponsor**

Plan Sponsor shall mean The University of Akron.
Plan Summary
Plan Summary shall mean this Plan Document and Schedule of Benefits, which shall represent both the Plan Document and the Summary.

Plan Year
Plan Year shall mean a period of one year beginning January 1st and ending December 31st.

Provider
Provider shall mean a person or organization responsible for furnishing health care services, including a Hospital; Physician; Doctor of Dental Surgery (D.D.S.); Doctor of Podiatry (D.P.M.); Doctor of Chiropractic (D.C.); Licensed Clinical Psychologist (Ph.D.); Certified Nurse Midwife acting within the scope of his license under the direction and supervision of a licensed Physician; Licensed Physical Therapist (L.P.T.), Licensed Occupational Therapist (L.O.T.), Licensed Speech Therapist (L.S.T.), Licensed Independent Social Worker (L.I.S.W.), Licensed Professional Clinical Counselor (L.P.C.C.), Certified Chemical Dependency Counselor (C.C.D.C.) or Certified Alcohol Counselor (C.A.C.) acting within the scope of his license and performing services ordered by a Doctor of Medicine or Doctor of Osteopathy.

Reasonable and Customary Charges (R&C)
Reasonable and Customary Charges (R&C) shall mean charges made for medical services or supplies in the amount normally charged by the Physician or other Provider for similar services and supplies, which do not exceed the amount ordinarily charged by most Physicians or other Providers for comparable services and supplies in the locality where the services or supplies are received, or which do not exceed such other charge allowance as may be determined by the Plan’s Third Party Administrator. Determination of whether or not a charge is R&C will be made by the Plan’s Third Party Administrator based upon nationally obtained and recognized survey data and/or other methods as deemed appropriate by said Third Party Administrator.

Room and Board
Room and Board shall mean charges made by a Hospital or other covered institution for the cost of the room, general duty nursing care and other services routinely provided to all Inpatients, not including Special Care Units.

Skilled Nursing Facility
Skilled Nursing Facility shall mean a facility, either freestanding or part of a Hospital, that accepts patients in need of rehabilitation and medical care that is of a lesser intensity than that received in a Hospital.

Special Care Units
Special Care Units shall mean specific Hospital units that provide concentrated special equipment and highly skilled personnel for the care of critically ill patients requiring immediate, constant and continuous attention. This term includes intensive care, coronary care and acute care units of a Hospital but does not include surgical recovery areas or post-operative rooms. The unit must meet the required standards of the Joint Commission on Accreditation of Health Care Organizations for Special Care Units.

Stabilize
Stabilize shall mean to provide such medical treatment of an Emergency Medical Condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.
The Plan covers Emergency Services for an Emergency Medical Condition treated in any hospital emergency department. The Plan will not require prior authorization or impose any other administrative requirements or benefit limitations that are more restrictive if you receive Emergency Services from an out-of-network provider. However, an out-of-network provider of Emergency Services may send you a bill for any charges remaining after the Plan has paid (this is called “balance billing”).

Except where the Plan provides a better benefit, the Plan will apply the same co-payments and coinsurance for out-of-network Emergency Services as it generally requires for in-network Emergency Services. A deductible may be imposed for out-of-network Emergency Services, only as part of the deductible that generally applies to out-of-network benefits. Similarly, any out-of-pocket maximum that generally applies to out-of-network benefits will apply to out-of-network Emergency Services.

The Plan will calculate the amount to be paid for out-of-network Emergency Services in three different ways and pay the greatest of the three amounts: 1) the amount the Plan pays to in-network providers for the Emergency Services furnished (this calculation is not required if the Plan does not have negotiated per service amounts with in-network providers for the services furnished); 2) the amount that would be paid using the same method the Plan generally uses to determine payment for out-of-network services (such as the reasonable and customary charges), but substituting in-network co-payments and coinsurance amounts; and (3) the amount that would be paid under Medicare for the services provided. All three of these amounts are calculated before application of any in-network co-payments or coinsurance.

**Urgent Care**

Urgent Care shall mean treatment rendered outside the Physician’s office for health problems that require immediate medical attention but are not life- or limb-threatening emergencies.

**Urgent Care Request**

Urgent Care Request means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination could seriously jeopardize the life or health of the insured or the ability of the insured to regain maximum function; or in the opinion of a physician with knowledge of the insured’s medical condition, would subject the insured to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request. In determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the insurer shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine, however, any request that a physician with knowledge of the insured’s medical condition determines is an urgent care request within the meaning of this definition shall be treated as an urgent care request.

**Waiting Period**

Waiting Period shall mean the period of time, if any, for which you must be in the continuous, Active Employment of the Participating Employer, in an eligible Employee class before you become eligible for coverage under the Plan.
UNDERSTANDING THE PLAN

This Plan Summary has been developed to make it easy to understand the benefits that are provided by the Plan. If you have any questions regarding the Plan, please contact the Apex Health Solutions Customer Service Department at (330) 996-8515 or (800) 753-8429 for information.

How the Plan Works
The Plan has contracted with the Network to provide care to Covered Persons at discounted fees. There are several advantages to you when you use the services of Network Providers. For information about these advantages, see the section entitled "Schedule of Benefits."

Free Choice of Physician and Treatment
The Covered Person shall have free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. The Covered Person, together with his Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of such care. Providers who are members of any network used by the Plan are merely independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any Provider. The Plan shall not be liable for Injuries resulting from negligence, misfeasance, nonfeasance or malpractice on the part of any officer or Employee or on the part of any Physician in the course of performing services for Covered Persons.

Prior Authorization and Case Management
The Plan uses a managed care approach to control costs and enable it to provide the highest level of benefits to you. An important feature of managed care is providing medical care in the setting that is appropriate for your symptoms or condition, and at the same time, is cost efficient -- such as Outpatient versus Inpatient treatment. The Plan uses prior authorization procedures to accomplish this.

Prior authorizations are handled through the Health Services Management Program. Whenever prior authorization is required, your selected Network Provider will obtain the necessary approval. **If you do not choose a Network Provider for your care, you will be responsible for obtaining any necessary prior authorization.** To prior authorize the service; please call customer service at (330) 996-8515 or (800) 753-8429.

**If prior authorization is required and not obtained there will be a 10% penalty applied up to a $500 maximum per penalty. For services rendered with a Network Provider the provider will be penalized; for services rendered with an Out-of-Network Provider the member will be penalized.** This Plan procedure does not apply if this plan is not the primary coverage.

The Health Services Management Program uses both local and national medical standards for health service utilization in managing the prior authorization of services. This approach to delivering health care allows your Physician and the Plan to work together to provide you with quality, cost-effective medical care. In the event of a catastrophic Illness or other extreme circumstances, you may be able to obtain benefits for services not specifically covered by the Plan, if use of those services would substitute for a Hospital stay. Alternate benefits must be approved by the Health Services Management Program.
The Health Services Management Program also uses both local and national medical necessity standards to make sure that the Plan pays only for care that is medically necessary.
ELIGIBILITY FOR COVERAGE

Eligibility for Individual Coverage
To be eligible for coverage under the Plan, you must meet the Plan’s definition of "Employee," have elected to participate in this Plan and have paid your required contribution. If you are a new Employee, benefits will become effective on the first day of the month following your hire date. If you are not Actively at Work on the day your coverage is to begin your coverage will begin on the day that your status returns to Actively at Work.

Eligibility for Family Coverage
Each Employee will become eligible for coverage under this Plan or his Eligible Dependents on the latest of the following dates:

1. His date of eligibility for coverage for himself under the Plan;
2. The date coverage for his Eligible Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan; and
3. The first date upon which he acquires an Eligible Dependent.

Your newborn is automatically covered under the Plan for the first 31 days. You must enroll your newborn in the Plan within 31 days of the date of birth of the newborn. You must complete paperwork and submit it to The University of Akron’s Human Resources Department within 31 days of the date of birth or your newborn will not be covered under the Plan. Your next opportunity to enroll your newborn will be at the next Annual Open Enrollment Period.

Spousal Eligibility Provision
Effective January 1, 2012 the Plan will implement a Spousal eligibility provision with the following meaning. A spouse with access to subsidized medical benefit coverage available through their own employment must elect such coverage if the spouse’s employer contributes at least 50% of the cost. If such spouse does elect coverage through their employer they may also elect to be covered under The University of Akron’s plan for secondary coverage only. If your spouse does not have medical coverage available through their own employment or if their employer does not contribute at least 50% of the cost your spouse may be covered under The University of Akron’s plan with primary coverage.

Genetic Information Nondiscrimination Act of 2008 (GINA)
Individuals will be protected from discrimination in health plans on the basis of their genetic information. The Plan will not discriminate against individuals based upon their genetic information, which includes information about genetic tests, the genetic test of family members and the manifestation of a disease or disorder in family members. In addition, genetic information will be considered “health information” for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Enrolling in the Plan
If you wish to secure Plan coverage for yourself or yourself and your dependents, you must submit a fully completed enrollment application within 31 days of your eligibility date or during the Plan’s Annual Open Enrollment Period. For full-time employees your Open Enrollment period is in November; for an effective date of January 1st. Otherwise, you must wait until the next Annual Open Enrollment Period to apply for coverage under the Plan. Coverage for individuals enrolling during an Annual Open Enrollment Period will become
effective on January 1st, unless the Employee has not satisfied the Waiting Period, in which event coverage for the Employee and his Eligible Dependents will become effective on the day following completion of the Waiting Period.

Special Enrollment
Unless the Plan Sponsor has provided you with notice that it has exempted itself from these provisions, the following Special Enrollment features are available.

Special Enrollment for Individuals Losing Coverage
An Employee is entitled to enroll in the Plan during a Special Enrollment Period if he meets all of the following requirements:

1. The Employee is eligible for coverage under the Plan but is not currently covered under the Plan;
2. The Employee previously declined to enroll in the Plan and signed a written waiver of coverage, stating as the reason the existence of alternative group or other health coverage; and
3. The Employee was covered under such alternative group or other health coverage at the time he signed the waiver, and such coverage is no longer available.

An Eligible Dependent is entitled to enroll in the Plan during a Special Enrollment Period if he meets all of the following requirements:

1. He is eligible for coverage under the Plan but is not currently covered under the Plan;
2. The Employee, the Eligible Dependent or another appropriate person previously declined, on the Eligible Dependent’s behalf, to enroll in the Plan and signed a written waiver of coverage, stating as the reason the existence of alternative group or other health coverage; and
3. The Eligible Dependent was covered under such alternative group or other health coverage at the time he signed the waiver, and such coverage is no longer available.

Coverage (other than COBRA continuation coverage) will be considered no longer available when it terminates because of Loss of Eligibility or termination of Plan Sponsor contributions toward the cost of such coverage. COBRA continuation coverage will be considered no longer available when the COBRA coverage is exhausted.

“Loss of Eligibility” shall mean loss of coverage resulting from divorce, death, termination of employment, a reduction in the number of hours of employment, or any loss of eligibility after a period that is measured based on any of those events. Loss of Eligibility shall not mean loss of coverage resulting from an individual’s failure to pay premiums on a timely basis or any termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of fact in connection with such coverage.)

Special Enrollment for New Dependents
An Employee is entitled to enroll himself and his Eligible Dependents in the Plan during a Special Enrollment Period if all of the following requirements are met:

1. The Employee is eligible for coverage under the Plan but is not currently covered under the Plan;
2. The Employee previously declined to enroll in the Plan; and
3. An individual became an Eligible Dependent of the Employee through marriage, birth, adoption or placement for adoption.
“Special Enrollment Period” shall mean, with respect to individuals losing coverage, the period which ends 31 days after:

1. The date on which the coverage is exhausted, if the coverage was COBRA continuation coverage; or
2. The date on which the coverage terminated because of Loss of Eligibility or termination of Plan Sponsor contributions toward the cost of such coverage, for other individual or group health coverage.

With respect to new dependents, the period which ends 31 days after the date of one of the following, triggers the special enrollment rights:

1. Marriage;
2. Birth;
3. Adoption;
4. Placement for adoption; or
5. A significant (25%) increase in premium. This plan procedure does not eliminate the spousal eligibility provision.

“Special Enrollment Period” shall mean, with respect to CHIPRA, the following:

The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires that the Plan permit you or your dependent, if eligible, but not enrolled, for coverage under your group health plan, to enroll if either of the following conditions is met:

1. You or your dependent covered under Medicaid or the State Children’s Health Insurance Program (SCHIP) has coverage terminated as a result of loss of eligibility, and you request coverage for you or your dependent within 60 days after termination; or
2. You or your dependent becomes eligible for Medicaid or SCHIP assistance (subsidy), if you request coverage within 60 days after the eligibility determination date.

Changes in Eligibility Status
After you become a Covered Person, you are responsible for informing The University of Akron’s Human Resources Department of any changes in your personal situation that may affect your coverage. You must report to The University of Akron’s Human Resources Department any changes which could affect your eligibility status (including but not limited to): your employee status; your marital status; the number of dependents or the eligibility status of dependents; your spouse’s employer or health coverage; or your residence. Notice of such change must be provided within 31 days of such change.

Qualified Medical Child Support Orders
The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a “Qualified Medical Child Support Order” (“QMCSO”) if such an individual is not already covered by the Plan as an Eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

“Alternate Recipient” shall mean any child of a Covered Person who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Covered Person’s Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent.
“Medical Child Support Order” shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Covered Person’s child or directs the Covered Person to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

“National Medical Support Notice” or “NMSN” shall mean a notice that contains the following information:

1. Name of an issuing state agency;
2. Name and mailing address (if any) of an Employee who is a Covered Person under the Plan;
3. 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
4. Identity of an underlying child support order.

“Qualified Medical Child Support Order” or “QMCSO” is a Medical Child Support Order 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:

1. The name and last known mailing address (if any) of the Covered Person and the name and mailing address of each such Alternate Recipient covered by the order;
2. 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;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of “National Medical Support Notice”;
2. Identifies either the specific type of coverage or all available group health coverage. If the Plan Sponsor receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Plan Sponsor and the Plan Administrator will assume that all are designated;
3. 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
4. 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 medical child support.
orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

1. 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
2. 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 National Medical Support Notice, the Plan Administrator shall:

1. 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:
   (a) Whether the child is covered under the Plan; and
   (b) 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
2. 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:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and
2. 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.
TERMINATION OF COVERAGE

Termination Dates of Individual Coverage
The coverage of any Employee for himself under this Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. The date, or with respect to which, he requests that such coverage be terminated, provided such request is made on or before such date;
3. The date of the last period for which the Employee has made a contribution;
4. The date in which he ceases to be eligible for such coverage under the Plan;
5. The date in which the termination of employment occurs; or
6. Immediately if you (or a person seeking coverage on your behalf), perform an act, practice, or omission that constitutes fraud; or you (or a person seeking coverage on your behalf) make an intentional misrepresentation of material fact, as prohibited by the terms of the Plan.

Termination Dates of Family Coverage
The coverage for any Eligible Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. Upon the discontinuance of coverage for dependents under the Plan;
3. When such Eligible Dependent becomes covered as an Employee under the Plan;
4. The date of termination of the Employee’s coverage for himself under the Plan;
5. The date of the last period for which the Employee has made a contribution;
6. In the case of a child for whom coverage is being continued due to mental or physical inability to earn his own living, the earliest to occur of:
   a. Cessation of such inability;
   b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or
   c. Upon the Child’s no longer being dependent on the Employee for his support.
7. The end of the month a dependent is no longer eligible for coverage. This is according to the definition of eligible dependent under the Definition Section.
8. The end of the month such person ceases to be an Eligible Dependent, except as may be provided for; or
9. Immediately if you (or a person seeking coverage on your behalf), perform an act, practice, or omission that constitutes fraud; or unless you (or a person seeking coverage on your behalf) make an intentional misrepresentation of material fact, as prohibited by the terms of the Plan.

Company Continuation of Coverage
Listed below are the non-bargaining unit employee regulations for continuation of coverage. If you are a bargaining unit employee please refer to your bargaining unit specific contract.
**Layoff Policy**
The Plan will continue coverage for up to four months if the Covered Person has been temporarily laid off. In the case of a Permanent Layoff the coverage will terminate on the last date of employment.

**Leave of Absence**
The Plan will continue coverage for a Covered Person on a full or partial approved leave of absence for up to one year. In the case of a Military Leave of Absence the Plan will continue coverage according to Federal and State Laws.

**Total Disability**
The Plan will terminate coverage at the earliest of the following, measured from the date of disability:

1. A period of time equal to prior service;
2. When the employee becomes eligible for Medicare or Ohio Retirement System benefits; or
3. Two years.

**Surviving Spouse and Insured Dependents of Deceased Active Employees**
The Plan will terminate coverage on the last day of the second month following the month of death.

**Certificates of Creditable Coverage**
The Plan will automatically provide a Certificate of Creditable Coverage to any Covered Person after the individual loses coverage in the Plan. In addition, a Certificate of Creditable Coverage will be provided upon request, if the request is made within 24 months after the individual loses coverage under the Plan. In that case, the Certificate of Creditable Coverage will be provided at the earliest time that the Plan, acting in a reasonable and prompt fashion, can furnish it.

The Plan will make reasonable efforts to collect information applicable to any Eligible Dependents and to include that information on the Certificate of Creditable Coverage, but the Plan will not issue an automatic Certificate of Creditable Coverage for Eligible Dependents until the Plan has reason to know that an Eligible Dependent has lost coverage under the Plan.
Network providers must obtain authorization 48 hours prior to rendering service for the procedures listed below. Apex Health Solutions bases authorization on plan benefits and appropriateness of care and service. Your provider may submit your request via fax to (330) 996-8501 using our Prior Authorization Fax Form. Out-of-Network providers may contact Apex Health Solutions at the appropriate phone numbers below. If your Out-of-Network provider will not make this contact, you are required to do this for them.

If prior authorization is required and not obtained a 10% penalty will be assessed up to a $500 maximum per penalty to the Provider in the case that services were rendered with an In-Network Provider or to the Covered Person in the case that services were rendered by an Out-of-Network Provider. This plan procedure does not apply if this plan is not the primary coverage.

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Subject to the limitations contained in the Summary of Benefits, as well as the Plan’s provisions, limitations and exclusions, the Plan provides benefits for the following services and supplies.

**Abortion**
Expenses incurred directly or indirectly as the result of an elective abortion (during the 1st trimester only) or when the life of the mother would be threatened if the fetus were carried to term, or when complications arise or in cases of rape or incest.

**Acupuncture**
Acupuncture services up to the calendar year maximum benefit for rehabilitation services.

**Allergies**
Allergy testing and desensitization treatment.

**Ambulance**
Charges for Emergency transportation to the nearest Hospital. Ambulance transportation must be provided by a professional ambulance service. Air ambulance is covered under the Plan when medically necessary. Non-emergent transportation services are also covered when prior authorized by the Health Services Management Program.

**Cancer Clinical Trials**
The costs of any routine patient care administered to you or your dependent participating in any stage of an eligible cancer clinical trial, if that care would be covered under the plan if you or your dependent were not participating in a clinical trial. An eligible cancer clinical trial is a cancer clinical trial that meets all of the following criteria:

1. A purpose of the trial is to test whether the intervention potentially improves the trial participant’s health outcomes;
2. The treatment provided as part of the trial is given with the intention of improving the trial participant’s health outcomes;
3. The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology;
4. The trial does one of the following:
   a. Tests how to administer a health care service, item or drug for the treatment of cancer;
   b. Tests responses to a health care service, item, or drug for the treatment of cancer;
   c. Compares the effectiveness of a health care service, item or drug for the treatment of cancer with that of a health care service, item, or drug for treatment of cancer; or
   d. Studies new uses of a health care service, item, or drug for the treatment of cancer.
5. The trial is approved by one of the following entities:
   a. The National Institutes of Health or one of its cooperative groups or centers under the United States Department of Health and Human Services;
   b. The United States Food and Drug Administration;
   c. The United States Department of Defense; or
d. The United States Department of Veteran’s Affairs.

**Chiropractic/Musculoskeletal Care**
Chiropractic X-rays or skeletal adjustments are covered up to the calendar year maximum benefit for rehabilitation services.

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

In order to be eligible for benefits, the Covered Person must be eligible to participate in an Approved Clinical Trial, according to the trial protocol with respect to treatment of cancer or other Life-threatening Conditions.

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

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or Condition and is described in any of the following:
1. A federally funded trial.
2. The study or investigation is conducted under an Investigational new drug application reviewed by the Food and Drug Administration.
3. The study or investigation is a drug trial that is exempt from having such an Investigational new drug application.

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

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

"Subject of a Clinical Trial" means the health care service, item, or drug that is being evaluated in the Approved Clinical Trial and that is not a Routine Patient Cost. No benefits are payable for the following:
1. A health care service, item, or drug that is the subject of the Approved Clinical Trial;
2. A health care service, item, or drug provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;
3. An Experimental or Investigational drug or device that has not been approved for market by the United States Food and Drug Administration;
4. Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the Approved Clinical Trial;
5. An item or drug provided by the Approved Clinical Trial sponsors free of charge for any patient;
6. A service, item, or drug that is eligible for reimbursement by an entity other than Apex Health Solutions, including the sponsor of the Approved Clinical Trial;
7. A service, item, or drug that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

**Contraceptive Devices**
Charges for devices used for contraception including but not limited to IUD, diaphragm, vaginal ring and cervical cap. Including the appointments for the fitting thereof.

**Dental Services**
Benefits are payable for Hospital charges for certain dental Surgery performed by a Surgeon when hospitalization is required to safeguard the health of the patient. Oral Surgery, such as the removal of tumors and cysts and treatment of accidental injury to healthy teeth. Dental services rendered by a physician or dentist for treatment of an accidental injury must be received within two years of the date of injury.

**Diagnostic Services**
Diagnostic services, such as lab, X-ray, etc.

**Durable Medical Equipment (DME) and Prosthetic Devices**
The rental or purchase of durable medical equipment is covered if the equipment is medically necessary. Such items include wheelchairs and hospital beds. Also covered are the first prosthesis and medically necessary replacement prosthesis for a Covered Person. To be covered by the Plan, prosthetic devices must be on the Plan’s list of approved prosthetic appliances. Deluxe versions will not be covered, unless medically necessary. DME must be prior authorized by the Health Services Management Program.

**Emergency and Urgent Care**
Treatment for an Emergency or Urgent Care.

**Glaucoma**
Treatment of glaucoma, cataract surgery and one set of lenses (contact or frame type) as required for the treatment of glaucoma or cataract surgery. Lens insertion into the eye as part of the surgery will cover the basic lenses only.

**Gynecological Visits**
Office visits for gynecological exam.

**Habilitative Services**
Medically necessary health care services that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition to the maximum extent practical. Habilitative services address the skills and abilities needed for functioning in interaction with an individual’s environment. Habilitative services does not include health care services such as respite care, day care, residential care, residential treatment, social services, custodial care, or education services of any kind, including but not limited to vocational training. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under this Plan. Habilitative services include, but are not limited to, children (ages 0-21) with a medical diagnosis of autism spectrum disorder, which, at a minimum, includes:
- Outpatient physical rehabilitation services, including speech and language therapy and/or occupational therapy, performed by a licensed therapist, 20 visits per calendar year of each service; and clinical therapeutic intervention defined as therapies supported by empirical evidence, which include but are not limited to applied behavioral analysis, provided by an appropriate agency of the State of Ohio to perform the services in accordance with a treatment plan, 20 hours per week; and
- Mental/behavioral health Outpatient services performed by a licensed psychologist, psychiatrist, or Physician to provide consultation, assessment, development and oversight of treatment plans, 30 visits per calendar year total.

**Home Health Care Services**
The following home health care services are covered if medically necessary. These services must be based upon a written Home Health Care Plan:

1. Nursing services provided by a registered or licensed practical nurse;
2. Physical, occupational or speech therapy when you are unable to go to a facility to receive these services;
3. Medical supplies;
4. Home health aide services; and
5. Medical social services;

**Hospice Care**
The following hospice services are covered if medically necessary and designed to treat patients with a life expectancy of six months or less. Benefits may exceed six months should the patient continue to live beyond on the prognosis for life expectancy. The following services are eligible:

1. All covered home health care services listed above, except nursing services which may be authorized for up to eight hours in any 24-hour period;
2. Room and Board while in a Hospice Facility;
3. Services and supplies furnished by the Hospice Facility during the admission, including part-time nursing care by or under the supervision of a registered nurse;
4. Dietary guidance;
5. Durable medical equipment; and
6. Home Health Aide visits.

Homemaker, volunteer and spiritual counseling services, food or home-delivered meals and Custodial Care, rest care or care for someone’s convenience are not covered. Chemotherapy or radiation therapy if other than palliative treatment is not covered under the hospice care, but may be covered elsewhere.

**Infertility Diagnosis and Treatment**
Medically necessary infertility diagnosis and treatment. Coverage includes, but is not limited to, opening of blocked fallopian tubes, hysterosalpingectomy and varicocelectomy. Coverage does not include infertility drug therapy, monitoring, surrogate parenting or procedures used to induce pregnancy.

**Mastectomy**
Unless the Plan Sponsor has notified you that it has exempted itself from the provisions described below, charges in connection with a Mastectomy will be covered as follows:

1. Reconstruction of the breast on which the Mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications from all stages of Mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the Covered Person.

Maternity Services
Maternity services for you or your Eligible Dependent are covered. The following services are covered:

1. Hospital charges related to your pregnancy;
2. Pre- and post-natal care; and
3. Treatment for complications of pregnancy, childbirth and any obstetrical disorder, Injury or condition arising from childbirth.

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under Federal Law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a Physician obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. This benefit covers up to a 48-hour Hospital admission for routine vaginal delivery and up to a 96-hour admission for routine cesarean section delivery, unless authorization for an extended Hospital stay has been obtained through the Health Services Management Program.

If mother or newborn are discharged prior to 48 hours (vaginal) or 96 hours (cesarean), home follow-up care that is provided within 72 hours of the time of discharge will be covered.

Also covered is Physician-directed follow-up care, which includes: physical assessment of the mother and newborn; parent education; assistance and training in breast or bottle feeding; assessment of the home support system; performance of any medically necessary clinical tests; any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals. This coverage applies to services provided in a medical facility and/or through home health care visits. These Physicians or Providers must be knowledgeable and experienced in newborn care.

Emergency deliveries are covered, regardless of Provider. Your Physician or other Provider must notify the Health Services Management Program within 48 hours after the delivery or as soon thereafter as medically possible.

Mental Health Services
Covered services include individual, group and family therapy. Inpatient, Partial Hospitalization and intensive Outpatient therapies are also covered.

Nursing Services
General nursing services.

**Operating Room**
Operating room, anesthesia and supplies.

**Physician Services**
Physician services related to medical treatment or surgery.

**Podiatry Services**
Medically necessary treatment by a podiatrist; routine foot care is not covered.

**Prescribed Drugs**
Prescribed drugs consumed while in the Hospital or administered during a visit to your Physician. Nutritional supplies or supplements or vitamin/mineral supplements are excluded.

**Preventive Health Services**
A variety of periodic health examinations that conform to The Affordable Care Act (for a complete listing of services with an A or B rating please visit [www.uspreventiveservicestaskforce.org/uspsf/uspsabrecs.htm](http://www.uspreventiveservicestaskforce.org/uspsf/uspsabrecs.htm)). This list is subject to change per updates from the United States Preventive Services Task Force. Examples of preventive health services include, but are not limited to those listed below. Please see the chart under “Preventive Health Guidelines” section for recommendations based on age and frequency.

1. Well Baby/Child Exams;
2. Adult Physical Exams;
3. Immunizations;
4. Cholesterol Screening;
5. Blood Pressure Checks;
6. Routine Endoscopic Services;
7. Routine Mammograms;
8. Routine Gynecological/PAP smears and cytological screening to detect cervical cancer;
9. Routine PSA testing;
10. Bone Density Screenings; and
11. Nutritional Counseling (limited to 5 visits per calendar year).

**Primary Physician Office Visits**
Office visits to a provider with the specialty of Family Medicine, General Practice, Internal Medicine, Pediatrics and Gynecology.

**Private-Duty Nurses**
Services provided by private-duty nurses to you or your Eligible Dependent while in the Hospital will be covered only if these services are medically necessary.

**Rehabilitation Services**
Rehabilitation services, including acupuncture, cardiac, chiropractic, physical, pulmonary, occupational, and speech therapies, will be covered up to the Plan’s maximum.
Speech therapy is designed to provide treatment following acute conditions, congenital hearing loss and congenital conditions for which corrective surgery has been performed (e.g. cleft palates). Conditions such as behavioral speech disorders, learning disorders, stuttering, slow speech development, chronic muscle imbalance, and language therapy are excluded. Cardiac Phase I and Phase II/Pulmonary rehabilitative services to provide treatment following acute conditions are covered.

**Room and Board**
Semi-private Room and Board, private room if medically necessary, and Special Care Units.

**Second Surgical Opinions**
Second opinions upon approval from the Health Services Management Program.

**Skilled Nursing/Extended Care Facilities**
Skilled Nursing Facility services are covered if the need for services meets medical necessity criteria.

**Sleep Disorders**
Care and treatment for sleep disorders that are deemed medically necessary.

**Smoking Cessation**
Services for physician office visits, laboratory services and up to 3 NRT courses of treatment per lifetime through the Ohio Quit Line are covered.

**Specialist Visits**
Office visits to medical or surgical specialists.

**Substance Abuse Rehabilitation**
Prior authorized admissions to a facility for intensive chemical dependency detoxification and rehabilitation services in an Inpatient setting or through a structured Outpatient program. A diagnosis of abuse or addiction to alcohol and/or drugs must be established and approved for treatment by the Health Services Management Program. Individual or group therapy sessions are covered when required for the treatment of abuse or addiction to alcohol or drugs and authorized for treatment by the Health Services Management Program.

**Supplies and Services**
Medically necessary supplies and services, such as:

1. Oxygen, including equipment required for its administration;
2. Blood and blood plasma (if not replaced) and other fluids to be injected into the circulatory system; and,
3. Braces, crutches, casts, splints, trusses, surgical dressings and ostomy supplies;

**Surgery**
Eligible surgical procedures and anesthesia.

**Temporomandibular Joint (TMJ) Disorder**
Medical treatment including physical and occupational therapies and office visits for TMJ disorders are covered. The physical and occupation therapies will be included in the limitations for the rehabilitation
services. The Plan covers care or treatment of jaw-joint problems including orthognathic or osteotomy surgery which relates to malposition of the jaw, cranial mandibular disorders, nerves and other tissues related to the joint or associated myofascial pain. The Plan will also cover an occlusal guard as part of treatment. The Plan has a $3,000 non-surgical lifetime limitation on the occlusal guard and the medical treatment excluding the physical and occupational therapies.

**Therapy**
Physical, speech, occupational, cardiac/pulmonary, radiation, renal dialysis and chemo therapy.

**Transplants**
Non-Experimental organ transplants are covered for the Covered Person if the recommended treatment Program is prior authorized and approved by the Health Services Management Program and performed at an approved facility. In addition, major solid organ transplants (heart, kidney, heart-lung, liver and pancreas) must be prior authorized using guidelines including those set by the Ohio Major Solid Organ Transplant Consortium. Covered transplants include: heart, lung, liver, pancreas, cornea, kidney, bowel and non-Experimental bone marrow and any combination of. The Covered Person can apply for multiple transplants lists, but the Plan will cover the evaluation process for the initial list only. The Plan will cover travel, lodging and meals for the family of a transplant recipient if the required travel from home to facility is greater than 75 miles. The Plan will allow up to $100 per day for a combination of travel, meals and lodging.

**Weight Management**
Weight Management services are limited to the employee, spouse and same gender domestic partner. Medical weight loss programs, $150 per year reimbursement on Weight Watchers membership fees and in-network surgical treatment are covered services for the employee, spouse and same gender domestic partner. The plan will cover up to $20,000 per lifetime for all covered weight management services. Surgical treatment (includes gastric bypass and adjustable gastric band) must be prior authorized through the Health Services Management Program and performed by an in-network provider. In order for surgical treatment to be approved you must meet the following criteria:

1. Obesity has been present for at least 5 years;
2. The patient is at least 18 years of age and not more than 65 years of age;
3. The patient has reached full growth;
4. The patient is determined to be at least 100 lbs. over their ideal body weight, or to have a BMI of at least 35 and at least one of the following clinically serious conditions:
   a. Type II Diabetes;
   b. Dyslipidemia;
   c. Hypertension;
   d. Serious Cardiopulmonary Disorder;
   e. Clinically significant Obstructive Sleep Apnea; or
   f. Musculoskeletal dysfunction.
5. The patient does not have a major psychiatric disorder;
6. The patient does not have a history of drug or alcohol abuse;
7. The patient has attempted a medical weight loss program in the past without successful long-term weight reduction; and
8. The patient must utilize an In-Network provider.

The Plan will not cover any exercise programs, club fees, membership costs, exercise equipment, surgical treatments not listed as covered (i.e. loop gastric bypass, gastroplasty, duodenal switch, biliopancreatic bypass, mini-gastric bypass) or cosmetic surgery following surgical treatment for the removal of excess skin, etc.

**Women’s Health**

If not already covered under your Plan’s preventive benefits, the following healthcare services will be covered under your Plan without application of a copayment, coinsurance or deductible, when received from a network provider:

1. Annual well-woman preventive care visits for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care (Several visits may be needed to obtain all necessary recommended services;  
2. Screening for gestational diabetes in pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes;  
3. Screening at least every three years for human papillomavirus testing in women age 30 and over;  
4. Annual counseling for sexually transmitted infections for all sexually active women;  
5. Annual counseling and screening for human immune-deficiency virus for all sexually active women;  
6. FDA-approved contraceptive methods, sterilization procedures, patient education and counseling for all women with reproductive capacity, as prescribed;  
7. Breastfeeding support and counseling; and  
8. Annual screening and counseling for interpersonal and domestic violence.
# GOLD PLAN SCHEDULE OF BENEFITS

## Deductible, Out-of-Pocket and Benefit Maximums

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$200</td>
<td>$400</td>
</tr>
<tr>
<td>Family</td>
<td>$400</td>
<td>$800</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,500</td>
<td>$3,000</td>
</tr>
<tr>
<td>Family</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

## Covered Services

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency/Urgent Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Facility Services</td>
<td>$75 Co-payment per visit (Co-payment waived if admitted)</td>
<td>$75 Co-payment per visit then 100% of R&amp;C (Co-payment waived if admitted)</td>
</tr>
<tr>
<td>Emergency Room Physician Services</td>
<td>90% subject to deductible</td>
<td>90% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>$35 Co-payment per visit</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td><strong>Hospital Facility Only</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td><strong>Surgical Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery Center</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Office Surgery</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
</tbody>
</table>

1. The amounts applied to the in-network deductible apply toward the out-of-network deductible and vice versa.
2. The out-of-pocket maximum includes medical co-payments, deductible and coinsurance amounts. The amounts applied to the in-network out-of-pocket maximum apply toward the out-of-network out-of-pocket and vice versa. Once the out-of-pocket maximum is met services will be covered 100%.
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon Services</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Anesthesia Services</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td><strong>Reproductive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre and Postpartum Maternity Care Visits</td>
<td>$20 Co-payment initial visit only</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Elective Sterilization</td>
<td>See the surgical services benefit</td>
<td>See the surgical services benefit</td>
</tr>
<tr>
<td>Infertility Diagnosis and Medical Treatment</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>(See Covered Services Section)</td>
<td>(office visit co-payment will apply for outpatient professional visits)</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health and Substance Abuse/Alcohol Abuse Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$20 Co-payment per visit</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Detoxification</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Residential</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Preventive Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Routine Well Care Visit</td>
<td>100%</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Child Routine Well Care Visit</td>
<td>100%</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Other Well Care Services</td>
<td>100%</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Routine Eye Exam</td>
<td>100%</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>(limited to one/24 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Tests</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Desensitization Treatment</td>
<td>100%</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Specialist Office Visits</td>
<td>$25 Co-payment per visit</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Primary Physician Office Visits</td>
<td>$20 Co-payment per visit</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
</tbody>
</table>
### Covered Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Services Performed During a Physician’s Office Visit</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Convenience Clinics</td>
<td>$20 Co-payment per visit</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Inpatient Physician Services</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Outpatient Physician Services</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
</tbody>
</table>

### Other Services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Diabetic Supplies (Monitors when provided in conjunction with supplies, Lancets, Test Strips and Control Solutions)</td>
<td>100%</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Home Health Care (limited to 120 days per year)</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Rehabilitation/Therapy Services (limited to 60 visits per year; see Rehabilitation Services under the Covered Services section)</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Skilled Care Facility (limited to 120 days per year)</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Diagnostic X-ray &amp; Laboratory Services</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>TMJ (See Covered Services for more information)</td>
<td>90% subject to deductible (office visit co-payment will apply)</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Transplants</td>
<td>90% subject to deductible</td>
<td>70% of R&amp;C subject to deductible</td>
</tr>
</tbody>
</table>

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions.

Failure to comply with prior authorization requirements will result in a 10% penalty assessed to the Provider in the case that services were rendered with an In-Network Provider or to the Covered Person in the case that services were rendered by an Out-of-Network Provider. This plan procedure does not apply if this Plan is not the primary coverage.
The Plan contracts with the Network to access discounted fees for service for Covered Persons. Hospitals, Physicians and other Providers who have contracted with the Network are called “In-Network Providers.” Those who have not contracted with the Network are referred to in this Plan as “Out-of-Network Providers.” This arrangement results in the following benefits to Covered Persons:

1. The Plan provides different levels of benefits based on whether the Provider Covered Persons use is an In-Network or Out-of-Network Provider. Unless one of the exceptions shown below applies, if a Covered Person elects to receive medical care from the Out-of-Network Provider, the benefits payable are generally lower than those payable when an In-Network Provider is used. The following exceptions apply:
   
   a. The In-Network Provider level of benefits is payable at the R&C rates when a Covered Person receives Emergency Care at an Out-of-Network Hospital.
   b. The In-Network Provider level of benefits is payable at the R&C rates when a Covered Person is emergently admitted to an Out-of-Network Hospital.
   c. The In-Network Provider level of benefit is payable at the R&C rates for an out-of-network ancillary charge (radiologist, anesthesiologist, pathologist and emergency physicians) when the Covered Person utilizes an In-Network Hospital.

2. If the charge billed by an Out-of-Network Provider for any covered service is higher than the Reasonable and Customary Charges determined by the Plan, Covered Persons are responsible for the excess. Since In-Network Providers have agreed to accept the negotiated discounted fee as full payment for their services, Covered Persons are not responsible for any billed amount that exceeds that fee.

3. To receive benefit consideration, Covered Persons must submit claims for services provided by Out-of-Network Providers to the Third Party Administrator. In-Network Providers have agreed to bill the Plan directly, so that Covered Persons do not have to submit claims.
# BLUE PLAN SCHEDULE OF BENEFITS

## Deductible, Out-of-Pocket and Benefit Maximums

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$400</td>
<td>$800</td>
</tr>
<tr>
<td>Family</td>
<td>$800</td>
<td>$1,600</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Family</td>
<td>$6,000</td>
<td>$12,000</td>
</tr>
</tbody>
</table>

1 The amounts applied to the in-network deductible apply toward the out-of-network deductible and vice versa.

2 The out-of-pocket maximum includes medical co-payments, deductible and coinsurance amounts. The amounts applied to the in-network out-of-pocket maximum apply toward the out-of-network out-of-pocket and vice versa. Once the out-of-pocket maximum is met services will be covered 100%.

## Covered Services

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency/Urgent Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room Facility Services</td>
<td>$100 Co-payment per visit (Co-payment waived if admitted)</td>
<td>$100 Co-payment per visit; then 100% of R&amp;C (Co-payment waived if admitted)</td>
</tr>
<tr>
<td>Emergency Room Physician Services</td>
<td>80% subject to deductible</td>
<td>80% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>$50 Co-payment per visit</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td><strong>Hospital Facility Only</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td><strong>Surgical Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery Center</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Office Surgery</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Surgeon Services</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Covered Services</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>------------------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Anesthesia Services</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Reproductive Care</td>
<td>$25 Co-payment For initial visit only</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Elective Sterilization</td>
<td>See the surgical services benefit</td>
<td>See the surgical services benefit</td>
</tr>
<tr>
<td>Infertility Diagnosis and Medical Treatment</td>
<td>80% subject to deductible (office visit co-payment will apply if applicable)</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse/Alcohol Abuse Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$25 Co-payment per visit</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Detoxification</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Residential</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Preventive Care Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Routine Well Care Visit</td>
<td>100%</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Child Routine Well Care Visit</td>
<td>100%</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Other Well Care Services</td>
<td>100%</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Routine Eye Exam (limited to one/24 months)</td>
<td>100%</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Medical Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Tests</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Desensitization Treatment</td>
<td>100%</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Specialist Office Visits</td>
<td>$35 Co-payment per visit</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Primary Physician Office Visits</td>
<td>$25 Co-payment per visit</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Other Services Performed During a Physician’s Office Visit</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Covered Services</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>------------------</td>
<td>------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Convenience Clinics</td>
<td>$25 Co-payment per visit</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Inpatient Physician Services</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Outpatient Physician Services</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Diabetic Supplies (Monitors when provided in conjunction with supplies, Lancets, Test Strips and Control Solutions)</td>
<td>100%</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Home Health Care (limited to 120 visits per year)</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Rehabilitative-Therapy Services (limited to 60 visits per year; see Rehabilitation Services under the Covered Services section)</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Skilled Care Facility (limited to 120 days per year)</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Diagnostic X-ray &amp; Laboratory Services</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>TMJ (See Covered Services for more information)</td>
<td>80% subject to deductible (office visit co-payment will apply for outpatient professional visits)</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
<tr>
<td>Transplants</td>
<td>80% subject to deductible</td>
<td>60% of R&amp;C subject to deductible</td>
</tr>
</tbody>
</table>

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions.

Failure to comply with prior authorization requirements will result in a 10% penalty up to a $500 maximum per penalty assessed to the Provider in the case that services were rendered with an In-Network Provider or to the Covered Person in the case that services were rendered by an Out-of-Network Provider. This plan procedure does not apply if this Plan is not the primary coverage.
The Plan contracts with the Network to access discounted fees for service for Covered Persons. Hospitals, Physicians and other Providers who have contracted with the Network are called “In-Network Providers.” Those who have not contracted with the Network are referred to in this Plan as “Out-of-Network Providers.” This arrangement results in the following benefits to Covered Persons:

1. The Plan provides different levels of benefits based on whether the Provider Covered Persons use is an In-Network or Out-of-Network Provider. Unless one of the exceptions shown below applies, if a Covered Person elects to receive medical care from the Out-of-Network Provider, the benefits payable are generally lower than those payable when an In-Network Provider is used. The following exceptions apply:
   
a. The In-Network Provider level of benefits is payable at the R&C rates when a Covered Person receives Emergency Care at an Out-of-Network Hospital.
   
b. The In-Network Provider level of benefits is payable at the R&C rates when a Covered Person is emergently admitted to an Out-of-Network Hospital.
   
c. The In-Network Provider level of benefit is payable at the R&C rates for an out-of-network ancillary charge (radiologist, anesthesiologist, pathologist and emergency physicians) when the Covered Person utilizes an In-Network Hospital.

2. If the charge billed by an Out-of-Network Provider for any covered service is higher than the Reasonable and Customary Charges determined by the Plan, Covered Persons are responsible for the excess. Since In-Network Providers have agreed to accept the negotiated discounted fee as full payment for their services, Covered Persons are not responsible for any billed amount that exceeds that fee.

3. To receive benefit consideration, Covered Persons must submit claims for services provided by Out-of-Network Providers to the Third Party Administrator. In-Network Providers have agreed to bill the Plan directly, so that Covered Persons do not have to submit claims.
PREVENTIVE HEALTH GUIDELINES

These guidelines provide you with detailed recommendations of the frequency for diagnostic testing, immunizations and other preventive health procedures. The list of recommendations will be updated on an ongoing basis and will include the date on which the recommendation or guideline was accepted or adopted.

SCREENING RECOMMENDATIONS FOR CHILDREN FROM BIRTH TO 24 MONTHS

Frequency
Visits at 2, 4, 6, 12, 15 months (minimal visits for immunizations – additional visits at 2-3 days after discharge and at 9 and 18 months are recommended) for physical examination, appropriate screenings and counseling/education.

History and exam services
- Measurement of length/height and weight
- Head circumference (including percentiles)
- Hemoglobin and Hemocrit (once at about 1 year of age)
- Lead screening
- Developmental screening that includes physical and mental development
- Counseling regarding diet, safety and exercise
- Hearing screening
- Vision screening
- TB Testing

Immunizations
- Hepatitis B
- Hepatitis A
- Rotavirus
- DTaP
- Haemophilus (Hib)
- Pneumococcal
- IPV
- Influenza
- Measles, Mumps, Rubella (MMR)
- Varicella
- PCV7 (Prevnar)

SCREENING RECOMMENDATIONS FOR CHILDREN FROM 2 THROUGH 6 YEARS

Frequency
Annually for physical examination, appropriate screenings and counseling/education.

History and exam services
- Measurement of height and weight
- Obesity/calculate BMI
• Measurement of blood pressure
• Exam of head, ears, eyes, nose and throat; respiratory, cardiovascular, gastrointestinal, reproductive, musculoskeletal and neurological systems
• Lead screening
• Developmental screening that includes physical and mental development
• Counseling regarding diet, safety and exercise
• Hearing screening
• Vision screening
• Dental assessment and fluoride supplements if indicated
• Autism Screening

Immunizations
• DtaP (age 4-6)
• MMR Second Dose (age 4-6)
• OPV or IPV (age 4-6)
• Hepatitis B Series (for those not previously tested)
• Hepatitis A Series
• Influenza Vaccine (age 24-59 months-annually)
• Varicella

SCREENING RECOMMENDATIONS FOR CHILDREN 7 THROUGH 12 YEARS

Frequency
Annually for physical examination, appropriate screenings and counseling/education.

History and exam services
• Measurement of height and weight
• Obesity/calculate BMI
• Measurement of blood pressure
• Exam of head, ears, eyes, nose and throat; respiratory, cardiovascular, gastrointestinal, reproductive, musculoskeletal and neurological systems
• Screening for scoliosis (starting at age 10)
• Screening for developmental disorders
• Counseling regarding diet, safety and exercise
• Dental Referral and Fluoride supplements
• Hearing screening
• Vision screening
• TB risk assessment

Immunizations
• MMR Second Dose (if not yet given)
• Varicella (if without history of Chickenpox or not previously vaccinated)
• Hepatitis B (for those not previously vaccinated)
• Influenza Vaccine
• HPV
- Meningococcal (MCV4)
- Tetanus, Diptheria, Pertussis (Tdap) Booster

SCREENING RECOMMENDATIONS FOR CHILDREN 13 THROUGH 20 YEARS

Frequency
Annually for physical examination, appropriate screenings and counseling/education.

History and exam services
- History regarding
  - Nutrition
  - Physical Activity
  - Tobacco/alcohol/drug abuse
  - Sexual Activity
- Measurement of height and weight
- Obesity/calculate BMI
- Measurement of blood pressure
- Exam of head, ears, eyes, nose and throat; respiratory, cardiovascular, gastrointestinal, reproductive, musculoskeletal and neurological systems
- Screening for scoliosis (through age 14)
- Counseling regarding diet, safety and exercise
- Dental Referral, Fluoride if indicated
- Hearing screening
- Vision screening
- Pap smear, VDRL/RPR, Gonorrhea and Chlamydia (every 1-3 years – at physician’s discretion, starting at age 16, younger if sexually active)
- Breast inspection and palpation, including breast self-exam instructions
- Testicular exam
- Hemoglobin and/or Hemocrit (at least once)
- Routine screening for Rubella susceptibility by history of vaccination or by serology
- Fasting lipoprotein profile (once every 5 years, starting at age 20)
- TB risk assessment

Immunizations
- Tetanus, Diptheria, Pertussis, DtaP (ages13-18 who has not yet received a Td booster, should receive Tdap in place of Td. Those through 18 who have received a Td are encouraged to receive a single dose of Tdap to further protect against Pertussis)
- Varicella (susceptible persons age 13+ should receive 2 doses at least 4 weeks apart)
- MMR (1 dose if MMR vaccine history unreliable; 2 doses for persons with occupational or other indication)
- Hepatitis B Series (for those not previously vaccinated)
- Influenza Vaccine
- HPV
- Meningococcal
SCREENING RECOMMENDATIONS FOR AGES 21 THROUGH 39

Frequency
Annually for physical examination, appropriate screenings and counseling/education.

History and exam services
- History regarding
  - Nutrition
  - Physical Activity
  - Tobacco/alcohol/drug abuse
  - Depression Screen
- Measurement of height and weight
- Obesity/calculate BMI
- Measurement of blood pressure
- Breast exam for women
- Mammogram (at physician’s discretion for women with higher than average risk and age <40)
- Testicular exam (through age 35)
- Fasting lipoprotein profile (once every 5 years)
- Fasting glucose (Obese/family history)
- Depression screening
- Pap smear, VDRL/RPR, HIV, Gonorrhea, Chlamydia (every 1-3 years – at physician’s discretion)
- Routine screening for Rubella susceptibility by history of vaccination or by serology (all women of child bearing age)
- TB skin test
- Skin exam
- Hearing screening
- TSH (Women at age 35 at physician’s discretion)

Immunizations
- Tetanus, Diptheria, Pertussis, DtaP (Tdap if not previously given in individual’s lifetime)
- Measles, Mumps, Rubella (if born after 1956, not known to be immune to Measles; 2 doses for persons with occupational or other indication)
- Hepatitis B (if not previously vaccinated)
- Varicella (susceptible persons should receive 2 doses 4-8 weeks apart)
- Influenza Vaccine
- HPV
- Meningococcal Vaccine (MCV4) – for those at high risk or travelers to areas with high rates of meningococcal disease

SCREENING RECOMMENDATIONS FOR AGE 40 THROUGH 64 YEARS

Frequency
Annually for physical examination, appropriate screenings and counseling/education.
History and exam services

- History regarding
  - Nutrition
  - Physical Activity
  - Tobacco/alcohol/drug abuse
  - Sexual practices
- Measurement of height and weight
- Obesity/calculate BMI
- Measurement of blood pressure
- Depression screening
- Baseline ECG
- Clinical breast exam (annually) and discuss breast cancer chemoprevention
- Dental screening/Oral exam
- TB skin testing
- Skin exam
- Aspirin Therapy
- Type 2 Diabetes screening (adults with hypertension and hyperlipidemia)

Laboratory Services

- Mammogram (every 1-2 years)
- Pap smear, VDRL/RPR, HIV, Gonorrhea, Chlamydia (screening may be stopped for women who have had a total hysterectomy for benign conditions and have no prior history of high grade CIN)
- Prostate Specific Antigen (PSA) and digital Rectal exam (offered to men beginning at age 50 with at least a 10 year life expectancy, along with information on potential risks and benefits)
- Fasting Lipoprotein profile (once every 5 years)
- Routine screenings for Rubella susceptibility by history of vaccination or by serology (women of child bearing age)
- Fecal occult blood test annually from age 50 or
- Colonoscopy (every 10 years from age 50) or if Colonoscopy not available,
- Flexible Sigmoidoscopy (every 5 years from age 50) or
- Double-contrast barium enema (every 5 years from age 50)
- Bone mineral content (peri-menopausal at high risk)

Immunizations

- Td (every 10 years through age 64. Tdap if not previously given in individual’s lifetime)
- Influenza
- Hepatitis B (if not previously vaccinated)
- MMR (one dose if MMR vaccination history is unreliable or if born after 1956, 2 doses for persons with occupational or other indications)
- Pneumococcal vaccine (high risk persons)
- Varicella for susceptible persons
- Meningococcal Vaccine (MCV4) for those at high risk or travelers to areas with high rates of meningococcal disease
- Zostavax (>age 60)
Screening Recommendations for Age 65 and Over

Frequency
Annually for physical examination, appropriate screenings and counseling/education.

History and exam services
- History regarding
  - Changes to cognitive function
  - Medications that increase the risk for falls
  - Nutrition
  - Exercise
  - Tobacco/alcohol/drug abuse
  - Home status (level of independence)
- Measurement of height and weight
- Obesity/calculate BMI
- Measurement of blood pressure
- Hearing Screening
- Vision Screening
- Breast exam (discuss breast cancer chemoprevention)
- Pelvic exam (annually for women)
- Glaucoma testing, refer for evaluation by an eye specialist
- Depression screening
- Digital Rectal Exam
- Skin examination
- Type 2 diabetes screening
- TB skin testing
- Oral screening
- Carotid artery stenosis screening
- Aspirin therapy
- ECG
- AAA screening

Laboratory Services
- Annual Mammogram for women
- Pap Smear (at discretion of physician)
- Annual Prostate Specific Antigen (at physician’s discretion) for men
- Bone Mineral Density testing (women)
- Fecal occult blood test annually and Flexible Sigmoidoscopy every 4 years (preferred over FOBT or Flexible Sigmoidoscopy only) or Fecal occult blood test (annually) or
- Colonoscopy (every 10 years) or if Colonoscopy not available,
  - Flexible Sigmoidoscopy (every 4 years) or
  - Double-contrast barium enema (every 4 years)
- Cholesterol, High Density Cholesterol and Triglyceride Screening
Immunizations

- TD (every 10 years)
- Influenza (annually — each Fall)
- Pneumococcal
- Hepatitis B (if not previously vaccinated)
- Varicella for susceptible individuals

Additional assessment and testing may be performed for patients who are at risk due to hereditary or environmental conditions.
The Plan will not provide coverage for:

**Alternative Medicine**
Treatment classified as “alternative medicine” such as massotherapy, biofeedback, herbal remedy, etc. unless specifically listed as a covered service in the Schedule of Benefits.

**Benefit Maximum**
Services or charges that exceed the Maximum Benefit Amount.

**Complications of Non Covered Treatment**
Care, services or treatment required as a result of complications of a treatment not covered by the Plan.

**Coordination of Benefits**
Amounts which are not payable under the Plan’s “Coordination of Benefits” provisions.

**Cosmetic Services**
Treatment or surgery to improve appearance (such as liposuction, breast augmentation, hair transplants, hair growth stimulants, etc.) except when it is needed to correct congenital defects of your covered newborn; or to give breasts a symmetrical appearance after a Mastectomy.

**Court Ordered Care**
Testing and/or treatment ordered by a court or agreed to through a plea bargain.

**Custodial Care**
Custodial Care, such as sitters, homemaker’s services or care in a place that services you primarily as a resident when you do not require skilled nursing.

**Educational Treatment**
Treatment of conditions related to autistic disease or mental retardation; behavioral speech disorders, learning disorders, stuttering, slow speech development, chronic muscle imbalance, and language therapy; charges in connection with any treatment, therapy, teaching technique or program for remedial education, rehabilitation or training that is primarily intended to overcome, improve or compensate for any learning impairment whatsoever, regardless of whether such impairment is diagnosed as functional or organic, except in the case of rehabilitation after a stroke unless specifically listed as a covered service elsewhere within this document.

**Environmental Change**
Hospitalization or treatment for environmental change.

**Excess Charges**
Services which exceed the amount of the Plan's Maximum Allowable Charge or Reasonable and Customary Charge.
Experimental/Investigational
Services which are Experimental or of a research nature.

Felony/Illegal Act
Care or treatment as a result of being engaged in an illegal occupation or activity or in the commission of, or attempted commission of, a felony, assault or other criminal activity.

Foot Care
Foot care that is not medically necessary, including:

1. Diagnosis and treatment for weak, strained, unstable or flat feet;
2. Trimming and care of corns and calluses are not covered except for individuals with diabetes or significant peripheral vascular disease; or
3. The treatment of corns, calluses or toenails, unless the charges are for the removal of nail roots or in conjunction with the treatment of a metabolic or peripheral vascular disease.

Foot Orthotics
Foot Orthotics are not covered unless they are part of a shoe integral to a brace, or for members with a diagnosis of diabetes, rheumatoid arthritis, arterial insufficiencies of the lower limbs, or Peripheral Vascular Disease.

Genetic Testing
Services for Genetic Testing unless they are for breast or colon cancer which is considered a standard of care and prior authorized by the Health Services Management Program.

Government Provided
Services in any Hospital operated or controlled by any governmental agency of the United States or any state or political subdivision thereof; treatment provided or furnished by the United States Government or the government of any other country.

Hazardous Hobby
For any condition, Illness or Injury, or complication thereof, arising out of engaging in a team sport where the Covered Person is being compensated financially (including scholarships) or hazardous hobby or activity, which is an unusual activity characterized by a constant threat of danger, such as but not limited to: 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, snowmobile, all-terrain vehicle riding and team sports.

Hearing Aids
Hearing aids and the expenses incurred for fitting them as well as hearing therapy and any related diagnostic testing.

Hormone Therapy
Growth hormone therapy.
Immediate Relative or Same Household
Services provided by people who ordinarily reside in your household, or the household of your Eligible Dependent, or who are related by blood or marriage or legal adoption to you or your Eligible Dependent.

Impregnation and Infertility
In-vitro fertilization, embryo transplant (including surrogate parenting procedures), artificial insemination, test-tube babies, drug therapy for infertility or other treatments to induce pregnancy; reversal of elective sterilization procedures.

Intelligence Testing
Testing for intelligence, aptitude or interest.

Job Related
Care or treatment of an Injury or Illness for which you or your Eligible Dependent is entitled to benefits under any worker’s compensation or occupational disease law, whether or not any coverage for such benefits is actually in force, or whether or not you claimed these benefits.

Military Service
Care or treatment while a member of the armed forces of any state or country.

Miscellaneous
Charges for telephone consultations, missed appointments or the completion of claim forms, medical reports or certifications.

No Legal Obligation
Charges or services for which you or your Eligible Dependent are not legally required to pay, or that would not have been made or provided if no coverage had existed.

No Coverage
Services which were provided or received after the date you or your Eligible Dependent’s coverage is terminated under the Plan or prior to the effective date of coverage under the Plan.

Not Covered
Any other service or supply which is not specifically referred to herein as a covered benefit or supply.

Not Medically Necessary
Diagnostic tests and services not related to a specific Injury or Illness or a specific set of symptoms, or for Inpatient admissions primarily for diagnostic therapy; services which are not considered medically necessary for your diagnosis and treatment.

Personal Service
Rest cures, travel, recreation or diversional therapy even though prescribed by a Physician; personal services such as haircuts, shampoos and sets, guest meals and radio/television rentals; personal convenience items such as vacuum cleaners, air conditioners, humidifiers, elevators, chair lifts, physical fitness equipment and other such devices even though prescribed by a Physician.
**Prescription Drugs**
Prescription drugs, except those drugs prescribed and administered during a visit to a Physician or during an Inpatient Hospital stay.

**Private Room Expenses**
Expenses incurred for private room accommodations which are in excess of the Hospital’s average daily charge for a semi-private room.

**Radial Keratotomy**
Radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses.

**Required Examinations**
Sports examinations or physical or psychological examinations required by:

1. An employer in order to begin or continue working or certification;
2. A school or institution;
3. An insurance company in order to obtain insurance; or
4. A governmental agency.

**Residential Care**
Expenses incurred for residential care.

**Reversal of Sterilization**
Charges for the reversal of sterilization procedures.

**Riot**
Care or treatment arising out of your or your Eligible Dependent’s participation in a riot.

**Sanitarium**
Services provided by a sanitarium.

**Sclerotherapy**
Sclerotherapy, unless medically necessary. For example; following occurrence of venous stasis ulcers, thromboembolic disease, or has history of previous deep venous phlebitis.

**Sexual Disorders**
Transsexual surgery or any services leading to or in connection with transsexual surgery, including disturbances of gender identification or any complication thereof.

**Subrogation**
For or in connection with any Injury or Illness subject to the “Subrogation and Right of Reimbursement” provision of this Plan, unless and until the required, unaltered subrogation agreement has been properly signed, returned to, and received by the Third Party Administrator.

**Therapy**
Marital counseling or therapy or sex therapy.
**Timely Filing**
Claims submitted after 365 days from the date of service.

**Training and Education**
Services or supplies for training or education, such as prenatal classes, excluding diabetic education classes (considered under the 5 visits per calendar year limitation under Preventive Health Services) and cardiac education classes.

**Travel**
Travel and lodging, even though prescribed by a Physician.

**Vision**
The vision examination for prescribing or fitting eyeglasses or contact lenses and vision therapy.

**War**
Charges incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression, when the Covered Person is a member of the armed forces of any country, or during service by a Covered Person in the armed forces of any country. This exclusion does not apply to any Covered Person who is not a member of the armed forces.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise 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).
The procedures outlined below must be followed by Covered Persons ("claimants") to obtain payment of health benefits under this Plan. "Health benefits" includes medical claims.

**Health Claims**
The responsibility to process claims in accordance with the Plan Document and Plan Summary is delegated to the Third Party Administrator. All claims and questions regarding health claims shall be directed to the Third Party Administrator. The Third Party Administrator shall be responsible for adjudicating such claims and for providing full and fair review of the decision on such claims up to and including Second Level Appeals under the Plan. Benefits under the Plan will be paid as stated herein only if the Third Party Administrator determines that the claimant is entitled to them in accordance with the provisions of the Plan. However, the Third Party Administrator does not have the authority to make claim payment determinations involving the use of discretion.

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

**When Health Claims Must Be Filed**
Health claims must be filed with the Third Party Administrator within 365 days of the date charges for the services were incurred. Benefits are based on the Plan’s provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. Claims filed later than that date shall be denied.

A claim is considered to be filed when the following information is received by the Third Party Administrator, together with a Form HCFA or Form UB92:

1. The date of services;
2. The name, address, telephone number and tax identification number of the provider of the service or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges;
6. The name of the Plan;
7. The name of the covered employee; and
8. The name of the patient.

Upon receipt of this 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 (48 hours in the case of pre-service urgent care...
claims) from receipt of the request by the claimant. **Failure to do so may result in claims being declined or reduced.**

**Timing of Claim Decisions**
The Third Party Administrator shall notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of pre-service claims, of decisions that a claim is payable in full) within the following timeframes:

**Pre-service Urgent Care Claims**
If the claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim.
If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible taking into account the medical exigencies, but not later than 24 hours after receipt of the claim. The claimant will be notified of a determination of benefits as soon as possible, but no later than 48 hours, taking into account the medical exigencies, after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the claimant to provide the information.

**Pre-service Non-urgent Care Claims**
If the claimant 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.
If the claimant has not provided all of the information needed to process the claim, then the claimant 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 claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, but no later than the earliest of the following dates:

1. If an extension was requested, prior to the end of the extension period; and
2. If additional information was requested during the initial processing period, prior to the end of the extension period, unless additional information was requested during the extension period, then by the date agreed to by the Third Party Administrator and the claimant.

**Concurrent Claims**
If the Third Party Administrator is notifying the claimant 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 claimant will be notified sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

If the Third Party Administrator receives a request from a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, the Third Party Administrator will decide as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

If the claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of
time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

If the request from the claimant does not involve 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 claimant 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 extension period.

If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant 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 claimant will be notified of the determination by a date agreed to by the Third Party Administrator and the claimant.

Extensions
Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with pre-service urgent care claims.

Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Third Party Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day 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 30 days, provided that the Third Party Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day 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 Third Party Administrator shall provide a claimant with an explanation of benefits (EOB), either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method), advising that a claim is denied, in whole or in part, and the claimant’s right to appeal any denial.
COMPLAINT AND APPEAL PROCEDURE

If you are not happy with a decision about a claim, or have another complaint, you can call Customer Service at (330) 996-8515 or (800)753-8429. A Customer Service representative will ask you questions about your complaint and investigate the facts. You will receive a verbal response to your complaint within five business days.

If you are still not happy, you can pursue your complaint further through one of two formal complaint processes. They are the Grievance and the Appeal Process. The Appeal Process should be used whenever you disagree with the decision to deny, reduce, or terminate a service or a claim. The Grievance Process is used for all other complaints, regarding such things as service, quality of care, or timely access to doctors and other providers. Each process is explained in detail below:

Grievances

If you are not happy with the care or service you receive from Apex Health Solutions or any of our contracted providers, you may address those concerns through our formal grievance process. Some examples of a grievance are:

1. A very long time on hold when calling Customer Service;
2. Rude treatment by a provider or his office staff;
3. You believe that the care you received from an Apex Health Solutions provider was not appropriate;
4. You believe an Apex Health Solutions employee has violated your privacy rights; or

To file a grievance, send your request to:

Apex Health Solutions
Grievance Department
P.O. Box 3620
Akron, Ohio 44309-3620

You may also fax your grievance to (330) 996-8545 or submit electronically to appeals@apex-healthsolutions.com, or you may also bring your grievance to the Apex Health Solutions offices located at 10 N. Main Street, Akron, Ohio. Please be as clear as possible when describing your grievance. If you need help with your grievance, please call Customer Service for assistance. A Customer Service Representative will help document the details of your grievance over the phone. If your complaint is about the quality or appropriateness of care, you must file your grievance within 180 days from the date you received the service.

The Plan will investigate your grievance and respond to you in writing within 30 calendar days. The response will inform you of the findings and any action that the Plan will take as a result of your grievance.

If you are not happy with our response, you may file a second level grievance at the same address listed above. Your second level grievance will be reviewed by individuals who were not previously involved in investigating your complaint. A written response will be issued within 40 calendar days. The response will inform you of any further action the Plan will take.
Urgent Benefit Determinations
You will receive notification of any benefit determination, whether adverse or not, with respect to a claim involving urgent care, as soon as possible, but not later than 24 hours after receipt of the claim. A claim involving urgent care is one that could result in any of the following:

1. Place you or your unborn child in serious jeopardy;
2. Cause serious impairment to bodily functions or serious dysfunction of any organ or part; or
3. Place you in severe pain that cannot be adequately managed without the care or treatment in question.

To request that your benefit determination be expedited, you must call Customer Service at (330) 996-8515 or (800) 753-8429. If your expedited benefit determination is denied in whole or in part, you may proceed immediately with an expedited independent review (Please refer to Instructions for Requesting an External Independent Review below).

Internal Apex Health Solutions Insurance Appeals
You have the right to appeal decisions that deny or limit your health care benefits. If a service is denied, reduced or terminated, or if payment of a claim is fully or partially denied, or if your coverage is rescinded, you may appeal that denial or rescission and your benefits will continue during the appeal. To file an appeal, send a written request to:

Apex Health Solutions
Appeals Department
P.O. Box 3620
Akron, Ohio 44309-3620

You may also fax your appeal to (330) 996-8545 or submit electronically to appeals@apex-healthsolutions.com, or you may bring your appeal to the Apex Health Solutions offices located at 10 North Main Street, Akron, Ohio. Please be as clear as possible when describing your appeal. Any additional documentation that supports your request should be submitted with your appeal. If you need help with your appeal, please call Customer Service for assistance. A Customer Service representative will help document the details of your appeal over the phone. However, you will still need to follow-up with a signed, written appeal. You must file your appeal within 180 days from the date you first received notice of the denial you want to appeal. The Plan may accept an appeal from you after 180 days for just cause, but we are under no obligation to do so. An authorized individual, who may be a friend, family member, doctor, or anyone you choose, may appeal for you; but the Plan must receive a signed and dated statement from you or other legal authority authorizing that person to act on your behalf.

After the Plan investigates the facts, your appeal will be reviewed by individuals who had no previous involvement with the decision. If your appeal is in any way related to the medical appropriateness of the care or services in question, the appeal would be reviewed by a board certified physician. The Plan does not hire, compensate, terminate or promote any individuals based upon their likelihood to support a denial of benefits. The exact time frame for resolving your appeal depends upon a number of factors that are explained below. However, in every case the Plan will resolve both levels of internal appeal within 60 days from the date we received your first appeal letter, or as fast as is medically necessary.
The Plan must also provide you, free of charge, any new or additional evidence considered, relied upon, or generated by us in connection with your claim. Additionally, if the Plan relies on a new or additional rationale, the Plan must provide you, free of charge, with the rationale.

**First Level Post-Service Appeals**
If your appeal is about a service that you have already received, it will be handled as a post-service appeal. The Plan will notify you in writing of the outcome to your first level post-service appeal within 30 calendar days from the date your appeal was received.

**First Level Pre-Service Appeals**
If your appeal is asking that the Plan cover a service or medical item that you have not yet received, the Plan will notify you in writing of the outcome within 15 calendar days. The response will explain the basis of the decision and inform you of any action that the Plan has or will take as a result of your appeal.

**Expedited or Fast Appeals**
You may request an expedited appeal if you believe that waiting 15 days for a pre-service decision could result in any of the following:

1. Place you or your unborn child in serious jeopardy;
2. Cause serious impairment to bodily functions or serious dysfunction of any organ or part;
3. Place you in severe pain that cannot be adequately managed without the care or treatment in question.

Expedited appeals are only granted in medically urgent situations. The Plan does not have to expedite your appeal if it believes that it does not meet any of the three reasons listed above. If the Plan determines that your appeal does not qualify for a fast/expedited review, it will still process it as a standard pre-service appeal. If a licensed physician indicates that expedition is necessary for medical reasons, the Plan will automatically expedite your appeal. You also have the right to request a concurrent expedited external review at the same time you request an expedited appeal.

Expedited appeals will be completed within 24 hours from the time they are received or as fast as medically necessary. To request that your appeal be expedited, you must call Customer Service at (330) 996-8515 or (800) 753-8429. If your expedited appeal is denied in whole or in part, you may skip the second level of internal appeal and proceed immediately with an expedited independent review (Please refer to Instructions for Requesting an External Independent Review below).

**Second Level Appeals**
The Plan will complete the entire appeals process within 60 calendar days from receipt of your first level appeal request. In order to meet this requirement, the Plan will automatically begin reviewing your appeal at the second level of review if your first level appeal is not approved.

For post-service appeals you will have **seven days after** the Plan issues its first level decision to contact the Plan and let the Plan know that you want it to complete the second level appeal process. For pre-service appeals you will have **45 days from the date we received your first level appeal letter** to contact the Plan and let it know that you want us to complete the second level appeal process described below. You may contact the Plan over the phone, by fax, mail or email. If the Plan does not hear from you within these time frames, it will be noted that you agree with the first level decision and do not want to have your appeal
considered at the second level. Your second level appeal may then be dismissed. If you contact the Plan after these time frames and ask to proceed with the second level of appeal, the Plan may not be able to complete both levels of appeal within 60 calendar days. For this reason, the Plan may not be able to consider your request at the second level. However, even if you have missed the time frame for filing a second level appeal, you may still have the right to appeal further via one of the additional external appeal processes described below.

Your second level appeal will be reviewed by individuals who were not involved in either the initial denial or the first level appeal. If your second level appeal is in any way related to the medical appropriateness of the care or services in question, the appeal will be reviewed by a board certified physician or other appropriately licensed healthcare professional in the same or similar specialty that typically treats the medical condition or provides the procedure or treatment in question.

**Second Level Post-Service Appeals**
The Plan will send you a written response to your second level post-service appeal within 30 calendar days from the date we receive your second level request and within 60 calendar days from the date we received your first level appeal letter (whichever comes first).

**Second Level Pre-Service Appeals**
Apex Health Solutions will send you a written response to your second level pre-service appeal within 15 calendar days from the date we received your second level request and within 60 calendar days from the date we received your first level appeal letter (whichever comes first).

**Please Note:** The time frame for resolving any of the internal appeals described above may be shortened if the seriousness of your condition requires a faster review. In certain situations, we may, with your permission, choose to skip the internal appeal process and proceed directly with one of the additional external appeal processes described below. The Plan may choose to skip the second level of internal appeal without your permission.

**Immediate External Appeals**
If we fail to adhere to our internal claims and appeals process, you may immediately request an external appeal.

**Additional External Appeals**
If you are still not happy with the Plan’s decision, you may request a review from another source. You may appeal denials for an adverse benefit determination based on the plan’s requirements for medical necessity, appropriateness, health care setting, and level of care or effectiveness of a covered benefit. You may also request an external review for the following:

1. You or your dependent has a terminal condition that, according to the current diagnosis of your or your dependent’s physician, has a high probability of causing death within 2 years, or you or your dependent’s authorized representative has requested a treatment or therapy that the Plan has determined is experimental or investigational;
2. Your request is not later than 180 days after your receipt of the adverse benefit determination;
3. You or your dependent’s physician certifies that you or your dependent has a condition described in number 1 above and any of the following is applicable:
4. You or your dependent’s physician has recommended a drug, device, procedure, or other therapy that the physician certifies, in writing, is likely to be more beneficial to you or your dependent, in the physician’s opinion, than standard therapies, or the Plan has requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition;

5. You or your dependent has been denied coverage by the Plan for a drug, device, procedure, or other therapy, recommended or requested pursuant to number 4 above of this section, and has exhausted the Plan’s internal claims and appeals process unless the Plan’s internal procedures have been deemed exhausted, the Plan has waived exhaustion, or you or your dependent has simultaneously filed requests for internal and external expedited reviews; and

6. The drug, device, procedure, or other therapy, for which coverage has been denied, would be a covered health care service, except for the Plan’s determination that the drug, device, procedure, or other therapy is experimental or investigational.

These additional appeals are available only after you complete the internal appeal process. The procedures for appealing denials beyond the Plan are explained below.

**Instructions for Requesting an External Independent Review**

You must request an external review in writing within 180 days of receiving notice from the Plan that your request for coverage is denied. You, an authorized person, the provider, or the health care facility representative may request the review. The provider and health care facility must have your signed authorization to request a review. You do not need the authorization of the provider. You are not required to pay for the review. The Plan pays for the review.

To file a request for an external review, send a written request to:

Apex Health Solutions  
Appeals Department  
P.O. Box 3620  
Akron, Ohio 44309-3620

You may also fax your request to (330) 996-8545 or submit electronically to appeals@apex-healthsolutions.com, or you may bring your appeal to the Apex Health Solutions offices located at 10 North Main Street, Akron, Ohio.

The independent review organization must provide you with a response within 30 days. The decision of the IRO must include:

1. A description of the patient’s condition;
2. The principal reason for the decision; and
3. An explanation of the clinical rationale for the decision.

**Expedited External Review**
When the independent review must be completed quickly because of your medical condition, you may request an external review by phone, fax or email. However, you must follow up this request with a written request within five days. The independent review organization must provide you with a response to an expedited review within 72 hours of your initial request. You may request an expedited external review if the adverse benefit determination relates to an admission, availability of care, continued stay or health care service for which the claimant received emergency services, but has not been discharged from a facility, or involves a medical condition for which the standard external review time frame would seriously jeopardize the life or health of you or your dependent or jeopardize you or your dependent’s ability to regain maximum function.

Provider Reconsiderations
Your provider has the right to request in writing, on your behalf, a review of a decision with which you disagree. The Plan requires your provider to obtain your signed statement authorizing him or her to request reconsideration. The Plan will work with your provider to get the information needed to review the decision. The Plan will reply to your provider’s request within three business days.

If you are dissatisfied with a decision about a claim, or have another complaint, you are encouraged to contact Apex Health Solutions Customer Service at (330) 996-8515 or (800) 753-8429. A Customer Service representative will ask you questions about your complaint and, if required, investigate the facts. You will receive a verbal response to your complaint within five business days.

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COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.
The order of benefit determinations rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the **Primary plan**. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expense. The Plan that pays after the Primary plan is the **Secondary plan**. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

Apex Health Solutions pays for health care only when you follow our rules and procedures as stated in this Plan Summary. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans.

**Definitions for COB**

1. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
   a) **Plan** includes:
      - Group and non-group insurance contracts;
      - Health insuring corporations (“HIC”) contracts;
      - Closed panel plans or other forms of group or group-type coverage (whether insured or uninsured);
      - Medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts, and;
      - Medicare or any other federal governmental plan as permitted by law.

   b) **Plan** does not include:
      - Hospital indemnity coverage or other fixed indemnity coverage;
      - Accident only coverage;
      - Specified disease or specified accident coverage;
      - Supplemental coverage as described in Revised Code Sections 3923.37 and 1751.56;
      - School accident type coverage;
      - Benefits for non-medical components of long-term care policies;
      - Medicare supplement policies;
      - Medicaid policies; or
      - Coverage under other Federal governmental plans, unless permitted by law.

   Each contract for coverage under (a) or (b) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

2. **This Plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
3. The order of benefits determination rules determine whether this Plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

When this plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan’s benefits. When this plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

4. **Allowable Expense** is a health care expense, including deductible, coinsurance and co-payments that are covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

a) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses;
b) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense;
c) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense;
d) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan’s payment arrangement shall be the Allowable Expense for all Plans. If the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan’s payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary plan to determine its benefits;
e) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred provider arrangements.

5. **Closed Panel Plan** is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that has contracted with or is employed by the Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

6. **Custodial Parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year without regard to temporary visitation.
Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan:

2. (a) Except as provided in paragraph (b), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provision of both Plans state that the complying plans is primary;
   (b) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverage that are superimposed over base plan hospital and surgical benefits, and coverage that is written in connection with a Closed panel plan to provide out-of-network benefits.

3. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

4. Each Plan determines its order of benefits using the first of the following rules that apply:

   (a) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, (e.g. as an employee, member, policyholder, subscriber or retiree) is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. If the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

   (b) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

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

         • The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
         • If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan;
         • However, if one spouse’s plan has some other coordination rule (for example, a “gender rule” which says the father’s plan is always primary), we will follow the rules of that plan.

      ii. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
a. If a court decree states that one of the parents is responsible for the dependent child’s health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

b. If the parent with responsibility for health coverage does not have health coverage for the expenses of the dependent child, but the spouse of that parent does, then the plan of that parent’s spouse is the primary plan. This rule applies to plan years if a court decree states that both parents are responsible for the dependent child’s health care expenses or health care coverage, benefits should be coordinated as though the parents were married or living together as stated in provision (i) above;

c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, benefits should be coordinated as though the parents were married or living together as stated in (i) above;

d. If there is no court decree allocating responsibility for the dependent child’s health care expenses or health care coverage, the order of benefits for the child are as follows:

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

iii. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the order of benefits is determined as if those individuals were the parents of the child. The custody rule is applicable to anyone who has legal custody of the dependent child.

(c.) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4(a) can determine the order of benefits;

(d.) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored;

(e.) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the plan that covered the person the shorter period of time is the Secondary plan;

(f.) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary Plan.
Effects on the Benefits of This Plan
When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans, during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan; COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. Apex Health Solutions may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. Apex Health Solutions need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Apex Health Solutions any facts it needs to apply those rules and determine benefits payable.

Facility of Payment
A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, Apex Health Solutions may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. Apex Health Solutions will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery
If the amount of the payments made by Apex Health Solutions is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes
If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us at Apex Health Solutions, (330) 996-8515 or www.apex-healthsolutions.com and initiate your appeal rights as stated in the Plan Summary. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526 or visit the Department’s website at http://insurance.ohio.gov.
Integration with Medicare
Under Federal law, if you or your covered dependents are covered by both Apex Health Solutions and Medicare benefits, usually Apex Health Solutions is the primary plan and Medicare is the secondary plan. But when permitted by law, Apex Health Solutions PPO is the secondary plan.
THIRD PARTY RECOVERY, SUBROGATION 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 for which benefits are paid by the Plan. The Injuries or Illness may be caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of any charges incurred in connection with the Injuries or Illness. If so, the Covered Person may have a claim against that other person or a third 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 third party and will be entitled to Reimbursement. In addition, the Plan shall have a lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. 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:

1. Assign and subrogate to the Plan his rights to recovery when this provision applies;
2. 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;
3. Immediately reimburse the Plan out of the Recovery made from the other person, the other person’s insurer or the third party, 100% of the amount of medical or other benefits paid for the Injuries 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);
4. 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
5. 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, the Covered Person will execute and deliver all required instruments and papers, including a subrogation 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. If the Plan pays any medical or other benefits for the Injuries or Illness before these papers are signed and any action taken, the Plan will still be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing to prejudice the right of the Plan to subrogate and be reimbursed and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines. If the Covered Person retains an attorney, the Covered Person agrees to only retain one who will not assert the common-fund or made-whole doctrines. Attorneys’ fees will be payable from the Recovery only after the Plan has received full Reimbursement.
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**
All 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.

**Another Party**
Another Party shall mean any individual or organization, 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 organization 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 (and no matter how those monies may be characterized or designated) to compensate for all 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 the other person, the other person’s insurer and the third 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 the Covered Person is a Minor or is Deceased**
These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor’s 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 reduce future benefits payable under the Plan by the amount due as Reimbursement to the Plan. If the Plan
must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan’s attorneys’ fees and costs, regardless of the action’s outcome.
CONTINUATION OF PLAN COVERAGE (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) may require that you and/or your dependents be provided with the opportunity to continue your group health care coverage on a contributory basis under the following circumstances.

Who May Continue Coverage, When, and for How Long
If your medical care coverage terminates, you and your covered dependents may continue medical care coverage for up to 18 months:

1. If your employment terminates for any reason; or
2. If you lose your health care coverage due to a reduction in your hours of employment; or
3. If you or a dependent become disabled within the first 60 days of COBRA continuation, coverage may be continued for an additional 11 months.

Your covered dependents may continue such coverage under this Plan for up to 36 months:

1. If you die while covered by the Plan; or
2. If you and your spouse are divorced, your marriage is annulled or you are legally separated from your spouse; or
3. If you become eligible for Medicare; or
4. If your dependent child is no longer eligible for coverage under the Plan.

If you are entitled to Medicare benefits at the time coverage terminates due to your termination of employment or reduction in hours, the continuation period for covered Dependents will be the longer of:

1. 18 months from the date coverage terminates due to your termination of employment or reduction of hours; or
2. 36 months from the date you became entitled to Medicare.

When Continued Coverage Ends
The continued coverage will end for any qualified person when:

1. The cost of continued coverage is not paid on or before the date it is due; or
2. That person becomes eligible for Medicare, if later than the date of the COBRA election; or
3. That person becomes covered under another group health plan unless that other plan contains an exclusion or limitation with respect to any pre-existing health condition; or
4. The Plan terminates for all Employees; or
5. You or your dependent are no longer deemed disabled during the additional 11-month extended period; or
6. The last day of the applicable 18, 29 or 36 month time limit.
**Similarly Situated Beneficiary**

Generally, for purposes of any benefits payable under this continuation coverage, qualified persons will be considered the same as any similarly situated Beneficiary covered under the Plan. A similarly situated Beneficiary means an Employee or Dependent of an Employee.

**Notices**

Notice will be given when you or your covered dependents become entitled to continue COBRA health care coverage under the Plan. You or your dependents will then have up to 60 days to elect to continue coverage. Each qualified person is entitled to an individual election of COBRA continuation. A qualified person may waive COBRA continuation coverage during the 60-day election period. This waiver of coverage may be revoked at any time before the end of the election period. In this case, coverage will be effective on the date the waiver revocation notice is received by the Plan Sponsor or its representative; coverage will not be provided retroactively. The written notice from the Plan Sponsor’s representative will include the cost per month of COBRA continuation coverage. Any person who elects this coverage must pay the full cost for periods preceding the election within 45 days after the date of election. The first payment received for COBRA continuation coverage will be applied to those periods. Payments for periods subsequent to the election must be made monthly, no later than the due date determined by the Plan Sponsor, or within the grace period allowed. However, you or your covered spouse or your covered child must notify the Plan Sponsor within 60 days in the event you become divorced or your marriage is annulled, when your dependent child no longer qualifies as a covered dependent under the Plan or after a disability determination has been made and prior to the expiration of the 18 month continuation period. Notification must include a copy of the Social Security Administration determination of disability letter.

COBRA regulations may change from time to time. The extension of coverage will be provided in accordance with current law.

Because COBRA rules are complicated, if you have any questions about eligibility, contact your human resource representative.

**Veteran Reemployment**

The Plan Sponsor will also comply with the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994. This law enables associates who take leaves of absence to serve in the armed forces to continue their medical coverage in a manner similar to COBRA.
Plan Administrator
The Plan is administered by the Plan Sponsor and Administrator. 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. The Plan Sponsor and Administrator has designated a Third Party Administrator to process claims for benefits submitted under the Plan and serve as a Claims Adjudicator under the Plan. In this role, the Third Party Administrator shall be responsible for adjudicating all claims for benefits and for providing full and fair review of the decision on such claims up to and including Second Level Appeals under the Plan. However, the Third Party Administrator shall not have the authority to make claim payment determinations involving the use of discretion.

Except as provided above with respect to the functions of the Plan’s Third Party Administrator, the Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices and procedures. It is the express intent of this Plan that the Plan Administrator 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 Covered Person’s rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

Duties of the Plan Administrator
Except as provided above with respect to the functions of the Plan’s Third Party 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 Covered Person’s rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
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 an order is a national medical support notice;
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 some of which may be delegated to the Third Party Administrator.
Amending and Terminating the Plan
The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settler of the Plan, the Plan Sponsor, through its directors and officers, 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 or the trust agreement (if any).

If the Plan is terminated, the rights of the 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.

Rescissions
The Plan Administrator may not void your Plan Summary based on a misrepresentation by you unless you have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact as prohibited by the terms of your Plan Summary.
Clerical Error/Delay
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.

Conformity with Applicable Laws
This Plan shall be deemed to automatically 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 which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Summary.

Fraud
The following actions by any Covered Person, or a Covered Person’s 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 the Covered Person is a member:

1. 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;
2. Attempting to file a claim for a Covered Person for services which were not rendered or drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

Gender
The use of masculine pronouns in this Plan Summary shall apply to persons of both sexes unless the context clearly indicates otherwise.

Headings
The headings used in this Plan Summary are used for convenience of reference only. Covered Persons are advised not to rely on any provision because of the heading.

HIPAA Privacy Requirements
Apex Health Solutions must internally use your protected health information in order to conduct our business and provide you with the care and services to which you are entitled. We may use or disclose information about you in order to facilitate your treatment and/or payment by or to a health care provider, third party administrator, insurance company, or other appropriate entities, including government and law enforcement agencies, without your signed authorization. Additional disclosures that may be made include the following:
1. Individuals involved in arranging for your care or payment of your care;
2. Business Associates, who are persons or organizations contracted with to assist us with our health care operations;
3. As required by law or law enforcement agencies;
4. Public Health Activities;
5. The Food and Drug Administration;
6. Employer Sponsors;
7. Health Oversight Activities;
8. Lawsuits and Disputes;
9. Coroner, Medical Examiners and Funeral Directors;
10. Organ and Tissue Donations;
11. Research;
12. Military and Veterans;
13. National Security and Intelligence; or

We will use and disclose your protected information as necessary, and as permitted by law, for our health care operations. Such operations include processing claims, payment, treatment, coordination of care, business management, accreditation and licensing, quality improvement, enrollment, underwriting, compliance, auditing and other functions related to your health benefits.

Data used for research purposes will not include personal identification information and must be approved by the Privacy Officer. The release of this information does not require your authorization.

In the event that you are deemed incompetent or cannot provide authorization, we require documented proof of power of attorney or guardianship prior to release of any information. Legal counsel will review the documentation prior to release of information.

Limitation on Actions for Fiduciary Breach
Any action with respect to a fiduciary’s breach of any responsibility, duty or obligation hereunder must be brought within one year after the expenses due to Injury or Illness are incurred or are alleged to have been incurred.

No Waiver or Estoppel
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.

Plan Contributions
The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Plan Sponsor and the amount to be contributed (if any) by each Covered Person.
The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be 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 Administrator.

Right to Receive and Release Information
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 from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Waiver
The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator reserves the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

Written Notice
Any written notice required under this Plan which, as of the effective date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such 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 Eligible 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, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, 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.

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

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery in Subrogation if a Covered Person fails to comply with the provisions stated in the section entitled “Third Party Recovery, Subrogation and Reimbursement;” or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Illness to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by an Employee or by any of his Eligible Dependents if such payment is made with respect to the Employee or any person covered or asserting coverage as an Eligible Dependent of the Employee.

**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.

**Right of Recovery**
Whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person’s legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount.
IMPORTANT TELEPHONE NUMBERS

| The University of Akron’s Human Resources Department | 330-972-7072 or 330-972-6488 or 330-972-7886 |
| • For questions about eligibility and enrollment | |
| • For information about payroll deductions and purchasing COBRA continuation coverage | |
| Apex Health Solutions Customer Service | 330-996-8515 |
| Prior Authorization | 888-996-8710 |

Visit our website at www.apex-healthsolutions.com to:

1. View your Eligibility;
2. View Claim Status;
3. View your Authorizations
4. Request an identification card;
5. Update your coordination of benefits information;
6. Request paperless explanation of benefits (EOB) and
7. To locate a Participating Provider.