

**PORTAGE AREA SCHOOLS
CONSORTIUM
STREETSBORO CITY SCHOOLS
EMPLOYEE BENEFIT PLAN**

EFFECTIVE
October 1, 1983

REVISED
September 1, 2006

**FOR VERIFICATION OF COVERAGE OR
TO CONTACT THE CLAIMS OFFICE:**

BENEFIT SERVICES, INC.
P.O. Box 4138
Akron, Ohio 44321
Phone: (330) 666-0337 or
1-800-367-3762 National Toll Free

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INTRODUCTION

This booklet (otherwise known as the “Summary Plan Description” or “SPD”) describes the health care benefits provided by Streetsboro City Schools for Eligible Employees and their covered Dependents. We encourage you to take the time to become familiar with this document and how best to utilize the benefits available to you.

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

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

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

ELIGIBILITY FOR MEDICAL COVERAGE

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

EMPLOYEE ELIGIBILITY

Eligible Employee determination is based upon the negotiated agreement between the Employee and each participating school. If applying for family coverage, an Employee contribution towards the cost of the Plan is required by the Plan sponsor for participation in the Medical Plan. Should you wish to participate, you must complete an enrollment form. Benefit Services, Inc. must receive the enrollment form within 31 days from the date you are eligible to enroll.

DEPENDENT ELIGIBILITY

It is the Employee’s responsibility to keep the status of the Dependents covered by their plan current. Failure to do so will jeopardize the coverage of the individual whose status is incorrect.

You may enroll yourself alone or you and your Dependents. A Dependent includes:

- * Lawful Spouse of an Employee who is not legally separated from the Employee.

Note: If a Spouse is eligible (or becomes eligible or re-eligible at a later date) for non-contributory group health insurance coverage through the Spouse’s Employer, the spouse is (will be) required to take the available coverage from the Spouse’s Employer in order to be covered under the Streetsboro City Schools Plan as secondary coverage. Employees of Streetsboro City Schools may elect coverage for children without regard to any other available coverage for the Spouse. Portage Area Schools Consortium reserves the right to pay the Spouse’s contribution to any contributory employee benefit plan.

- * Your natural children, foster children, adopted children, children placed for adoption with you, or stepchildren, from birth to age 25 who are unmarried and not working full-time and who live with you in a parent-child relationship and who are principally Dependent upon you or your Spouse for support. Grandchildren, nieces and nephews are not covered unless you have assumed legal guardianship.

- * Your unmarried Dependent children of any age who reside with you are eligible for coverage if they are incapable of self-support by reason of a mental or physical handicap which commenced prior to age 25. However, notification of the child's condition must be given within 31 days of the child's normal termination date. A non-permanent Total Disability where medical improvement is possible is not considered to be a "handicap" for the purpose of this provision. This includes substance abuse and non-permanent mental impairments.

For a Dependent to become eligible for the plan, they must enroll when the Employee is enrolled in the plan. If a Dependent is not enrolled due to employment or eligibility for other coverage and subsequently becomes re-eligible for the plan, it is necessary for said Dependent to reapply for coverage within thirty-one (31) days of becoming re-eligible for the coverage and provide evidence of (1) loss of coverage, (2) full dependency upon the Employee, and (3) unmarried status.

The birth of a newborn baby, if the Employee is already on a family Plan, will automatically be added to the benefit program as an Eligible Dependent as of the date of birth. However, if the Employee is currently carrying a single Plan, the Employee is required to notify the Plan Administrator within 31 days of the date of birth, in order to have the newborn child added at the time of birth without a pre-existing condition limitation applying, or possible denial of coverage.

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

- a. Adopted children are eligible for coverage immediately upon placement with the family and are not subject to the Pre-existing Conditions limitations of the Plan.

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

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

If you are required by a "qualified medical child support order", as defined in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), to provide coverage for your children, you can enroll these children as timely enrollees as required by OBRA 93. If you are not already enrolled in the Plan, you must also enroll at the same time.

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

ENROLLMENT IN THE PLAN

The Employee who does not enroll when eligible because of waiver of coverage or for other reasons may apply for acceptance into the group by contacting Streetsboro City Schools. Each eligible Employee who enrolls more than 31 days after the date he/she becomes eligible, or who applies for reinstatement of his/her coverage after it has been terminated for any reason, shall be required to furnish, at his/her own expense, evidence of insurability satisfactory to the Consortium; such coverage shall not become effective prior to the date determined by the Consortium or the Claims Administrator.

However, if the Employee or Dependent refused coverage because of other coverage, such evidence of insurability will not be required provided the other coverage terminates or reduces benefits and the Employee/Dependent applies for the Portage Area School Consortium coverage within 31 days of the termination or reduction date. Evidence of terminated or reduced coverage will be required.

CHANGE OF FAMILY STATUS

For any change in your Dependent status as a result of marriage, birth, or death of Spouse you must file an application for change of status as early as possible but no later than 31 days after such change. Newly covered Dependents are subject to the pre-existing conditions limitation of this plan.

New Dependents will be eligible on the following dates:

- a. New Spouse - date of marriage
- b. Dependent children of new Spouse - date of marriage
- c. Newborns - date of birth

VERIFICATION OF DEPENDENT STATUS

The Claims Administrator may require documentation proving Dependent status, including, but not limited to, birth certificates, marriage records, or initiation of legal proceedings severing spousal or parental rights. The Claims Administrator may also require proof that the Employee or Employee's Spouse is legally responsible for providing at least 50% of the annual support of a Dependent child who does not reside with the Employee.

VERIFICATION OF INCAPACITATED DEPENDENT STATUS

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

PREFERRED PROVIDER ORGANIZATION (PPO)

A Preferred Provider Organization (PPO) is a group of Hospitals, Physicians, and other Health Care Providers who have agreed to work with an organization to help control health care costs by negotiating reduced fees. The PPO helps employers contain the skyrocketing cost of providing health benefits. The PPO encourages Covered Persons to be cost-minded and become “Partners in Health Care”. By using more cost-effective Preferred Providers, you will help stabilize health care coverage costs both to you and to your benefit plan. The PPO also protects your freedom to choose any Physician or Hospital you desire. Alternatives to the PPO include reducing your benefits and increasing your cost. The PPO is a much more attractive solution. The PPO will save you money. The PPO providers have agreed to charge cost-effective rates. You can use any Physician and any health care facility that qualifies under your health plan the same as you have in the past. You make the choice of using or not using a Preferred Provider each time you require services. Following is the PPO Network information for your Plan:

**Medical Mutual of Ohio
(MMO)**

Phone: (800) 349-8587

Website: www.supermednetwork.com

You may also view and print a copy of the provider directory by visiting the Board of Education Office, or by contacting your Claims Administrator.

**SCHEDULE OF BENEFITS
COMPREHENSIVE MAJOR MEDICAL BENEFITS**

Following is a summary of benefits covered under this Plan. All benefits are subject to medical necessity unless otherwise stated herein.

Unless otherwise stated, all benefits are subject to the following deductible, coinsurance and maximum amounts:

Lifetime Maximum Benefit For Eligible Expenses \$2,000,000 per covered person

Calendar Year Deductible:

per covered person \$100.00
to a family limit of \$200.00

Percentage for all Eligible Care and Treatment:

In-Network Single 90% of the first \$4,000.00
In-Network Family 90% of the first \$8,000.00

Out-of-Network Single 80% of the first \$3,500.00
Out-of-Network Family 80% of the first \$7,000.00

Individual Out-of-Pocket Maximum per year including deductible:

In-Network:

Per person \$500.00
Per family \$1,000.00

Out-of-Network:

Per person \$900.00
Per family \$1,800.00

COVERED SERVICES

	Benefit Percentage	
	<u>Network</u>	<u>Non-Network</u>
Maximum Daily Service Charge (Semi-Private Room Charge of confining hospital)	90%	80%
Special Care Units (ICU & CCU)	90%	80%
Ancillary Services Maximum	90%	80%
In-Hospital Physician Visits	90%	80%
Diagnostic, X-ray & Lab, - In & Out-Patient	90%	80%
Surgical Services	90%	80%
Durable Medical Equipment.....	90%	80%
Anesthesia	90%	80%
Therapy Services	90%	80%
Occupational Therapy.....	90%	80%
Home Health Care Services	90%	80%
Calendar Year Maximum: 100 visits		
Hospice Care	80%	80%
Limited to 6 months of coverage		
Skilled Nursing/Rehabilitation Facility Services	80%	80%
Up to 365 days of coverage		
Pregnancy Services ..	90%	80%
Routine Nursery Care	90%	80%
Newborn Exam - first inpatient visit only	90%	80%
Pre-Admission Testing (no deductible)	100%	100%
Voluntary Second or Third Surgical Opinion (no deductible)	100%	100%
Ambulance Services	90%	80%
Emergency Room Treatment Accident	100%	100%
	to a limit of \$300.00	to a limit of \$300.00
	then 90%	then 80%
(care received within 90 days as long as initial treatment is received within 72 hours of accident)		

	<u>Network</u>	<u>Benefit Percentage Non-Network</u>
Emergency Room Treatment Illness.....	90%	80%
Physician Office Visits.....	90%	80%
Office Related Charges (X-Ray, Lab and Injections)	90%	80%
Allergy Testing & Injections.....	90%	80%
Mental, Nervous Disorders & Substance Abuse.....	90%	80%
Inpatient Calendar Year Maximum: \$50,000.00		
Outpatient Calendar Year Maximum: \$5,000.00		
(must complete program, if applicable, for any part to be eligible)		
Gyn Exam, Pap Smear or Prostate Test (no deductible).....	100%	100%
Calendar Year Maximum: 1 per Calendar Year		
Routine Mammogram (no deductible).....	100%	100%
Calendar Year Maximum: \$100.00		
Well Baby Care (Birth to 1 year) (no deductible)	100%	100%
Maximum: \$500.00		
Well-Child Care (age 1 to the age of 9) (no deductible).....	100%	100%
Maximum: \$150.00		
Temporomandibular Joint Disorder.....	90%	80%

PRESCRIPTION DRUG BENEFITS

Retail Copay:	
Generic.....	\$10.00
Brand	\$10.00
Mail Order Copay:	
Generic.....	\$10.00
Brand	\$10.00

Please Note: If you choose a brand name instead of an available generic, you will pay the copay plus the difference between the generic and brand name cost.

DENTAL BENEFITS

Calendar Year Deductible (Applies to Class II, III and IV):

Individual	\$25.00
Family.....	\$50.00

Maximum Benefit each Calendar year for Class I, II and III.....\$2,000.00

Lifetime Maximum for Orthodontic Services (per individual).....\$1,500.00
(covered persons under age 19 only)

Percentages of Payment:

Class I	100%
Class II	80%
Class III	80%
Class IV.....	60%

PRE-EXISTING CONDITIONS FOR NEW PARTICIPANTS:

A condition is deemed to be pre-existing if treatment was received or expense incurred during the three (3) months immediately preceding the effective date.

The pre-existing limitation of the contract is satisfied if the participant has gone without treatment or expense incurred for three (3) consecutive months or twelve (12) months expired while covered under the Plan. (The usage of a prescription drug is considered treatment).

PPO PROVISIONS

Treatment from Non-PPO (Non-Network) Providers in Certain Circumstances

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

- * Ancillary providers rendering care in a PPO facility (i.e.: pathologist, radiologist, anesthesiologist);
- * If a Covered Person has no choice of network providers in the specialty that the Covered Person is seeking within the PPO service area;
- * If a Covered Person is out of the PPO service area and has a medical emergency requiring immediate care;
- * When a PPO provider utilizes the services of a Non-PPO provider for the reading or interpretation of x-ray or laboratory tests;
- * If a Covered Person does not live within a 50 mile radius of a PPO facility / provider.
- * If a Covered Person receives a referral from a PPO Physician to a non-PPO provider.

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

**PRECERTIFICATION OF BENEFITS
FOR IN-HOSPITAL CONFINEMENT**

This Plan is designed to assist you, your Physician and your Hospital to contain costs, while providing you with full, Medically Necessary care.

When you or your eligible dependent are scheduled for any non-emergency surgical procedure, which would require an inpatient Hospital stay, including pregnancy admittance, you must call the utilization review company MedValu.

NOTIFICATION OF HOSPITAL ADMISSION

An elective Hospital admission refers to a pre-planned admission to the Hospital for an overnight stay or longer. This includes pregnancies. All elective admissions must be precertified by MedValu at least 24 hours prior to admission.

Emergency Admissions

An emergency/urgent admission refers to a situation that requires immediate Hospitalization. In such case, the patient must call MedValu within 48 hours of admission and provide them with the pertinent information concerning the admission.

Med-Valu
1-800-349-8587

Pregnancy/Childbirth

Special notification rules apply, as follows:

- * **Inpatient Confinement for Delivery of Child** - MedValu must be notified only if the inpatient care for the mother or child is expected to continue beyond:
 - * 48 hours following a normal vaginal delivery, or
 - * 96 hours following a cesarean section.
 - * For inpatient care (for either the mother or child) which continues beyond the 48/96 hour limits stated above, MedValu must be notified before the end of these time periods.
- * **Non-Emergency Inpatient Confinement Without Delivery of Child** - Confinement during pregnancy but before the admission delivery, which is not Emergency Care, requires notification as a scheduled Confinement. MedValu must be notified prior to the scheduled admission.

Retrospective Review

A retrospective review of the Medical Necessity of both the hospital stay, as well as the length of stay will be performed when the patient was not identified to the review organization in a timely manner to permit a preadmission or emergency review. If it is determined that the Plan Participant could not reasonably ensure that the required procedures for timely notification could be met then the results of the retrospective review will be honored with no additional penalties.

The following information will be required:

- Employee's Name
- Patient's Name
- Name of Hospital and Date of Admission
- Admitting Diagnosis
- Estimated Length of Stay

Please Note: Notification of a Hospital admission does not guarantee benefit payment under the Plan. If precertification is not utilized, eligible benefits will be subject to an additional penalty of 10%, not to exceed \$500.00. This Plan procedure does not apply if this plan is not the primary coverage.

If you have completed the Predetermination of Benefits and have been approved for in-hospital confinement, it is not necessary to follow this procedure.

COMPREHENSIVE MAJOR MEDICAL BENEFITS

BENEFITS PAYABLE

If you or a Dependent incur covered expenses after the effective date of your Major Medical coverage, payment will be made, at the appropriate coinsurance level, for expenses incurred during a Calendar Year which exceed the deductible, and any applicable coinsurance amounts as listed in the Schedule of Benefits. These percentages apply until the covered person reaches the maximum out-of-pocket amount; then, eligible expenses will be payable at 100% of the Reasonable and Customary Charge, unless otherwise specified.

DEDUCTIBLE

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

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

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

OUT-OF-POCKET MAXIMUM

The out-of-pocket amount applies each Calendar Year. Benefits will be payable at the appropriate Coinsurance level, subject to Reasonable and Customary, until you have paid the out-of-pocket amount as listed in the Schedule of Benefits. (The out-of-pocket amount includes the deductible amount). Then benefits will be payable at 100% of Reasonable and Customary with the exception of penalties for pre-certification non-compliance and Benefits for Mental Nervous Disorders, Alcohol and Substance Abuse, which do not accumulate toward the out-of-pocket amount and are never paid at 100%.

MAXIMUM BENEFIT AMOUNT

The Lifetime Maximum amount available for all injuries and illnesses for each Individual covered under the plan is \$2,000,000.00.

METHOD OF PAYMENT

Your Health Benefit Plan uses a **Reasonable and Customary (R&C)** fee method of payment for covered services. Charges will be paid for covered services that are equal to or lower than the R&C level.

- * **REASONABLE:** The charge considered for unusual medical circumstances or complications requiring additional time, skill or experience in connection with a particular case.
- * **CUSTOMARY:** Charges of physicians generally of similar training and experience in that geographical area for same or similar services.

MEDICAL NECESSITY

Benefits for these services are to be provided only when the services are based on valid medical need according to accepted standards of medical practice in the State of Ohio, when performed by a Physician licensed to render such services; and when billed by the Physician.

COVERED SERVICES

HOSPITAL SERVICES

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

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

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

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

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

Blood and Blood Plasma

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

Outpatient Hospital Services

- * **Diagnostic:** Lab and x-ray services.
 - * **Emergency Medical Treatment:** Life-saving services for treatment of an acute medical emergency. A medical emergency is the sudden and unexpected onset of one or more acute conditions which results in direct admission to the hospital, including restoring consciousness or respiration, relieving severe convulsions or asphyxiation, and similar services. For benefit purposes, "acute medical emergency" means a situation that arises suddenly and unexpectedly so as to require immediate medical treatment and which involves hazard to the patient's life, health or physical well-being. These and other acute conditions are medical emergencies when all of the following are met, as determined by the Plan:
 1. The Covered Person requires immediate medical care; and
 2. The onset of the severe symptom(s) of the acute condition(s) is sudden and unexpected. The symptom(s) must be severe enough to cause a reasonably prudent person to seek medical care right away, no matter what time of day it is; and
 3. Immediate care must be obtained (if it is not, it's not a medical emergency); and
 4. A Health Care Provider's diagnosis of the symptom(s) indicates the condition(s) required immediate medical care.
-

- * **Emergency Accident Benefits:** Your Plan covers treatment for Injury due to an accident provided the treatment was sought within 72 hours of the accident.
- * **Operating room and supplies;**
- * **Preadmission Testing:** For Diagnostic Testing up to 10 days prior to admission to the hospital for an elective surgical procedure, benefits will be payable at 100% R&C.
- * **Surgery:** Surgical services and supplies.

MEDICAL-SURGICAL BENEFITS

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

AMBULANCE SERVICE

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

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

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

ANESTHESIA: Your plan covers administration of general anesthesia done in connection with Covered Service, when administered by a physician other than the operating surgeon or his assistant, or by a nurse (under the supervision of a physician) who is not a salaried Employee of the hospital.

CARDIAC REHABILITATION

Phase I and II will be covered benefits; Phase III is not covered.

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

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

Phase III is an outpatient exercise program held at various community fitness facilities. Patients engage in conditioning activities supervised by a Registered Nurse and an exercise physiologist.

CONCURRENT MEDICAL CARE: Your Plan will pay for the care of more than one condition during the same period of Hospital Confinement if all of the following qualifications are met:

- * The condition requiring concurrent care must be unrelated to the condition for which the patient was admitted to the Hospital.
- * The care must be rendered by a Physician other than the attending Physician, surgeon, or surgical assistant.
- * Care must require the services of a Physician, surgeon, or assistant surgeon.

CONSULTATIONS: When requested by the Attending Physician and rendered in the Hospital. The Consultant must be a Physician and possess special knowledge, training, and skill in the special phase of the patient's Injury, Illness or disease. Staff consultations required by Hospital rules are excluded.

CONTRACEPTIVE DEVICES: Benefits are payable for prescribed Contraceptive devices and the necessary office procedures.

DENTAL SERVICES

For Accidental Injury

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

Oral Surgery

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

- * Surgical removal of impacted, (non erupted) teeth;
- * Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;
- * Surgical procedures to correct injuries to the jaw, cheeks, lips, tongue, roof, and floor of the mouth;
- * Apicoectomy (excision of the apex of the tooth root);
- * Root canal therapy, if performed simultaneously with an apicoectomy;
- * Excision of extosis (bony outgrowth) of the jaws and hard palate;
- * Frenotomy (incision of the membrane connecting the tongue to the floor of the mouth);
- * Incision of drainage of cellulitis (tissue inflammation) of the mouth;
- * Incision of accessory sinuses, salivary glands, or ducts;
- * Gingivectomy (excision of gum tissue to eliminate infection);
- * Alveolectomy; if performed for reasons other than for dentures;
- * Functional osteotomies.

Temporomandibular Joint Dysfunction (TMJ)

Payment will be made, the same as any other treatment required to correct TMJ including mandibular staple implants, maxillary or mandibular frenectomy and bony impactions. Appliances for correction are not covered by your Medical Plan.

DIAGNOSTIC SERVICES: When performed for the diagnosis of a condition, disease or Injury, the following services and physician's interpretation of these examinations are covered as stated in the schedule of benefits:

- * X-ray examinations, ultrasound and nuclear medicine
- * Diagnostic medical examinations such as EKG's and EEG's
- * Pathology services
- * Allergy Testing
- * Hearing Tests
- * Diagnostic Testing to determine infertility (treatment of infertility is not a covered service).

Diagnostic services may be provided either in or out of a hospital. The actual physical exam performed by the physician is a covered service.

HOME HEALTH CARE SERVICES: Provides home visits for the treatment of an Injury, Illness or

condition for which you were hospitalized. Visits must begin within 30 days from the date you were discharged. Home Health Care must be prescribed by a Physician and reviewed and approved by the Physician every two weeks. Benefits are not provided for any visit made more than 365 days after the date of the first visit. Benefits are paid as listed in the Schedule of Benefits.

- * Professional services of a R.N. or L.P.N.
- * Treatment by physical means, occupational therapy or speech therapy.
- * Medical and surgical supplies.
- * prescribed drugs.
- * Oxygen and its administration.
- * Medical social service consultations.
- * Health aid services when you are also receiving covered nursing or Therapy Services.

We do not pay Home Health Care Services for:

- * Dietician services.
- * Homemaker services.
- * Maintenance therapy.
- * Dialysis treatment
- * Purchase or rental of dialysis equipment.
- * Food or home delivered meals.
- * Training.

HOSPICE BENEFITS

Hospice services consist of health care services provided to a terminally ill Covered Person. Hospice services must be provided through a Hospice Facility or a Hospice program sponsored by a Hospital or Home Health Care Agency. Hospice services may be received by the Covered Person in a private residence.

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

- * professional services of a registered or licensed practical nurse;
- * treatment by physical means, occupational therapy, and speech therapy;
- * medical and surgical supplies;
- * prescription drugs; (these prescription drugs must be required in order to relieve the symptoms of a condition, or to provide supportive care);
- * oxygen and its administration;
- * medical social services, such as the counseling of patients;
- * home health aide visits;
- * acute inpatient Hospice services;
- * respite care;
- * dietary guidance; counseling and training needed for a proper dietary program;
- * Durable Medical Equipment; and
- * Bereavement counseling by a licensed social worker or a licensed pastoral counselor for patient's immediate family as follows:
 - a. the benefit percentage will be 80% R&C up to a maximum of \$1,000.00 for such services; and
 - b. such services will only be covered during the six month period following the patient's death.

Limitations: Hospice Benefits will only be paid if the eligible individual's attending physician certifies that:

1. The eligible individual is terminally ill; and
2. The eligible individual is expected to die within 6 months or less.

Any covered charge paid under hospice benefits will not be considered a covered charge under any other benefit in this program.

"Patient's immediate family" is the patient's Spouse and children eligible under this program.

HUMAN ORGAN AND TISSUE TRANSPLANTS

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

You must receive services at an approved Center of Excellence Facility. Payment for services received at a facility other than one of the Centers of Excellence Facilities may be at a reduced level.

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

Tissue Transplants

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

Benefits are payable for the following:

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

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

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

- * Acute Myelogenous Leukemia
- * Acute Lymphoblastic Leukemia
- * Pediatric Tumors

Human Organ Transplants

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

Benefits are payable up to the Lifetime Maximum, if any, shown in the Schedule of Benefits for the following transplants:

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

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

The maximum for both human organ and tissue transplants, if any, is specified in the Schedule of Benefits.

Exclusions

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

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

INPATIENT HOSPITAL MEDICAL CARE

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

MASTECTOMY

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

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

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

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

Maternity care is provided for Employees and, under a family contract, the Employees Spouse and Dependent daughters. Coverage will be paid as shown in the Schedule of Benefits.

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

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

In addition, a Plan may not, under Federal law, require that a Physician or other Health Care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. Therefore, if your Plan contains a precertification requirement, you or your Provider must still precertify the stay to avoid any additional out-of-pocket expenses; however, your stay will automatically be precertified for 48 or 96 hours as required by this Federal law.

Birthing Center

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

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

Routine Nursery Care (Newborn Exam): The initial newborn exam is the first inpatient visit to examine a newborn Dependent child. A Physician other than the one who performed the obstetrical delivery or who administered the anesthesia must do the exam. A newborn infant is defined as up to 15 days old or until the discharge date from the hospital, whichever occurs first. Circumcision will also be covered.

Surgical Sterilizations

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

MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES

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

Medical and Surgical Supplies

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

Durable Medical Equipment

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

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

Orthotic Devices

A rigid or semi-rigid supportive device which limits or stops motion of a weak or diseased body part, such as: casts, splints; strapping; orthopedic braces; and crutches. These do not include orthotics, special shoes, or devices to protect the feet unless the device is a permanent part of an orthopedic leg brace.

Prosthetic Appliances

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

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

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

MENTAL & NERVOUS DISORDERS, ALCOHOLISM & SUBSTANCE ABUSE BENEFITS:

Inpatient Services: Charges for inpatient services will be payable the same as any other illness subject to \$50,000 Calendar Year maximum.

Outpatient Benefits: Charges for outpatient services will be subject to the deductible and co-insurance to a maximum benefit of \$5,000.00 per Calendar Year.

Note: Must complete program for any part to be eligible, if applicable.

Electroshock Therapy will be a Covered service.

OUTPATIENT MEDICAL CARE

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

SKILLED NURSING FACILITY / REHABILITATION FACILITY SERVICES:

Benefits are payable if a person, while eligible, incurs charges for confinement to a rehabilitation facility due to accidental injury or sickness, subject to the maximums per disability shown in the schedule of benefits.

Benefits will be paid for the facility's room and board charges, based on average daily rate for semi-private accommodations, for each day of confinement provided that in no event will the daily benefit exceed the daily room and board maximum for which the person is covered under the Hospital Benefits as shown in the Schedule of Benefits.

If a covered individual is admitted to a Skilled Nursing Rehabilitation Facility for the treatment of a Mental & Nervous/Substance Abuse condition, these benefits will be considered part of the maximums for Mental/Nervous/Substance Abuse.

Other eligible expenses incurred while confined in a rehabilitation facility are as follows:

- * Use of special treatment rooms, x-ray and laboratory examinations; physical, occupational, or speech therapy, oxygen and other gas therapy; and other medical services customarily provided by a rehabilitation facility except private duty or special nursing services.
- * Drugs, biological, solutions, dressing and casts.

In order for a rehabilitation period to begin, an individual must have been confined in a hospital for at least three consecutive days and then, within 14 days following termination of the hospital confinement, become confined in a Skilled Nursing Rehabilitation Facility to receive therapy from the Injury or disease which caused the hospital confinement.

NOTE: Maintenance care or custodial care will **not** be eligible under this coverage.

SURGERY: Your plan covers you for surgical services performed both in and out of a hospital. As well as covering most operative and cutting procedures, your plan covers several services that you might not think of when you think of surgery. Additional covered services include treatment of burns, fractures, and dislocations, surgical pathology examinations, cast and suture removals.

Multiple Surgical Procedures: If you have two or more surgical procedures during a single operating period or a continuous anesthetization period, and through the same incision or natural body opening or in the same operative field, you are covered only for the most complex procedure, unless more than one body system is involved or the procedures are needed for the handling of a multiple trauma.

When more than one surgical procedure is performed through more than one body opening during one operation, you are covered for the most complex procedure and for one-half of the benefit for the less complex procedure, or for each of the next three procedures. More than four procedures may be covered subject to medical review.

Voluntary Second Surgical Opinion: A second surgical opinion is helpful for some elective (non-emergency) procedures. Non-emergency surgery is any surgery performed that is not immediately life threatening if not performed. The intent of this program is to provide patients with additional information before a decision is made attempting to promote the delivery of high quality health care as well as to eliminate unnecessary surgery.

The following are non-emergency procedures in which a Second Surgical Opinion is helpful in

providing patient with additional information.

Some of the procedures which are recommended for a voluntary second opinion are:

- | | |
|--|---|
| - Abdominoplasty | - Gastroplasty, Gastrectomy, Gastrotomy (Stomach Surgery) |
| - Adenoidectomy | - Hemorrhoidectomy |
| - Anterior Cervical Discectomy | - Herniorrhaphy |
| - Blephanoplasty/Blepharotomy (eyelid surgery) | - Hysterectomy |
| - Bone Graft, Any Site | - Hip Replacement |
| - Breast Surgery, including Mastectomy | - Knee Surgery (Any type) |
| - Carpal Tunnel Release | - Cataract Extraction |
| - Laminectomy (Spinal Surgery) | - Varicose Vein |
| - Chemonucleolysis | - Myringotomy (Ear) |
| - Cholecystectomy (Gall Bladder Surgery) | - Nasal Surgery |
| - Coronary Angiography | - Orchiectomy (Testicle Surgery) |
| - Coronary Angioplasty | - Coronary Artery Bypass Graft |
| - Pacemaker | - Prostatectomy |
| - Dilation and Curretage | - Rib Resection |
| - Endarectomy (Vein Stripping) | - Tonsillectomy |
| - Facial/Eyelid Rhytidectomy | - Tympanotomy (Ear) |
| - Foot Surgery, Bunionectomy | |

NOTE: A third opinion will be covered if the participant elects to receive one.

Surgical Assistance: When an operating surgeon requests surgical assistance from another Physician, this assistance is payable if the surgery is performed in a Hospital, and assistance is rendered by a surgeon other than an intern, resident or Hospital Employee.

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

Chemotherapy -- The treatment of malignant disease by chemical or biological antineoplastic agents. Oral chemotherapy must be performed in a Hospital.

Dialysis Treatments -- The treatment of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

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

Occupational Therapy - The treatment of a physically disabled person by means of constructive activities designed and adopted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living.

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

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

Speech Therapy - Treatment for the correction of a speech impairment resulting from disease, surgery or Injury. This does not include articulation problems.

Therapy by Physical Means -- Treatment given to relieve pain, restore maximum function and prevent disability following disease, Injury or loss of body part. Services include hydrotherapy; heat or similar modalities; physical agents; hyperbaric therapy; bio-mechanical, neurophysiological principles and devices.

WELLNESS BENEFITS: The following benefits are included under this provision:

Routine Screenings: Prostate, mammograms, pap smears and the office visit are covered to a limit of one per Calendar Year.

Pap Test - For all eligible members, one pap test including the doctor's visit will be covered.

Mammogram - One mammogram per year for all eligible members age 35 and older will be covered as listed in the Schedule of Benefits.

Prostate Test - For all eligible members, one prostate test including the doctor's office visit will be covered.

Well-Baby Care - Charges for well-baby care, including immunizations, from birth to age 1 year payable at 100% of R&C and limited to a maximum of \$500.00.

Well-Child Care: Charges for well-child care from age 1 to the age of 9, including immunizations, payable to a limit of \$150.00 per Calendar Year.

GENERAL LIMITATIONS AND EXCLUSIONS

The following are not covered by the Benefit Plan:

1. **Absence of coverage.** Charges which would not have been made had coverage not existed;
2. **Absent.** Services and/or supplies furnished during periods when the patient is temporarily absent from the Hospital;
3. **Acupuncture / Acupressure;**
4. **Biofeedback.** Biofeedback, recreational, or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing;
5. **Blood.** Whole blood or plasma when donated or otherwise replaced by or on behalf of the patient;
6. **Chelation therapy;**
7. **Civil insurrection or riot.** Treatment or services resulting from participating in a civil insurrection or riot;
8. **Close Relative.** For services provided by a "Close Relative," meaning Spouse, or Covered Person's or Spouse's parent, brother, sister or child, or the Spouse of the Covered Person's parent, brother, sister or child;
9. **Completion** of claim forms or missed appointments;
10. **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan;
11. **Cosmetic services.** Services rendered for cosmetic purposes, unless made necessary by accidental injury. This includes, but is not limited to stomach stapling, breast augmentation and face lifting;
12. **Custodial Care.** For or in connection with Custodial Care;
13. **Dental procedures,** except as specified in the Plan;
14. **Diagnostic Hospital Admission.** Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting;
15. **Educational or vocational testing.** For or in connection with educational or vocational testing or training.
16. **Excess charges.** Charges that exceed the Reasonable and Customary allowance.
17. **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy, as specified by this Plan. This exclusion includes exercise equipment;

18. **Experimental or Investigative services**, procedures, or substances, which have not been recognized as accepted standards of medical practice (Federal Drug Administration, American Medical Association);
19. **Eye care.** Radial keratotomy or keratoplasty, eyeglasses, contact lenses or examinations for prescribing or fitting them (except for aphakic patients and soft lenses or sclera shells for use as corneal bandages).
20. **Felony.** Services and/or supplies for treatment of an accident or illness that resulted while committing a felony, unless due to a medical condition;
21. **Foot care.** Only to improve comfort or appearance such as arch supports, corrective shoes, or care for flat feet, subluxation, corns, bunions, calluses, or toenails (except capsular, bone surgery);
22. **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid, to Medicare or when otherwise prohibited by law;
23. **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician;
24. **Hearing Care.** Hearing aids or examinations for prescribing or fitting them;
25. **Hospital Employees.** Professional services billed by a Physician or nurse who is an Employee of a Hospital or Skilled Nursing Facility and who is paid by the Hospital or facility for the service;
26. **Housekeeping, shopping, or meal preparation services** (except as provided through an approved Home Health Care Program, as described in Covered Services in this booklet);
27. **Hypnosis;**
28. **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence not caused by organic disease;
29. **Infertility.** In vitro fertilization; artificial insemination, surgical reversal of elective sterilization, or any charges relating to infertility. (Reproductive infertility services including but not limited to - family planning; fertility tests; infertility (male or female) including any services or supplies rendered for the purpose or with the intent of inducing conception. Examples of fertilization procedures are ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance the reproductive ability; premarital examinations; impotence, organic or otherwise);
30. **Marital counseling.** Treatment, services and supplies for marriage counseling, health education, holistic medicine or other programs with an objective to provide complete personal fulfillment;
31. **Massotherapy.** Charges billed by a massotherapist unless provided under the direct supervision of a medical provider;

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32. **Medicare Parts A or B.** Services for which payment was made or would have been made under Medicare Parts A or B if benefits were claimed. This applies when the Covered Person is eligible for Medicare, even if the Covered Person did not apply for or claim Medicare benefits. However, if under law, the Covered Person may elect this coverage (instead of Medicare) to pay first and if does so elect, then this exclusion will not apply;
 33. **Milieu Therapy.** Any confinement in an institution primarily to change or control one's environment;
 34. **No charge.** Services for which there is no charge received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group;
 35. **No fault.** To the extent those expenses are in any way reimbursable through "No-Fault" automobile insurance;
 36. **Non-emergency Hospital admissions.** Charges related to a weekend admission to a hospital, except in the case of emergency admission.
 37. **Not Medically Necessary.** For unnecessary care or treatment, as determined by a review board.
 38. **No obligation to pay.** Charges Incurred for which the Covered Person has no legal obligation to pay;
 39. **No Physician recommendation.** Any expenses Incurred for any service or treatment which is not provided or recommended by a Physician;
 40. **Not specified as covered.** Services, treatment and supplies which are not specified as covered expenses under the Plan;
 41. **Notice of Claim.** Treatment, services and supplies for which proof of claim is not provided to the Plan in accordance with the When to File a Claim section;
 42. **Nuclear accident;**
 43. **Nutritional supplements;**
 44. **Obesity.** Treatment of obesity or for weight reduction, including any care which is primarily dieting or exercise for weight loss; except morbid obesity when the individual is more than 2 times his/her ideal body weight and are experiencing other medical illnesses;
 45. **Outside the United States;** Services provided for a Covered Person whose primary residence is outside of the United States. Additionally, charges incurred outside the United States if the Covered Person traveled to such a location primarily for the purpose of obtaining medical services, drugs, or supplies;
 46. **Payment prohibited by law** to the extent that payment under this Plan is prohibited by any law to which you or your Dependent is subject at the time expenses are Incurred;
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47. **Personal comfort items.** Personal comfort items or other equipment such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, first-aid supplies and non-Hospital adjustable beds;
48. **Reimbursable through any public program.** To the extent those expenses are in any way reimbursable through any public program, other than Medicare, except as otherwise required by law;
49. **Routine care.** Routine physical examinations and preventive care not incidental or necessary to the treatment of an illness or injury, except as specified.
50. **Self-inflicted injuries, or threatened suicide,** whether sane or insane, unless due to a medical condition;
51. **Services before or after coverage.** Care, treatment or supplies for which a charge was Incurred before a person was covered under this Plan or after coverage ceased under this Plan;
52. **Services rendered or billed** for by a school or halfway house or by a member of its staff;
53. **Sex changes.** Care, services, or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, and medical or psychiatric treatment, both pre and post operative care;
54. **Telephone or internet consultations;**
55. **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as defined by the Plan;
56. **War.** Disease or Injury resulting from participation in a war, or act of war, whether declared or undeclared;
57. **Without Cost.** Care received without cost under the laws of the United States or any other country or government entity;
58. **Work related.** Expenses Incurred as a result of accidental bodily Injury or sickness arising out of or in the course of any occupation or employment for wage or profit, or for which the Covered Person may be entitled to benefits under any Workers Compensation or occupational disease policy, whether or not any such policy is actually in force. However, this exclusion only applies to persons who can elect, or could have elected for them, coverage under a worker's compensation act, policy or similar law.

PRE-EXISTING CONDITIONS FOR NEW PARTICIPANTS:

A condition is deemed to be pre-existing if treatment was received or expense incurred during the three (3) months immediately preceding the effective date.

A pre-existing limitation of the contract is satisfied if the participant has gone without treatment or expense incurred for three (3) consecutive months or twelve (12) months have expired while covered under the Plan. (The usage of a prescription drug is considered treatment).

PRESCRIPTION DRUG BENEFITS

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

Retail Copay:

Generic.....	\$10.00
Brand	\$10.00

Mail Order Copay:

Generic.....	\$10.00
Brand	\$10.00

Please Note: If you choose a brand name instead of an available generic, you will be required to pay the copay plus the difference between the generic and brand name cost.

ELIGIBILITY FOR PRESCRIPTION COVERAGE

EMPLOYEE ELIGIBILITY

Eligible Employee determination is based upon the agreement between the Employee and each participating school.

DEPENDENT ELIGIBILITY

You may enroll yourself alone or your Dependents. A Dependent includes:

- * Lawful Spouse of an Employee who is not legally separated from the Employee.

Note: If a Spouse of an Employee is eligible for coverage under a non-contributory plan, that Spouse must take at least single coverage. If he/she does not, this Plan will not pay any claims for that participant. Portage County Schools Consortium reserves the right to pay the Spouse's contribution to any contributory employee benefit plan.

- * Unmarried children including foster child, adopted child, step-child, grandchild, niece or nephew from birth to age nineteen (19) who are principally dependent upon the Employee or the Spouse of the Employee for support.
- * Unmarried children from age 19 to age 25 who are full-time students at school, college or university and who are dependent upon the Employee or Spouse of the Employee for support.

- * Proof of dependency for unmarried children will be satisfied by claiming a child for federal income tax purposes.
- * Your unmarried Dependent children of any age who reside with you are eligible for coverage if they are incapable of self-support by reason of a mental or physical handicap which commenced prior to age 19. However, notification of the child's condition must be given within 31 days of the child's normal termination date.

COVERED PRESCRIPTION DRUGS

Items covered under this benefit include up to a 34-day supply of legend drugs and compound prescriptions containing at least one legend drug.

The amount of drugs, including Insulin, which is to be dispensed per prescription or refill will be in quantities prescribed up to a 34-day supply or up to and including 100 units, whichever is greater.

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

HOW THE PLAN WORKS

When your doctor writes a prescription for a covered drug item for you or for an eligible member of your family, take the prescription and your identification card and present them both to a participating pharmacy.

You will be charged the corresponding copay for each prescription filled or refilled. Any cost beyond that is paid to the pharmacy by the prescription card company.

If you have a prescription filled at a non-participating pharmacy or you do not have your card with you at the time the prescription is filled, pay the pharmacist, then complete a reimbursement form and send that to us along with the itemized pharmacy receipt. Reimbursement forms are available by contacting the claims office.

If you have any questions regarding your prescription coverage, you may call Benefit Services, Inc. at (800) 367-3762, or Pharmicare at (800)237-6184.

MAIL-ORDER DRUG PROGRAM

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

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

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

EXCLUSIONS AND LIMITATIONS

This prescription drug program does not provide benefits for the following:

1. Drugs obtained without a Physician's prescription;
2. Drugs for which the provider's Reasonable and Customary charge is less than the Copay amount of the Plan;
3. Drugs not requiring a prescription under federal law;
4. Any charge for fertility drugs/agents regardless of use;
5. Charges for growth hormones, unless prior approval is obtained by the Plan;
6. Charges for Retin-A or similar products for those over age 21 unless prior approval is obtained by the Plan;
7. Smoking cessation products;
8. Drugs which sole purpose are to promote or stimulate hair growth;
9. Any charge for therapeutic devices or appliances, regardless of their intended use (except for disposable insulin syringes); support garments; medical supplies and equipment; other non-medical items regardless of their intended use;
10. Any charge for administration of drugs or insulin;
11. The charge for more than a 34-day supply of retail legend drugs;
12. The charge for any prescription order refill in excess of the number specified by a doctor or any refill dispensed after one year from the date of the original prescription order;
13. Immunizing agents, biological sera, blood or plasma, laterite, except insulin;
14. Dietary supplements and vitamins except prenatal vitamins used while receiving maternity benefits; health and beauty aids;
15. Injectable drugs, unless prior approval is obtained by the Plan;
16. Drugs labeled "Caution: limited by Federal law to investigational use" or experimental drugs, even though a charge is made;
17. Drugs taken or given while at a Hospital, convalescent care facility, or similar institution;
18. Fluoride preparations;
19. Weight control/Anti-Obesity Drugs;
20. Impotency agents (Viagra, MUSE, etc.); except as determined to treat a medical illness. Prior approval must be obtained by the Plan;

21. The charge for any medication for which you or your eligible Dependent is entitled to receive reimbursement under any Worker's Compensation law, or for which entitlement to benefits is available without charge from any municipal, state or federal program of any sort, whether contributory or not;
22. Drugs which do not have the required governmental approval when you receive them or are considered Experimental, investigative, or of a research nature; and
23. Drugs and medicines not covered under the Plan. Please see the General Limitations and Exclusions section.

PLEASE NOTE: If you or your eligible Dependent(s) coverage terminates, your coverage under this program also terminates. If you continue to use your prescription drug card you will be held responsible for payment of any bills incurred after such termination date.

**DENTAL BENEFITS
SCHEDULE OF BENEFITS**

Calendar Year Deductible (Applies to Class II, III and IV):	
Individual	\$25.00
Family	\$50.00
Maximum Benefit each Calendar year for Class I, II and III.....	\$2,000.00
Lifetime Maximum for Orthodontic Services (per individual).....	\$1,500.00
(covered persons under age 19 only)	
Percentages of Payment:	
Class I	100%
Class II	80%
Class III	80%
Class IV	60%

EMPLOYEE ELIGIBILITY

Eligible Employee determination is based upon the agreement between the Employee and each participating school.

DEPENDENT ELIGIBILITY

You may enroll yourself alone or you and your dependents. A Dependent includes:

- * Lawful spouse of an employee who is not legally separated from the employee.

Note: If a Spouse of an Employee is eligible for coverage under a non-contributory plan, that Spouse must take at least single coverage. If he/she does not, this Plan will not pay any claims for that participant. Portage County Schools Consortium reserves the right to pay the Spouse's contribution to any contributory employee benefit plan.

- * Unmarried children including foster child, adopted child, step-child, grandchild, niece or nephew from birth to age nineteen (19) who are principally dependent upon the Employee or the Spouse of the Employee for support.
- * Unmarried children from age 19 to age 25 who are full-time students at a school, college or university and who are dependent upon the Employee or Spouse of the Employee for support.
- * Proof of dependency for unmarried children will be satisfied by claiming a child for federal income tax purposes.
- * Your unmarried Dependent children of any age who reside with you are eligible for coverage if they are incapable of self-support by reason of a mental or physical handicap which commenced prior to age 19. However, notification of the child's condition must be given within 31 days of the child's normal termination date.

For a Dependent to become eligible for the plan, they must enroll when the Employee is enrolled in the plan. If a Dependent is not enrolled due to employment or eligibility for other coverage and subsequently becomes re-eligible for the plan, it is necessary for said Dependent to reapply for coverage within thirty (30) days of becoming re-eligible for the coverage and to provide evidence of (1) loss of coverage, (2) full dependency upon the Employee, (3) unmarried status and (4) insurability by providing a satisfactory "certificate of insurability".

The exception to the above is made for a newborn infant of an Employee or their Spouse, provided that the newborn infant is formally enrolled within thirty (30) days of birth.

It is the Employee's responsibility to keep the status of the Dependents covered by their plan current. Failure to do so will jeopardize the coverage of the individual whose status is incorrect.

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

- a) Adopted children are eligible for coverage immediately upon placement with the family and are subject to the pre-existing clause of the Plan.
- b) If an eligible Employee who is covered under this plan is divorced, the children of that Employee are eligible Dependents for the plan, regardless of other Dependent qualifications, if the eligible Employee is court ordered to provide coverage. The Dependent may not be terminated from coverage as long as the employee is eligible for coverage and the court order is still in effect.

COVERED EXPENSES

Class I - Preventative & Diagnostic (no deductible on Class I benefits)

- 1. Routine oral exams twice in any consecutive 12 month period
- 2. Prophylaxis (teeth cleaning) twice in any consecutive 12 month period
- 3. Fluoride treatments once every 12 months
- 4. Palliative Treatment (emergency pain treatments)
- 5. Space Maintainers (for preventive measures) including all adjustments within six months after installation.
- 6. Diagnostic X-rays
- 7. Tests & lab exams
- 8. Sealants for children up to age 14
- 9. Bitewings twice in any consecutive 12 month period.

Class II - Basic Restorative (deductible and maximum benefit amount apply)

1. Special consultation by a specialist for case presentation when diagnostic procedures have been performed by a general dentist;
2. Diagnostic X-ray and Pathology;
3. Oral Surgery including local anesthetics and routine postoperative care;
4. Extractions, including impacted (non-erupted) teeth;
5. Alveolar or Gingival Reconstructions;
6. Odontogenic Cysts and Neoplasms;
7. Anesthetics, general, only when provided in conjunction with a surgical procedure;
8. Periodontics except periodontal splinting;
9. Endodontics, including root canals;
10. Restorative Dentistry, excludes inlays, crowns and bridges (Multiple restoratives in one surface will be considered as a single restoration);
11. Repair and recementation of crowns, inlays, onlays, bridges and dentures

Class III - Major Restorative (deductible and maximum benefit amount apply)

1. Restorative. Gold restorations and crowns are covered only as treatment for a decay or traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge;
2. Inlays and Onlays;
3. Crowns;
4. Prosthodontics;
5. Bridge Abutments;
6. Pontics;
7. Removable Bridge (unilateral). One piece casting, chrome cobalt alloy clasp attachment (all types) including pontics;
8. Dentures and partials (Fees for dentures, partial dentures and relining within six months after installation. Specialized techniques and characterizations are not eligible)

Class IV - Orthodontia (Covered persons under age 19, lifetime maximum of \$1,500.00)

Benefits are payable for an orthodontic treatment for a child who is less than age 19 on the date the treatment commences and who is a covered Dependent.

An "Orthodontic Treatment Plan" is a report on a form satisfactory to the Plan that among other things describes the recommended treatment, gives the estimated charge, and is accompanied by cephalometric x-rays, study models and other supporting evidence.

Eligible charges are those made for an orthodontic procedure that:

- a. Is in an "Orthodontic Treatment Plan" that has been reviewed by the Plan prior to the treatment and has been returned to the dentist showing estimated benefits.
- b. Is required by an overbite of at least four millimeters, cross bite, or protrusive or retrusive relationship of at least one cusp.

The claim will be paid in monthly installments beginning when the orthodontic appliances are first inserted, as long as the patient remains covered or for a maximum period of two years. If the actual eligible charges for the Orthodontic Treatment Plan are less than or more than the estimated eligible charges, the last installment above will be:

- a. reduced by any excess of estimated over actual; or
- b. increased by an excess of actual over estimated.

Covered dental expenses include charges for the services listed in the Schedule of Dental Services. All dental services must be performed by or under the direction of a dentist.

Certain services have limitations on the frequency with which they are recognized as covered dental expense. These limitations are noted in the Schedule.

The plan will pay a percentage of the reasonable and customary fees charged for covered dental services. The applicable percentages are indicated in the schedule of benefits.

MAXIMUM BENEFITS

Class I, II and III expenses combined are subject to an annual maximum amount payable, per person, as shown in the Schedule of Benefits.

Orthodontic expenses (Class IV) are subject to a lifetime maximum amount payable, per person, as shown in the Schedule of Benefits.

PREDETERMINATION OF BENEFITS

Prior to beginning a course of treatment expected to cost \$200.00 or more, a "Dental Treatment Plan" is suggested to be submitted to the Claims Administrator. A "Dental Treatment Plan" shall consist of a written report describing recommendations for necessary dental services and the cost for such services. A dental care claim form completed and signed by the dentist shall be an acceptable "Dental Treatment Plan".

The Claims Administrator will notify the dentist of the services that will be rendered and the benefits payable. If the predetermined work is not completed within six (6) months from the date of approval, a new predetermination will be requested.

INCURRED DATES OF BENEFITS

A charge is Incurred on:

- a. The date the impression is taken, in the case of dentures or fixed bridges;
- b. The date the preparation of the tooth is begun, in the case of crown work;
- c. The date the work on the tooth is begun, in the case of root canal therapy; and
- d. The date the work is done, in the case of any other work.

EXCLUSIONS

No payment will be made for:

1. services performed solely for cosmetic reasons, including charges for personalization or characterization of dentures;
2. replacement of a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability;
3. treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride will be considered a covered dental expense if performed by a licensed dental hygienist under the supervision and guidance of the dentist;
4. services or supplies which are unnecessary or experimental according to accepted standards of dental practice;
5. replacement of a lost or stolen device or appliance;
6. spare or duplicate prosthetic devices or appliances;
7. For these items:
 - a. Tooth implants;
 - b. Athletic mouthguards;
 - c. Oral hygiene, dietary, plaque control and other educational programs;
 - d. Porcelain veneered crowns or pontics placed on or in place of a tooth behind the second bicuspid, to the extent the charges would be more than the charge that would have been a covered dental charge for acrylic veneered crowns or pontics;
8. appliances or restorations, other than full dentures, whose primary purpose is to increase vertical dimension or stabilize periodontally involved teeth, or to restore the occlusion;
9. services or supplies which are furnished prior to the effective date of coverage. In the case of prosthetic devices and crowns, charges will not be covered if the impressions were taken before the date coverage commenced, even though the prosthetic device or crown is not installed until after the date coverage commenced;
10. replacement of a bridge or denture within five years following the date of its original installation unless (a) such replacement is made necessary by the placement of an original opposing full denture or the extraction of natural teeth; or (b) the bridge or denture, while in the oral cavity, has been damaged beyond repair as a result of an Injury received while you or your family member is eligible for dental expense benefits;

11. services rendered by a Dentist beyond the scope of his/her license;
12. services rendered by more than one dentist. If you change Dentists during the course of treatment, or if more than one dentist treats you for a procedure, we do not pay added benefits;
13. optional techniques of treatment with different fees. In this case, we will pay for the treatment with the lesser fee;
14. expenses to the extent they are not payable according to the section of this certificate entitled General Limitations;
15. Disease or Injury resulting from participation in a war, or act of war, whether declared or undeclared;
16. Sterilization supplies and other infection control procedures;
17. for services for which expenses are covered or obtained under any worker' compensation or similar law, by stipulation or otherwise;
18. to the extent that you or your Dependents are reimbursed, are entitled to reimbursement, or are in any way indemnified in whole or in part by or through any public program, charitable or governmental, as now existing or under any law which may be enacted;
19. for charges by a hospital owned or operated by the United States Government, except in a foreign country;
20. for charges which you or your Dependents are not legally required to pay;
21. for charges which would not have been made had coverage not existed;
22. in excess of the reasonable and customary charge for the locality in which they are incurred;
23. to the extent that payment under this plan is prohibited by any law to which you or your Dependents are subject at the time expenses are incurred;
24. to the extent that they are otherwise payable as described under Coordination of Benefits;
25. for charges for completion of any insurance forms, or charges for failure to keep appointments.

GENERAL INFORMATION**CLAIMS PROCEDURES****Types of Claims**

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

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

Urgent Care Claim - An urgent care claim is any pre-service claim for medical care or treatment which, in the opinion of the treating Physician, lack of immediate processing decision on the claim could seriously jeopardize the life or health of you or your dependent. This type of claim generally includes those situations commonly treated as emergencies. Only the treating Physician can classify a pre-service claim as "urgent".

Concurrent Care Claim - A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously approved pre-service claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought.

Post-Service Care Claim - A Post-Service Claim is a claim for payment or reimbursement after services have been rendered.

Who Must File

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

Time Limit for Filing a Claim

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

Appointing an Authorized Representative. If you or your Dependent wish to have someone act on your behalf for purposes of filing claims, making inquiries and filing appeals, you must furnish the Claims Payor with a written designation of your Authorized Representative. You can appoint any individual as your Authorized Representative **except** a Health Care Provider. Nevertheless, a Health Care Provider with knowledge of your medical condition can act as your Authorized Representative for purposes of an urgent care claim as defined above. Once you appoint an Authorized Representative in writing, all subsequent communications regarding your claim will be provided to your Authorized Representative.

Where to File a Claim

Claims should be filed as indicated on your Identification Card.

What to File

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

Employee's Name and Social Security Number

Patient's Name

Name of Company/Employer

Method of Claims Delivery

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

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

Timing of Claims Determinations

Urgent Care Claims. If your claim involves urgent care, you or your authorized representative will be notified of the Plan's initial decision on the claim, whether adverse or not, as soon as is feasible, but in no event not more than 72 hours after receiving the claim. If the claim does not include sufficient information for the Plan Administrator to make an intelligent decision, you or your representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. You will have at least 48 hours to respond to this request; the Plan then must inform you of its decision within 48 hours of receiving the additional information.

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

Other Pre-Service Claims. If your claim is for any other pre-service authorization, the Plan will notify you of its initial determination, whether adverse or not, as soon as possible, but not more than 15 days from the date it receives the claim. This 15-day period may be extended by the Plan for an additional 15 days if the extension is required due to matters beyond the Plan's control. You will have at least 45 days to provide any additional information requested of you by the Plan.

Post-Service Claims. If your claim is for a post-service reimbursement or payment of benefits, the Plan will notify you within 30 days of receipt of the claim that the claim has been approved or denied. The 30 days can be extended to 45, if the Plan notifies you within the initial 30 days of the circumstances beyond the Plan's control that require an extension of the time period, and the date by which the Plan expects to render a decision.

If more information is necessary to decide a post-service claim, the Plan will deny the claim and notify you of the specific information necessary to complete the claim.

Notice of Claims Denial (Adverse Benefit Determination)

If, for any reason, your claim is denied, in whole or in part, you will be provided with a written notice containing the following information:

1. The reason(s) why the claim or a portion of it was denied;
2. Reference to plan provisions on which the denial was based;
3. If the denial was based in whole or in part on any internal rules, guidelines or protocols, a statement that you may request a copy of the rule, guideline or protocol, which will be provided free of charge;
4. If the denial was based in whole or in part on Medical Necessity, Experimental/Investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided free of charge;
5. What additional information, if any, is required to perfect the claim and why the information is necessary; and
6. What steps you may take if you wish to appeal the decision.

How and When to File a Claims Appeal

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

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

In connection with your right to appeal the initial claims determination, you also:

1. May review pertinent documents and submit issues and comments in writing;
2. Will be given the opportunity to submit written comments, documents, records, or any other matter relevant to your claim;
3. Will, at your request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and
4. Will be given a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination.

The claim review will be subject to the following rules:

1. The claim will be reviewed by an appropriate party, who is neither the individual who made the initial denial nor a subordinate of that individual.
2. The review will be conducted without giving deference to the initial denial.
3. If the initial denial was based in whole or in part on a medical judgment (including any determinations of Medical Necessity or Experimental/Investigative treatment), the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This medical expert shall not be an individual who was consulted on the initial claim denial nor the subordinate of such an individual. Any medical experts consulted in the review process shall be identified by name.

Timetable for Deciding Appeals

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

Urgent Care Claims - not later than 72 hours after receiving your request for a review.

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

Post-Service Claims - not later than 60 days after receiving your request for a review.

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

Notice of Decision on Appeal

If the appeal has been either partially or completely denied, you will be provided with a written notice containing the following information:

1. The specific reasons for the appeal denial;
2. Reference to the specific plan provisions on which the denial is based;
3. A statement that you may request reasonable access to and copies of all documents, records and other information relevant to your appealed claim for benefits, which shall be provided to you without charge;
4. If the appeal denial was based in whole or in part on any internal guidelines or protocols, a statement that you may request a copy of the guideline or protocol, which will be provided to you without charge;
5. If the appeal denial was based in whole or in part on Medical Necessity, Experimental/Investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided to you without charge.

You may not begin any legal action, including proceedings before administrative agencies, until you have followed these procedures and exhausted the opportunities described in this section. You may, at your own expense, have legal representation at any stage of these review procedures.

These review procedures shall be the exclusive mechanism through which determinations of eligibility and benefits may be appealed. If, after following the review process outlined here, you are not satisfied with the result, then you must file any legal action within 180 days of receiving the final review notice under these procedures.

RIGHT TO REVIEW CLAIMS AND RECEIVE NECESSARY INFORMATION

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

PLAN AMENDMENTS

Plan amendments will be distributed to all Plan Participants.

MATERIAL REDUCTIONS

In the case of any modification or change that is a “material reduction in covered services or benefit provided under the Group Health Plan,” plan participants must be furnished the summary of such modification or change no later than 60 days after the adoption of the modification or change.

PHYSICAL EXAMINATION

Benefit Services, Inc. shall, upon request and at the expense of the benefit program and by a Physician of its own choice, have the right and opportunity to physically examine any covered individual with respect to the Surgical and Medical Services listed in the Summary Plan Description.

FACILITY OF PAYMENT

When another plan makes payment which should have been made under this plan, Benefit Services, Inc. shall have the right to directly reimburse the other plan making payment.

RIGHT OF RECOVERY

If the Plan makes any payment which is determined in excess of the Plan's benefits, the Plan shall have the right to recover the amount determined to be in error. The Plan shall recover the amount of the overpayment directly from the person to which it was paid.

LARGE CASE MANAGEMENT

Large case management is a program which identifies potential high risk, high cost claims in order to direct the patient toward the most cost-effective, quality medical care available.

When a Covered Person's condition warrants (i.e. chronic illness, catastrophic injury, etc.) Benefit Services, Inc. shall have the right to waive the normal provisions of the Plan when it is reasonable to expect a cost effective result without sacrifice to the quality of patient care. The Case Manager will contact the person's attending physician to assure that all available resources are considered. Certain circumstances may cause Benefit Services, Inc. to allow charges that would not otherwise be covered if the proposed alternative is shown to be cost effective.

The catastrophic injury or sickness must have occurred while the patient was covered and the injury or sickness must have been covered under the Plan.

The Case Manager, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

COORDINATION OF BENEFITS

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

This provision is not to deny you benefits but to ensure that duplicate payments are not made when you are covered by this and any other contract. Under this plan of group coverage all benefits will be coordinated with all other plans you or your Dependent might have coverage through, so that the total amount payable under all plans will not exceed 100% of your total medical expense incurred during a calendar year. However, if your Dependents have coverage under any other plan and said plan is considered primary payor and the Dependent Spouse fails to comply with the requirements of the other plan or fails to utilize a Health Maintenance Organization (HMO) which has been selected by said Dependent Spouse under the other plan and the other plan would have been primary for the Dependent's actions, this plan will not pay any portion of the allowable expenses incurred by that Dependent Spouse. For a Dependent child who fails to utilize the services of the HMO, which would otherwise be considered as the primary payor for the Dependent, this Plan will pay its pro-rata share, up to one-half of the allowable benefits determined by this Plan.

The order of benefit determination will be handled as follows:

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

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

RIGHT OF SUBROGATION AND REFUND / THIRD PARTY RECOVERY**When This Provision Applies**

The Covered Person may Incur medical or dental charges due to Injuries which may be caused by the act or omission of another party or another party may be responsible for payment. In such circumstances, the Covered Person may have a claim against another party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those Incurred medical or dental expenses automatically assigns this Plan any rights the Covered Person may have to Recover payments from any other party or insurer. This Subrogation right allows this Plan to pursue any claim which the Covered Person may have to recover payments from any other party or insurer. This Subrogation right allows this Plan to pursue any claim which the Covered Person has against any other party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the other party or insurer, but in any event, this Plan has a first priority lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This first priority lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

1. Automatically assigns to this Plan his or her rights against any other party or insurer when this provision applies; and
2. Must repay to this Plan benefits paid on his or her behalf out of the Recovery made from the other party or insurer.

Amount Subject to Subrogation or Refund

The Covered Person agrees to recognize this Plan's first priority right to Subrogation and reimbursement OVER THE COVERED PERSON AS TO ANY FUNDS RECOVERED. These rights provide this Plan with a first priority with respect to any funds paid by another party to a Covered Person relative to the Injury or Illness, even if the Covered Person is only partially compensated for all losses. The Plan's priority recovery right includes a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Any so-called "make whole" or "full compensation" rule or doctrine is hereby explicitly rejected and disavowed.

Notwithstanding its priority to Refunds, this Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which this Plan has made, or will make, payments for medical or dental charges, as well as any costs and fees associated with the enforcement of its rights under this Plan.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure this Plan's right of subrogation as a condition to having this Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of this Plan to subrogate.

Defined Terms

"Recovered / Recovery" means monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the injuries or Illness whether or not said losses reflect medical or dental charges covered by this Plan.

“Subrogation” means this Plan’s rights to pursue the Covered Person’s claims for medical or dental charges against the other person.

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

Note: As used only in this provision, the term “Covered Person” is deemed to include any legal or personal representative, parent, guardian, or estate of the Covered Person.

Recovery from another Plan under which the Covered Person is covered. This right of refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan, homeowner’s plan, renter’s plan, medical malpractice plan, or any liability plan.

PROVISIONS APPLICABLE TO ALL COVERAGE

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

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

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

TERMINATION OF COVERAGE

Your coverage under this Plan will terminate at the earliest time stated below:

- * When you cease your contributions toward the Plan.
- * When this Plan is discontinued.
- * Retirement
- * For employees receiving accrued wages and resigning at the end of school year, benefits will cease. This includes:
 - * Reduction in Staff (RIS)
 - * Non-renewal
Insurance benefits will cease on August 31 of the current school year.
 - * Long-term substitute teachers
 - * 12 month Employees or Employees terminating during the school year

In addition to the above, coverage with respect to an individual Dependent terminates:

- * When such person becomes eligible as an Employee, except as specified in the Eligibility Rules at the beginning of this Summary Plan Description.

-
- * When such person ceases to be an eligible Dependent; except that the coverage of a Dependent child shall not cease because of the attainment of the anniversary of his date of birth specified in the definition of "Dependent" hereunder, if proof is furnished to the Administrator within 31 days after such anniversary that on such anniversary, the Dependent child is incapable of self-sustaining employment by reason of mental retardation or physical handicap and that such child is chiefly Dependent upon your support and maintenance. The coverage as to such child will be continued while such incapacity continues and while your coverage with respect to your Dependent remains in force, provided such child meets all the requirements of the definition of "Dependent" except age.

Under certain circumstances the Employer may allow you to continue coverage at your own expense.

DEPENDENT COVERAGE AFTER DEATH OF EMPLOYEE

If an Employee dies while covered under a family contract of the Plan, any of the Employee's Dependents who are covered at the time of his death will remain Covered for the benefits indicated in the section entitled "Benefits During Continuation" without further payment of premiums, but for no longer than two years from the date of the Employee's death. In no event will coverage on an Employee's Dependents be extended beyond the date the surviving Spouse, if any remarries nor will coverage on any Dependent be extended beyond the date that Dependents qualifies for Medicare or beyond the date that Dependent ceases to qualify as a Dependent for any reason other than lack of primary support by the Employee.

The Dependent benefits payable after the date of the Employee's death will be those in effect on the Employee's last day of active service, except that any provisions reducing or terminating benefits because of retirement or attainment of a specified age will be applied to the extent that those provisions would apply if the Employee were then living.

FAMILY AND MEDICAL LEAVE

If you take a leave of absence in accordance with the federal Family and Medical Leave Act of 1993, coverage for you and your dependents will be continued under the same terms and conditions as if you have continued performing services for Portage Area Schools Consortium, provided you continue to pay your regular contribution towards coverage.

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

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

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

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

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

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

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

If coverage lapses for any reason during an FMLA leave and you return to work on a timely basis following an approved FMLA leave, coverage will be reinstated as if you have continued performing services during the leave, including Dependent coverage. Reinstatement will be provided without having to satisfy any waiting period, or provide evidence of good health.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

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

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

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

The Plan Sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Plan Sponsor becomes aware.

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

- A. The Plan Sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. § 164.524.
- B. The Plan Sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R. § 164.526.
- C. The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. § 164.528.

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

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

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

Required separation between the Plan and the Plan Sponsor

- A. In accordance with the "504" provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan Sponsor who may have access to individuals' Protected Health Information received from the Plan or from a business associate or health care issuer servicing the Plan.
 - 1. Superintendent
 - 2. Treasurers Office
- B. This list reflects the employees, classes of employees, or other workforce members of the Plan Sponsor who may receive or at times access individuals' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including

termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, the provisions of this Amendment.

- C. The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

HIPAA SECURITY STANDARDS

This Section is intended to bring Portage Area School Consortium Employee Benefit Plan (hereinafter "Plan") into compliance with the requirements of 45 C.F.R § 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 (the regulations are referred to herein as the "HIPAA Security Standards") by establishing Plan sponsor's obligations with respect to the security of Electronic Protected Health Information. The obligations set forth below are effective April 21, 2005.

The Plan Documents of the Portage Area School Consortium Employee Benefit Plan are hereby amended as follows:

I. Definitions

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

II. Plan Sponsor Obligations

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

- A. Plan sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- B. Plan sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f) (2) (iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
- C. Plan sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
- D. Plan sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - 1. Plan sponsor shall report to the Plan within a reasonable time after Plan sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
 - 2. Plan sponsor shall report to the Plan any other Security Incident on an aggregate basis annually, or more frequently upon the Plan's request.

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

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

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

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

Qualifying Events

If you are an Employee of Portage Area Schools Consortium and you are covered by the Plan, you have a right to elect continuation coverage if you lose coverage under the Plan because of any of the following “qualifying events”:

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

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

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

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

1. The death of the Employee parent.
2. The termination of the Employee parent’s employment (for reasons other than gross misconduct) or reduction in the Employee parent’s hours of employment with Portage Area Schools Consortium.

3. Parents' divorce or legal separation.
4. The Employee parent becomes entitled to Medicare benefits.
5. The Dependent ceases to be a "Dependent child" under the Plan.
6. Employee parent becomes disabled.

Notices and Election Procedures

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

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

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

Notification of a disability determination must be made to the Plan Administrator within 60 days of the LATER of the date of determination, date of qualifying event, or date coverage is lost as a result of the qualifying event. Notification must be in writing as described in the above paragraph, and a copy of the SSA Determination must accompany your notice. Please note you have 30 days from the determination to notify Plan Administrator that you are no longer disabled.

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

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

You (the Employee) or your qualified beneficiaries must elect continuation coverage within 60 days after Plan coverage ends or, if later, 60 days after the Plan Administrator sends you or your family member notice of the right to elect continuation coverage. If you or your qualified beneficiaries do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage. Your (or your qualified beneficiaries) election is effective on the day the election is sent to the Plan Administrator. Please Note: No claims will be paid until the COBRA payment is received.

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

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

Type of Coverage; Payments of Contributions

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

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

Maximum Coverage Periods

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

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

There are three exceptions:

1. If an Employee or family member is disabled at any time during the first 60 days of continuation coverage (running from the date of termination of employment or reduction in hours), the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to Portage Area Schools Consortium or the Plan Administrator both within the 18-month coverage period and within 60 days after the date of the determination.

2. If a second qualifying event that gives rise to a 36-month maximum coverage period (for example, the Employee dies or becomes divorced) occurs within an 18-month or 29-month coverage period, the maximum coverage period becomes 36 months from the date of the initial termination or reduction in hours for the Spouse or dependent child.
3. If the Employee is entitled to Medicare at the time of an initial qualifying event due to termination or reduction of hours worked, then the period of continuation for other family members who are qualified beneficiaries is the later of 36 months from the date of Medicare entitlement, or 18 months from the date of the qualifying event.

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

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

Termination of COBRA before the End of Maximum Coverage Period

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

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

6. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered Employees or their Spouses or Dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of Federal law.

Other Information

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

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

Streetsboro City Schools
Attn: Board of Education
9000 Kirby Lane
Streetsboro, OH 44240
(330) 995-7704

USERRA

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

Continuation of Coverage Due to Military Leave

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

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

Reinstatement of Coverage Following Military Leave

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

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

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

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

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

If the requirements for reemployment are satisfied, coverage will continue as though employment had not been interrupted by a military leave, even if you decline continued coverage during the leave. No new waiting periods or preexisting condition limitation will apply to you or your Dependents. Credit will be given toward the preexisting conditions limitation for any time satisfied under the Plan from you or your dependent's original effective date. However, a waiting period preexisting condition limitation and/or plan exclusion may apply for Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during military service.

EFFECT OF MEDICARE ON THE PLAN

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

Coverage for a Covered Person will always be Primary if:

1. he is an active Employee or the Spouse of an active Employee; or
2. he is entitled to benefits under Medicare because of renal dialysis or kidney transplant. In this case coverage under this Plan will be Primary only during the first 18 months of the period such person is so entitled; or
3. he is under age 65 and has been receiving Social Security Disability Benefits for at least 2 years.

Coverage for a Covered Person will be Secondary if:

1. he has been entitled to benefits under Medicare because of renal dialysis or kidney transplant for more than 18 months. In this case coverage under the Plan will be Secondary only after the first 18 months of the period such person is so entitled; or
2. the Covered Person is a retired Employee or the Covered Dependent of a retired Employee.

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

If a Covered Person does not enroll for coverage under Part A and Part B of Medicare or does not make due claim for Medicare benefits, the Plan Administrator will calculate benefits as if he were enrolled in both parts of Medicare and full claim for benefits had been made.

DEFINITIONS

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

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

Billed Charges - charges for all services and supplies that the Covered Person has received from the Provider, whether they are Covered Services or not.

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

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

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

Centers of Excellence - a facility designated by the Plan to perform certain high cost/high risk procedures, such as organ transplants.

Certificate of Creditable Coverage - a certification of coverage to individuals who cease to be covered under a plan.

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

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

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

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

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

Convalescent Facility -

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

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

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

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

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

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

Drug Abuse and Alcoholism - condition diagnosed to be a Mental Illness listed under diagnostic code number 303 and 304 of the International Classification of Diseases of the U.S. Department of Health and Human Service (ICD-9-CM, as amended or revised).

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

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

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

Experimental/Investigative - any treatments, procedures, devices, drugs or medicines for which one or more of the following is true:

1. The device drug or medicine cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug, or medicine is furnished;
2. Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocols used by the treating facility and the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

Experimental or Investigative shall also mean: (a) any treatments, services or supplies that are educational or provided primarily for research; or (b) treatments, procedures, devices, drugs or medicines or other expenses relating to transplant of non-human organs.

Full-time Student - an eligible dependent who is enrolled at an accredited institution of higher learning. It must be certified each quarter or semester that the student meets the institution's requirements for full-time status. This will include attendance at more than one institution, including internships as long as this meets or combined meets full-time status.

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

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

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

Hospital - An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets all of the requirements set forth in (1), (2) or (3) below:

1. It is a hospital accredited by the Joint Commission on Accreditation of Hospitals.
2. It is a hospital, a psychiatric hospital, or a tuberculosis hospital as those terms are defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare.
3. It is an institution which fully meets all of the following:
 - a. It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified physicians; and
 - b. It continuously provides on the premises 24 hour-a-day nursing service by or under the supervision of registered graduate nurses; and
 - c. It is operated continuously with organized facilities for operative surgery on the premises.

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

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

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

In-Hospital Benefit Period - a period of time beginning when you enter a Hospital and ending when you have been out of the Hospital or Skilled Nursing Facility for 90 consecutive days.

Injury - Any accidental bodily damage or hurt sustained while the Covered Person is covered under the Plan and which requires treatment by a Physician.

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

Medically Necessary (or Medical Necessity) – Health care services, supplies or treatment that are required to identify or treat the illness or injury which a physician has diagnosed or reasonably suspects. To be medically necessary the service, supplies or treatment must be:

- * consistent with the diagnosis and treatment of the patient's condition
- * consistent with professionally recognized standards of health care;
- * not solely for the convenience of the patient, physician or supplier; and
- * performed in the least costly setting required by the patient's medical condition.
The fact that a physician may have prescribed, ordered, recommended, or approved the services, supplies or treatment does not necessarily mean that they satisfy the above criteria.

Mental Nervous Disorders - a condition diagnosed to be a Mental Illness and listed within diagnostic code numbers 290 to 302 and 306 to 319, inclusive of the International Classification of Diseases of the U.S. Department of Health and Human Services (ICD-9-CM, as amended or revised). Conditions included in the preceding diagnostic codes for which mental health treatment is received will be considered Mental Illness, regardless of the etiology of the patient's symptoms; i.e., even if symptoms are due to an organic (physical) cause, or are considered functional (non-physical) in origin.

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

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

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

Other Provider - the following entities, which are licensed where required, and provided their patients with covered services in exchange for compensation.

Other Professional Providers include only the following:

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

Other Provider Facilities include only the following institutions:

- * Alcoholism Treatment Facility - a facility which mainly provides detoxification and rehabilitation treatment for Alcoholism.
- * Day/Night Psychiatric Facility - a facility which is primarily engaged in providing diagnostic services and therapeutic services for the treatment of Mental Illness only during the day or during the night.
- * Dialysis Facility - a facility which mainly provides dialysis treatment, maintenance or training to patients on an Outpatient or home care basis.
- * Drug Abuse Treatment Facility - a facility which provides detoxification and rehabilitation treatment for Drug Abuse.
- * Home Health Care Agency - a facility which meets the specifications of Chapter 1739 of the Ohio Revised Code, except for the requirement that such institution be operated within the State of Ohio and which:
 - a. provides skilled nursing and other services on a visiting basis in the Covered Person's home; and
 - b. is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- * Outpatient Psychiatric Facility - a facility which mainly provides diagnostic services and therapeutic services for the treatment of Mental Illness on an Outpatient basis.
- * Psychiatric Hospital - a facility which is primarily engaged in providing diagnostic services and therapeutic services for the Inpatient treatment of Mental Illness. Such services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a registered nurse.

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

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

Physician - a person who is licensed to practice medicine, in all its branches; perform Surgery; and dispense drugs.

Plan – the Portage Area Schools Consortium Employee Benefit Plan.

Plan Administrator – Same entity as Plan Sponsor.

Plan Documents – the Plan’s governing documents and instruments (i.e., the documents under which the Plan was established and is maintained), including but not limited to this summary of benefits.

Post-Discharge Tests - Follow-up tests performed on you or your Dependent in a hospital after confinement as a resident inpatient provided:

1. such tests are ordered by the attending physician prior to the date you or your Dependent is discharged; and

2. such tests are performed within 7 days from the date you or your Dependent is discharged and must be related to the same condition for which you or your Dependent was confined.

PPO Network Provider - a Physician, Other Professional Provider, contracting Hospital or contracting Other Facility Provider which is included in a limited panel of Providers as designated by the Participating Network(s) and for which the greatest benefit will be payable when one of these Providers is used.

Pre-Admission Tests - Tests performed on you or your Dependent in a hospital prior to confinement as a resident inpatient provided:

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

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

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

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

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

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

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

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

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

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

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

Streetsboro City Schools shall not disenroll or eliminate coverage on such child until:

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

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

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

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

Reasonable and Customary - the term "Reasonable and Customary" refers to the designation of a charge as being the usual charge made by a Physician or other Provider of services and supplies, medication or equipment that does not exceed the general level of charges made by other providers rendering or furnishing such care or treatment within the same area. The term "Area" in this definition means a country or such other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances that require additional time, skill or expertise. Except where noted otherwise, if a PPO is utilized, the PPO allowance may become R&C for services rendered by a PPO Provider when the contracted rates exceed the Reasonable and Customary charge.

Recovered / Recovery - monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the injuries or illness whether or not said losses reflect medical or dental charges covered by this Plan.

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

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

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

Skilled Nursing Facility - other facility providers which mainly provides Inpatient skilled nursing and related services to patients requiring convalescent and rehabilitative care. Such care is given by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

1. minimal custodial, ambulatory, or part-time care; or
2. treatment for Mental Illness, Drug Abuse and Alcoholism or pulmonary tuberculosis.

Spouse – your legal Spouse (marriage between a man and a woman), provided you are not legally separated.

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

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

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

GENERAL PLAN INFORMATION

Plan Name: Portage Area Schools Consortium Employee Benefit Plan,
Streetsboro City Schools

Plan Sponsor: Portage Area Schools Consortium, Streetsboro City Schools
9000 Kirby Lane
Streetsboro, OH 44240
(330) 995-7704

Claims Administrator: Benefit Services, Inc.
3636 Copley Road
P.O. Box 4138
Akron, Ohio 44321
(330) 666-0337
1-800-367-3762

Plan Number: 501

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

Plan Year Ends: June 30

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