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PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

SOUTH CENTRAL OHIO INSURANCE CONSORTIUM HEALTH BENEFIT PLAN

FOR EMPLOYEES OF BLOOM CARROLL LOCAL SCHOOLS

MEDICAL BENEFITS

REVISED: JULY 1, 2024

NOTICE: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the Coordination of Benefits section, and compare them with the rules of any other plan that covers you or your family.

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TABLE OF CONTENTS

INTRODUCTION 1
SCHEDULE OF BENEFITS 3
ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS 7
OPEN ENROLLMENT 15
MEDICAL BENEFITS 16
COST MANAGEMENT SERVICES 24
DEFINED TERMS 27
PLAN EXCLUSIONS 33
PRESCRIPTION DRUG BENEFITS 37
HOW TO SUBMIT A CLAIM 39
COORDINATION OF BENEFITS 44
RECOVERY PROVISION 49
CONTINUATION COVERAGE RIGHTS UNDER COBRA 50
RESPONSIBILITIES FOR PLAN ADMINISTRATION 57
FUNDING THE PLAN AND PAYMENT OF BENEFITS 59
GENERAL PLAN INFORMATION 61

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

INTRODUCTION

This document is a description of South Central Ohio Insurance Consortium Health Benefit Plan (the Plan) for Employees of Bloom Carroll Local Schools – Medical Benefits. No oral interpretations can change this Plan.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

The Plan believes that it is a "grandfathered" health plan under the Patient Protection and Affordable Care Act ("Health Care Reform"). As permitted by Health Care Reform, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of Health Care Reform that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections under Health Care Reform such as the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document describes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Defined Terms. Defines those Plan terms that have a specific meaning.

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Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against or is being reimbursed by another party.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

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SCHEDULE OF BENEFITS

For verification of Eligibility please refer to the telephone number on the employees identification card.

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms, or other applicable section, of this document.

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

Hospitalizations
Durable Medical Equipment exceeding $2,000
Organ/Tissue Transplants Physical/Occupational Therapy in excess of 15 visits per Calendar Year
Drug Infusions & Injectables exceeding $1,250
All J-Codes exceeding $1,250

Note: It is recommended the following services be precertified:

Chemotherapy

Precertification does not have to be obtained from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Please see the Cost Management section in this booklet for details.

When a Covered Person uses a Network Provider, that Covered Person may receive a higher payment from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

- For any covered person who used the mental disorder/substance abuse benefit and is unable to access a Network provider, a Non-Network provider may be utilized, and the benefit will be paid at the In-Network level.
- For surgical removal of bony impacted teeth.

Deductibles/Copayments payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required. Deductibles do not accrue toward the maximum out-of-pocket pocket.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments do not accrue toward the maximum out-of-pocket.

MEDICAL BENEFITS SCHEDULE

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	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$250	$500
Per Family Unit	$500	$1,000
The Network Deductible amounts will be combined with the non-Network Deductible amounts.		
The Calendar Year deductible is waived for the following Covered Charges: - Preventive Care services - Emergency Room services - Network Urgent Care services - Network Office Visit charges		
COPAYMENTS		
Physician visits	$25	$35
Urgent Care Facility	$35	$45
Emergency room	$75	$75
The Emergency room copayment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator, should be notified at (614) 766-5800 within 48 hours (or 2 business days) of the admission, even if the patient is discharged within 48 hours (or 2 business days) of the admission.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
The Network Out-of-Pocket amounts will be combined with the Non-Network Out-of-Pocket amounts.		
Per Covered Person	$600	$1,000
Per Family Unit	$1,200	$2,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum: Deductible(s) Copayments Non-Precertification penalties Amounts over Usual and Reasonable Charges Non-Network Provider charges do not apply to the Network Provider out-of-pocket maximums Charges for Prescription Drugs obtained under the Prescription Drug Benefits section of this Plan. Amounts for products included in the ACMS Rx Assistance Program		
COVERED CHARGES		
Inpatient Hospital Services		
Room, Board, and Miscellaneous Expenses	80% after deductible	60% after deductible
Intensive Care Unit	80% after deductible	60% after deductible
Outpatient Hospital Services		
Surgical Facilities	80% after deductible	60% after deductible
Other Outpatient Services	80% after deductible	60% after deductible
Emergency Room Visit (including related services)	100% after copayment	Paid Same As Network
Urgent Care Facility (including related services)	100% after copayment	60% after deductible and after copayment
Skilled Nursing Facility	80% after deductible 31 day Calendar Year maximum	60% after deductible 31 day Calendar Year maximum
Physician Services		
Inpatient visits	80% after deductible	60% after deductible

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Office visits	100% after copayment	60% after deductible and after copayment
Surgery	80% after deductible	60% after deductible
Anesthesia	80% after deductible	Paid Same As Network
Second Surgical Opinion	80% after deductible	60% after deductible
Diagnostic Testing (X-ray & Lab)	80% after deductible	60% after deductible
Independent Laboratory Expenses	80% after deductible	Paid Same As Network
Radiology/Pathology Interpretation	80% after deductible	Pais Same As Network
Home Health Care	80% after deductible	60% after deductible
Private Duty Nursing	80% after deductible 30 day Calendar Year maximum	60% after deductible 30 day Calendar Year maximum
Hospice Care	80% after deductible	Paid Same As Network
Bereavement Counseling	2 visit Lifetime maximum	2 visit Lifetime maximum
Ambulance Service	80% after deductible	Paid Same As Network
Wig After Chemotherapy	80% after deductible $400 Lifetime maximum	60% after deductible $400 Lifetime maximum
Physical/Occupational Therapy	80% after deductible Visits exceeding 15 per Calendar Year must be precertified	60% after deductible Visits exceeding 15 per Calendar Year must be precertified
Speech Therapy 20 visit limit per Calendar Year	80% after deductible	60% after deductible
Spinal Manipulation/ Chiropractic	80% after deductible 15 visit Calendar Year maximum	60% after deductible 15 visit Calendar Year maximum
Mental Disorders/Substance Abuse	Paid based on the type of service(s) received.	
Preventive Care		
Routine Well Adult Care	100%	Paid Same As Network
Including, but not limited to: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory tests, immunizations/flu shots, colonoscopies, bone density scans, stress tests, sigmoidoscopies and services as required by law.		
Routine Well Child Care	100%	Paid Same As Network
Including, but not limited to: office visits, routine physical examination, laboratory tests, x-rays, immunizations/flu shots, and services as required by law.		
Eye Exam (Limited to 1 exam per Calendar Year)	100%	Paid Same As Network
Organ Transplants	Paid based on type of service(s) received.	
Other Medical Services and Supplies	80% after deductible	60% after deductible
Products included in the ACMS Rx Assistance Program	Requires enrollment in the ACMS Rx Assistance Program	

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PRESCRIPTION DRUG BENEFIT SCHEDULE

PRESCRIPTION DRUG BENEFIT	
	BENEFIT
Pharmacy Option (30 Day Supply)	
Generic Drugs	$10 copayment
Formulary Brand Name Drugs	$20 copayment
Non-Formulary Brand Name Drugs	$30 copayment
Specialty Pharmacy Services (30 Day Supply)	
Including injectables, other than insulin	$100 copayment, not to exceed $1,200 per Calendar Year Requires enrollment in the ACMS Rx Assistance Program
Mail Order Option (90 Day Supply)	
Generic Drugs	$20 copayment
Formulary Brand Name Drugs	$40 copayment
Non-Formulary Brand Name Drugs	$60 copayment
Refer to the Prescription Drug Section for details on the Prescription Drug benefit.	

Note: Prescription drug expenses under the Prescription Drug Benefit section do not apply to the Calendar Year Deductible or Maximum Out-of-Pocket Amount under the Medical Benefits section of this Plan.

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ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Claims Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. The following Classes of Employees:

(1) Active, full-time employees of the Employer who are regularly scheduled to work the number of hours specified in the applicable bargaining agreement or the Board Policy. Persons employed on a temporary, casual, or leased basis are not considered eligible for coverage in this plan.

No person may be covered under the SCOIC Member Employer Plan as an Employee of more than one Member Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) is in a class eligible for coverage.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse.

The term "Spouse" shall mean the person with whom covered Employee has established a valid marriage under applicable State law but does not include common law marriages. The term "Spouse" shall include an individual of the same sex as the covered employee, if they were legally married under the laws of a State or other foreign or domestic jurisdiction. The Plan Administrator may require documentation proving a legal marital relationship.

(2) A covered Employee's Child(ren).

An Employee's "Child" includes his natural child, stepchild, adopted child, or a child placed with the Employee for adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

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

This Plan will comply with provisions set forth in the State of Ohio budget passed in July 2009 which allows certain dependent children to remain on the Plan up to age 28. The Employee must request coverage under this provision from the Employer. Please refer to the Employer’s human resources representative for more information.

For Plan Years on and after July 1, 2016 the plan will provide coverage to dependent children of employees to age 26 and coverage will end on the last day of the child’s birthday month.

(3) A covered Employee's Qualified Dependents.

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The term "Qualified Dependents" shall include individuals who do not qualify as a Child as defined above, but who are children for whom the Employee is a Legal Guardian.

To be eligible for Dependent coverage under the Plan, a Qualified Dependent under the limiting age of 26 years. When a Qualified Dependent reaches the applicable limiting age, coverage will end on the last day of the month in which the Qualified Dependent ceases to meet the applicable eligibility requirements.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(4) A covered Dependent Child or Qualified Dependent who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country.

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

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse, Qualified Dependent or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. Bloom Carroll Local Schools shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be completed in a manner set forth by the Employer.

The level of any Employee contributions is set by the Employer. The Employer reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. The covered Employee is required to enroll for Dependent coverage, if he so chooses.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care and Physician care will be applied toward the Plan of the newborn child. If the

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newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

If the child is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment -** An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their eligible Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

Unless otherwise required by law, if an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her dependents (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days of the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Employer, Bloom Carroll Local Schools.

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period. The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) **Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) Either (i) the other coverage was COBRA coverage and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(d) The Employee or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(a) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example: part-time employees).

(b) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(c) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(d) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(3) **Acquiring a newly eligible Dependent may create a Special Enrollment right.** If:

(a) The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent may be enrolled under this Plan. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Special Enrollment Period for newly eligible Dependents is a period of 30 days and after the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 30-day period.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the date of the marriage;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(4) **Eligibility changes in Medicaid or State Child Health Insurance Programs may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

(1) The Eligible Classes of Employees/Dependents.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be

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offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The date the covered Employee's Eligible Class is eliminated.

(3) The day the covered Employee ceases to be in one of the Eligible Classes. This includes termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

(4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(5) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

(6) The date a covered Employee becomes a full-time member of the armed forces of any country, except as otherwise provided herein.

(7) The date an active covered Employee elects Medicare as the primary plan of benefits.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as specified in the appropriate bargaining agreement or the School Board Policy.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period. This includes the employee paying any required contributions.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements to the extent permitted by applicable law. However, if

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment waiting period.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's covered Dependents under such an election shall be the lesser of:

  (a) The 24 month period beginning on the date on which the person's absence begins; or

  (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Employer Bloom Carroll Local Schools. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason, except in the case of the Employee’s death. In the case of the Employee’s death, Covered Dependents may be covered to the end of the month in which the Employee’s death occurs. (See the section entitled Continuation Coverage Rights under COBRA.)

(3) The date a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) On the first date that a person ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)

(5) The date a covered Dependent becomes a full-time member of the armed forces of any country, except as otherwise provided herein. (See the section entitled Continuation Coverage Rights under COBRA.)

(6) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

(7) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

(8) The date an active Dependent elects Medicare as the primary plan of benefits.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

OPEN ENROLLMENT

During the open enrollment period (the month of September), covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

During the open enrollment period (the month of September), Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices made during the open enrollment period will become effective November 1st and remain in effect until the next November 1st, unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption), or loss of coverage due to loss of a Spouse's employment.

Benefit choice for Late Enrollees made during the open enrollment period will become effective November 1st.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.
Plan Participants will receive detailed information regarding open enrollment from their Employer.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits. This amount will not accrue toward the maximum out-of-pocket amount.

Deductible Three Month Carryover. Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next Calendar Year.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

Only one Calendar Year Deductible will apply to the mother and newborn child during the initial hospital confinement in which birth occurs. However, a separate deductible will apply to the newborn child if he is hospital confined following discharge of the mother, transferred to another hospital, or discharged and later re-admitted.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges excluded as shown in the Schedule of Benefits) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for any charges excluded, as shown on the Schedule of Benefits) for the rest of the Calendar Year.

COVERED CHARGES

Covered Charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits.

Coverage of Pregnancy. The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

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

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

(2) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility; and

(b) the attending Physician certifies that the confinement is needed for further care of the Illness; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

(3) **Physician Care.** The professional services of a Physician for surgical or medical services will be covered, including operative and cutting procedures when performed by a Physician acting within the scope of his license who is not an employee of the Hospital where the surgery is performed. Surgical sterilization—but not reversals of sterilization—, circumcision, and certain oral surgical procedures (including Medically Necessary Hospital admission and/facility charges) will also be covered, including:

- Surgical removal of fully impacted teeth
- Treatment rendered within 72 hours following an Injury to sound natural teeth
- Excision of tumors and cysts of the mouth and oral cavity

Note: The Case Manager may recommend a Second Surgical Opinion during a review process. Obtaining a Second Surgical Opinion is entirely voluntary on the part of the Covered Person.

With regard to services of an assistant surgeon, charges will be covered if provided by a Physician who is not a Hospital intern, resident, or employee and they are certified by the operating surgeon as medically necessary.

Reconstructive Surgery. Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

(4) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

A visit occurs each time a nurse visits a patient. Each four hours or less of private duty nursing services will be considered one visit.

(5) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

A visit occurs each time an employee of a Home Healthcare Agency visits the patient. Each four hours or less of home healthcare services will be considered one home healthcare visit.

(6) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or other covered Dependents). Bereavement services must be furnished within six months after the patient's death.

Charges for Bereavement counseling are subject to the limits as described in the Schedule of Benefits.

(7) **Other Medical Services and Supplies.** The Other Medical Services and Supplies include (but are not limited to) the following services. These services are covered as shown in the Schedule of Benefits under Other Medical Services and Supplies, unless otherwise listed individually as a separate benefit:

(a) Charges for professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest facility qualified to provide care, unless the Plan Administrator finds a longer trip was Medically Necessary. This includes a trip to a Skilled Nursing Facility from a Hospital when recommended by the attending Physician.

(b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(c) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a qualifying cardiac condition; and (c) in a Medical Care Facility as defined by this Plan.

(d) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included. Certain chemotherapy products may require pre-certification and enrollment in the ACMS Rx Assistance Program.

(e) Routine patient care charges for **Clinical Trials.** Coverage is provided only for routine patient care costs for a Qualified Individual in an approved clinical trial for treatment of cancer or other life-threatening disease or condition. For these purposes, a Qualified Individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing to the satisfaction of the Plan Administrator that the individual's participation in such trial would be appropriate. Coverage is not provided for charges not otherwise covered under the Plan, and does not include charges for the drug or procedure under trial, or charges which the Qualified Individual would not be required to pay in the absence of this coverage.

(f) **Diagnostic testing (X-ray & Lab).** Covered Charges for diagnostic x-ray and lab testing and services, including preadmission testing and radiology/pathology interpretation.

(g) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the purchase price, but only if agreed to in advance by the Plan Administrator.

(h) **Eye Exam.** Charges in connection for an eye exam (refractive or otherwise) limited as shown in the Schedule of Benefits.

(i) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome (TMJ)**.

(j) **Kidney dialysis.**

(k) **Medical supplies.** Casts, splints, trusses, orthopedic braces (but not orthopedic shoes or dental braces), crutches, surgical dressings, and similar items which serve a medical purpose.

(l) Treatment of **Mental Disorders and Substance Abuse**. Covered Charges for care, supplies, and treatment of Mental Disorders and Substance Abuse will be payable at the applicable benefit level for the specific services received as shown in the Schedule of Benefits.

Covered providers include Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.), as well as other Physicians performing within the scope of their license.

(m) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted teeth.

Reduction of dislocations and excision of temporomandibular joints (TMJs).

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(n) **Nutritional Counseling.** Nutritional Counseling with a registered dietitian or other health care professional specifically trained in nutrition, limited as follows:

- Three visits per Lifetime for the Covered Person newly diagnosed with Diabetes.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

- One visit per Lifetime as determined by Case Management for the Covered Person newly diagnosed with a specific qualifying condition.

(o) **Occupational therapy** by a licensed therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(p) **Organ transplant limits.** Charges for services and supplies provided in connection with organ and/or tissue transplant procedures, including bone marrow/stem cell transplants as outlined below:

Out-of-Network care will be considered at the In-Network level if the Case Management has coordinated the treatment.

Compatibility Tests for Potential Donors — All such diagnostic tests are payable on the same basis as the surgery outlined under "Donor Costs" below.

Donor Costs — Donor costs are only covered if the recipient is a Covered Person under the Plan.

Recipient Costs — When the recipient is a Covered Person, benefits are payable for recipient costs whether or not the donor is a Covered Person.

Organ and/or Tissue Acquisition — Benefits will be payable for Hospital standard acquisition costs (live donor or cadaver).

Travel and Lodging Expenses — The covered patient and one other individual (two individuals permitted for a minor child) are eligible for travel and lodging (not including food and drink) expenses to receive care at a Hospital in connection with the transplant procedure, subject to the following:

1) Total travel and lodging benefits will not exceed $10,000 per transplant.
2) The Hospital must be located at least 100 miles away (one way) from the patient's home.
3) The Case Manager must pre-approve all travel and lodging expenses.
4) Such expenses will be covered for a pre-transplant evaluation even if certification for the transplant is not deemed medically appropriate by the Case Manager.

Limitations — If the donor is <u>not</u> a Covered Person, benefits for donor costs are limited to those directly related to the transplant procedure itself, including complications, and do not include any medical care costs related to other treatment of the donor.

No benefits are payable for:

1) Donor transportation costs whether or not the donor is a Covered Person.
2) Artificial organs.
3) Any expenses in connection with any transplant procedure which is not in accordance with generally accepted professional medical standards, or for an Experimental or Investigative procedure which has not been proven successful and effective.
4) Any transplant procedure (recipient or donor) performed under a study, grant, or research program.

(q) The purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

(r) **Physical therapy** by a licensed therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

(s) **Prescription Drugs** which are administered through injections or infusion.

Note: All other prescription drugs must be obtained through the Prescription Drug Program.

(t) Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Standard Preventive Care shall be provided as required by applicable law if provided by a Network Provider. Standard Preventive Care for adults includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Screenings for: breast cancer, cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.
- Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
  - -Breastfeeding support, supplies, and counseling.
  - -Gestational diabetes screening.

Women's contraceptives, sterilization procedures, and counseling.

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness. Standard Preventive Care shall be provided as required by applicable law if provided by a Network. Standard Preventive Care for children includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:
  - -Diphtheria,
  - -Pertussis,
  - -Tetanus,
  - -Polio,
  - -Measles,
  - -Mumps,
  - -Rubella,
  - -Hemophilus influenza b (Hib),
  - -Hepatitis B,
  - -Varicella.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/

(u) The purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

(v) **Speech therapy** by a licensed therapist. Therapy must be ordered by a Physician and follow either: (i) surgery; (ii) an Injury; or (iii) a Sickness that includes Autism Spectrum Disorder..

Because not all speech therapy is covered, it is recommended that after the first visit a treatment plan be submitted to CareFactor for review.

(w) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.

(x) **Vision (orthoptic) therapy** is payable as shown in the Schedule of Benefits provided such therapy is Medically Necessary and performed by, or under the supervision of a Physician.

(y) **Autism Spectrum Disorder.** Includes:

- Speech and language therapy or occupational therapy performed by a licensed therapist, subject to benefit limits;
- Clinical therapeutic intervention provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform such services in accordance with a health treatment plan, twenty (20) hours per week;
- Mental or behavioral health outpatient services performed by a licensed psychologist, psychiatrist, or physician providing consultation, assessment, development, or oversight of treatment plans, thirty (30) visits per year.

The services must be prescribed or ordered by either a developmental pediatrician or a psychologist trained in autism.

Coverage also includes evidence-based care and related equipment prescribed or ordered by a licensed physician who is a developmental pediatrician or a licensed psychologist trained in autism who determines the care to be medically necessary, including any of the following:

- Clinical therapeutic intervention- therapies supported by empirical evidence, including, but not limited to, applied behavioral analysis, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the function of an individual and are provided by a certified Ohio behavior analyst, psychologist, professional counselor, social worker, or marriage and family therapist;
- Pharmacy care - medications prescribed by a licensed physician and any health-related services considered medically necessary to determine the need or effectiveness of the medications.
- Psychiatric care- direct or consultative services provided by a licensed psychiatrist.
- Psychological care - direct or consultative services provided by a licensed psychologist.
- Therapeutic care - services provided by a licensed speech therapist, occupational therapist, or physical therapist.

(z) **Gender Dysphoria Treatment.** Medically Necessary services for the treatment of gender dysphoria, subject to accepted medical clinical guidelines and medical policies.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

(aa) **Standard Patient Care.** Charges related to standard patient care costs incurred during participation in any stage of an eligible cancer clinical trial. Standard patient care costs include Covered Charge(s) for which benefits are typically provided for the treatment of cancer, including type and frequency of any diagnostic modality, absent a cancer clinical trial and not necessitated because of the cancer clinical trial to the drug manufacturer.

(bb) Charges associated with the initial purchase of a **wig after chemotherapy**.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

Please refer to the Employee ID card for the Cost Management Services phone number.

The provider, patient or family member must call this number to receive certification of certain Cost Management Services. This call should be made at least 7 Days in advance of services being rendered or within 48 hours (or 2 business days) after a Medical Emergency.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the maximum out-of-pocket amount.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

Hospitalizations
Durable Medical Equipment exceeding $2,000
Organ/Tissue Transplants Physical/Occupational Therapy in excess of 15 visits per Calendar Year
Drug Infusions & Injectables exceeding $1,250
All J-Codes exceeding $1,250

Precertification is also recommended for the following:

Chemotherapy

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.
Here's how the program works.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency inpatient basis or receives the other medical services listed above, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator **at least 7 Days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician should contact the utilization review administrator **within 48 hours (or 2 business days)** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan. If the Covered Person does not receive authorization as explained in this section for hospitalizations, the benefit payment will be reduced by 50% up to a maximum of $250. Physical and Occupational Therapy exceeding 15 visits per Calendar Year must be precertified or benefits will be denied.**

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.
A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

ACMS Rx Assistance Program means a Program where Plan participants must enroll in to receive coverage under the plan for Specialty Drugs and Orphan Drugs. All Participants seeking coverage for Specialty Drugs or Orphan Drugs, whether through the Medical Plan or Prescription Drug Plan, are required to enroll in the ACMS Rx Assistance Program. Plan Participants that choose not to enroll in the ACMS Rx Assistance Program are responsible for 100% of the cost of the Specialty Drug, Orphan Drug, or Gene or Cellular therapy.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

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

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Bloom Carroll Local Schools.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Essential Health Benefits include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental, Investigational or Unproven means any drug, medical device or procedure that:

- is not approved for use by the FDA;
- is not approved for the treatment of the specific condition;
- is the subject of an ongoing Phase I, II, III or IV clinical trial as defined by the National Institutes of Health (NIH);
- has documentation from peer reviewed literature which states that further research or trials are necessary to determine the safety or efficacy of the treatment; or
- is one that lacks scientific evidence in the peer reviewed literature demonstrating efficacy for the intended physical or mental condition.

Benefits may be payable for an Experimental & Investigational medication, device or procedure if the following criteria are met:

1. The drug, device or procedure is approved by the FDA for some illness or injury, AND
2. The drug, device or procedure has sufficient documentation in the peer reviewed literature which demonstrates efficacy and safety for the condition being treated, AND
3. The drug, device or procedure is currently being used within the medical community as a treatment for the proposed condition, AND
4. Other more conventional methods of treatment have been exhausted, AND
5. There is no clearly superior, non-investigational treatment alternative and there is a reasonable expectation that the treatment will be more effective than the non-investigational alternative, AND
6. The drug, device or procedure is not the subject of a Phase I or II clinical trial as defined by NIH, AND
7. There exists an evidence based support within the medical literature for the proposed treatment as outlined by the Agency for Healthcare Research and Quality (AHRQ) or the Cochrane reviews. For the treatment of cancer, there exists evidence based support present as published on the National Comprehensive Cancer Network (NCCN) or by the Association of Community Cancer Centers (ACCC) AND
8. No documentation exists in the peer reviewed literature that questions the safety or effectiveness for the use of the treatment for the condition being treated, AND
9. No documentation exists in the peer reviewed literature which suggests that further research or clinical trials are needed to establish safety or efficacy, AND
10. The drug, device or procedure is not otherwise excluded under the Plan.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Formulary/Preferred means a list of prescription medications of safe, effective therapeutic drugs specifically covered by this Plan.

Gene and Cellular Therapy Products are products included in the ACMS Rx Assistance Program, as defined by the Office of Tissues and Advanced Therapies (OTAT) of the US Food and Drug Administration.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved

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generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing inpatient diagnostic and therapeutic services at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission, the American Osteopathic Association, or other accreditation program approved by the Centers for Medicare and Medicaid Services; it maintains diagnostic and therapeutic facilities on the premises which are provided by or under the supervision of a staff of Physicians; and it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s). The Plan Administrator may accept accreditation of a Hospital by an organization other than those specifically listed, provided that the designation of an alternative accreditation body is consistently applied across institutions.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

- A facility operating legally as a rehabilitation facility for rehabilitative care.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

Illness means a bodily disorder, disease, physical sickness, Mental Disorder, or Substance Abuse disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Inpatient means a person who has been admitted to the hospital or other licensed facility for bed occupancy for purposes of receiving inpatient hospital services.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person. Changing to another option offered under the Plan or by the Employer will not create a new Lifetime maximum benefit.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body mass index exceeds the medically recommended level.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Orphan Disease: An orphan disease is defined as a condition that affects fewer than 200,000 people nationwide. This includes diseases as familiar as cystic fibrosis, Lou Gehrig's disease, and Tourette's syndrome, and as unfamiliar as Hamburger disease, Job syndrome, and acromegaly, or "gigantism."

Orphan Drug: An orphan drug is a pharmaceutical agent that has been developed specifically to treat a rare medical condition, the condition itself being referred to as an orphan disease. The FDA keeps a list of orphan drugs at their website. http:/www.accessdata.fda.gov/scripts/opdlisting/oopd

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home. For outpatient treatment that totals 48 hours or more, including any hours in observation or treatment room, shall be deemed an Inpatient stay.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means South Central Ohio Insurance Consortium Health Benefit Plan, which is a benefits plan for certain Employees of Bloom Carroll Local Schools and is described in this document.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Sickness is a Covered Person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, Custodial or educational care.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Specialty Drugs. A drug costing $1,250 or more per month that targets and treats specific complex conditions or illnesses (includes, but is not limited to: cancer, rheumatoid arthritis, multiple sclerosis, hepatitis C, and HIV/AIDS). Specialty Drugs require patient specific dosing and careful clinical management. Often these drugs are in the form of injected or infused Medicines. A Covered Person is encouraged to work with the ACMS Rx Assistance Program for covered drugs costing between $500 and $1249.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means the Covered Person is under the regular care of a Physician and is unable to perform any and every duty of his occupation and is not employed for wage or profit. In the case of a Covered Person who is not employed, “Totally Disabled” shall mean that he is unable to perform any of the normal activities of a person of like age and sex in good health.

Urgent Care Services means care and treatment for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

Usual and Reasonable Charge is the prevailing fee or fees most frequently accepted by providers of the same services with similar training and experience for comparable services, or services of comparable gravity, severity and magnitude, in the locality where the services were performed. The charge is established using historical data within a specific geographical area, supplemented by data provided by independent research firms that specialize in collecting this data. Updates are provided periodically. For Network charges, the Usual and Reasonable Charge is the fee set forth in the negotiated fee schedule. All charges shall be deemed to be incurred as of the date of the treatment that gives rise to the charge or as of the date of purchase of the supply or service covered by the charge.

The Claims Administrator will follow the prevailing and most commonly applied reimbursement rules and guidelines.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

PLAN EXCLUSIONS

Note: Additional exclusions related to Prescription Drugs are shown in the Prescription Drug Section.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Abortion.** Services, supplies care or treatment in connection with an abortion unless the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest.

(2) **Artificial Impregnation.** For artificial impregnation, including artificial insemination, in vitro fertilization, surrogacy, or freezing or storage of sperm, eggs, or embryos.

(3) **Complications of excluded treatments.** Care, services or treatment required as a result of complications from a treatment excluded under the Plan are not covered. Complications from a non-covered abortion are covered.

(4) **Cosmetic Surgery.** For Cosmetic Surgery, except as the result of an accidental Injury provided treatment begins as soon as medically possible following the date of the accident; due to surgical removal of tissue as a result of a cyst, tumor, or other carcinoma; or repair of congenital abnormalities of covered dependent children which results in improved physical function provided treatment begins as soon as medically possible after the date of the child's birth.

(5) **Court Ordered Care.** Charges for court-ordered care or voluntarily negotiated care to avoid incarceration or fines, except individual therapy, group therapy or partial hospitalization for mental health or substance abuse which is Medically Necessary.

(6) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance, Custodial Care or domiciliary care consisting chiefly of room and board.

(7) **Dental Care.** Care, services, or supplies for any dental care, except as specifically provided herein.

(8) **Educational or vocational testing.** Services for educational or vocational testing or training, except for services otherwise described herein.

(9) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(10) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational therapy, physical therapy, or as otherwise provided herein.

(11) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/ Investigational or not Medically Necessary, except for services otherwise provided herein.

(12) **Eye care.** Services related to eye surgery or other services to correct refractive disorders, including eyeglasses or contact lenses and exams for their fitting, and routine eye examinations (including refractions). This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages, the first pair of surgically implanted intra-ocular lenses after cataract surgery, or as otherwise described herein.

(13) **Foot care.** Charges incurred for foot care only to improve comfort or appearance, such as care for flat feet, subluxation, bunions (except capsular or bone surgery), corns calluses, and toenails, unless at least part of the nail root is removed or when needed because the patient has a metabolic or peripheral-vascular disease.

(14) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(15) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

(16) **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, except for one wig following chemotherapy or radiation therapy.

(17) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan.

(18) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(19) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring, directly or indirectly, as a result of a felonious illegal act or a riot or public disturbance. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(20) **Infertility.** Care, supplies and services for infertility, except for the initial tests to determine the diagnosis of infertility.

(21) **Miscellaneous.** Charges incurred for hypnosis; acupuncture or acupressure treatments, stand-by Physician or stand-by Anesthesia Services; vitamins, minerals, food supplements or food substitutes, except as otherwise provided herein or covered under the Prescription Drug Benefits section.

(22) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(23) **No obligation to pay.** Charges incurred for which the Participant has no legal obligation to pay.

(24) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(25) **Nutritional Therapy.** Nutritional supplements and therapies are not covered except for enteral and parenteral nutrition therapies when medically necessary. Medical necessity is determined on a case by case basis and the treatment plan and a detailed explanation of the medical necessity must be submitted to the Utilization Review Administrator for review and approval.

Not covered are:
a) Enteral tube feedings for individuals who are capable of adequate oral intake.
b) Food supplements, specialized infant formula, vitamins and/or minerals taken orally
c) Parenteral nutrition for individuals with a functioning gastrointestinal tract whose need for parenteral nutrition is only due to:

- swallowing disorder
- Temporary defect in gastric emptying
- psychological disorder
- hemodialysis
- Disorders inducing anorexia such as cancer
- Peritoneal dialysis [intraperitoneal amino acid (IPPA) supple-mentation for individuals on peritoneal dialysis may be considered if certain criteria are met]

(26) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

(27) **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, and first-aid supplies and nonhospital adjustable beds.

(28) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(29) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is otherwise provided herein or required by applicable law.

(30) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(31) **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, except as otherwise provided herein.

(32) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(33) **Tobacco cessation.** Care and treatment for tobacco cessation programs shall be covered to the extent required under Standard Preventive Care, including smoking deterrent products. Tobacco cessation care and treatment is otherwise excluded.

(34) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges and as otherwise provided herein.

(35) **War.** Any loss that is due to a declared or undeclared act of war.

(36) **Weight Loss.** For weight loss by diet control. Surgical treatment for obesity will not be covered unless a patient meets ALL of the following criteria:

a) The patient has had a diagnosis of morbid obesity for at least five years.

b) The patient has a body mass index (BMI) greater than or equal to 40 or a BMI greater than 35 with any of the following severe co-morbidities:

- Coronary heart disease
- Type 2 diabetes mellitus
- Hypertension
- Sleep apnea

c) The patient is over the age of 18.

d) The patient has been on a medically supervised weight loss and exercise program for 12 consecutive months prior to the surgery date and occurring within three years of the proposed surgery date. Medical supervision must occur under an M.D., D.O., N.P. or R.D. To review the medical necessity of the obesity surgery, all of the following documentation must be submitted for review:

- Description of the supervised dietary program
- Patient response to dietary program
- Documentation of the patient participating in an exercise program

e) Evaluation by a licensed psychologist or psychiatrist documenting the absence of significant

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

psychopathology that can limit a patient's ability to comply with the pre- and post-operative regimen.
f) Documentation that the patient is willing to comply with all pre- and post-operative treatment plans.

The Plan also excludes any reduction or removal of excess skin as a result of weight reduction (e.g. liposuction, panniculectomy, thigh/breast/arm reduction, etc.), regardless of the condition of the skin.

(37) **Workplace Clinic.** For services or supplies provided though a medical department, clinic, or other facility provided by or maintained by the Employer, or a medical clinic or similar facility for which services or supplies are or should be available without charge to the Covered Person.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

PRESCRIPTION DRUG BENEFITS

Definitions

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs.

Copayments/Coinsurance

The copayment is applied to each covered pharmacy drug charge and is shown in the schedule of benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one pharmacy prescription is limited to a 30-day supply and any Retail 90 pharmacy prescription is limited to a 90 day supply. Any one mail order prescription is limited to a 90-day supply.

Retail 90

Retail 90 allows Covered Person to receive a 90-day supply of maintenance medication through a participating retail pharmacy. The Plan will pay the full cost after the Covered Person pays the applicable copayment shown in the Schedule of Benefits. The copayment/coinsurance must be made at the time of purchase.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.).

Covered Prescription Drugs

(1) Drugs prescribed by a Physician that require a prescription either by federal or state law. This excludes any drugs stated as not covered under this Plan.

(2) Compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies when prescribed by a Physician.

(4) Injectable drugs.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

ACMS Rx Assistance Program

The Plan requires that Plan Participants needing Specialty Drugs, Orphan Drugs, or Gene or Cellular Therapy, through either the Medical Benefit or Prescription Drug Benefit, to enroll in the ACMS Rx Assistance Program. The ACMS Rx Assistance Program provides advocacy and cost containment options to assist Plan participants and reduce the cost of Specialty Drugs and Orphan Drugs. Plan Participants that choose not to enroll in the ACMS Rx Assistance Program are responsible for 100% of the cost of the Specialty Drug, Orphan Drug, or Gene or Cellular therapy.

Pre-Authorization

Many prescription drugs can be prescribed for both medical and non-medical purposes. To assure that the Plan pays benefits for these drugs only when prescribed to treat medical conditions, pre-authorization may be required. In addition, certain drugs may require pre-authorization with age limitations or after certain quantities.

If a Physician prescribes a medication that requires pre-authorization, the Covered Person or Physician should contact the Pre-authorization Department of the Prescription Benefit Manager. If approved, purchase of the drug will be authorized for a period of up to one year. If the drug is required for longer than one year, a new pre-authorization must be obtained each year.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressant or dietary supplements.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(5) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(6) **FDA.** Any drug not approved by the Food and Drug Administration.

(7) **Immunization.** Immunization agents or biological sera.

(8) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined.

(9) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(10) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(11) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(12) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or to over the counter drugs that are prescribed by a Physician as required for Standard Preventive Care.

(13) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

(14) **Vitamins.** Amy charges for vitamins or vitamin supplements, except for prenatal vitamins requiring a prescription.

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HOW TO SUBMIT A CLAIM

PROCEDURE FOR CLAIMING BENEFITS UNDER THE PLAN

All Out-of-Network claims submitted within the timely filing period should be submitted directly to the Claims Administrator. Network providers will submit their expenses directly to the Network. The Covered Person's health plan identification card indicates to providers and Covered Persons how to file a claim.

Note: ***Cancelled checks, balance-due statements, photocopies, faxes, handwritten claims and payment receipts do not contain sufficient information to meet claim-filing requirements and cannot be accepted.***

Complete and current information must be provided for:

1) **Accident or Injury Claims** — Explain how, when and where the Injury occurred and whether any other party was involved or responsible for the accident.
2) **Other Coverage** — List the name, address and telephone number of any other coverage or payer that may provide coverage, including, but not limited to, COBRA, Medicare and any other benefit plan.
3) **Prescription Drugs** — If the Plan has a pharmacy Network indicated on the Covered Person's health plan identification card, present the card when filling a prescription and pay any required co-payment. If the prescription is rejected at the pharmacy or through a mail-order drug program, if applicable, the Covered Person or the pharmacist should call the telephone number for the drug program shown on the health plan identification card for an explanation. If still not resolved, the Covered Person may file a written claim for benefit consideration. In the event the claim is denied, an explanation will be sent to the Covered Person in writing. The Covered Person has 180 days in which to file a written appeal and the Plan will respond in writing within 60 days.

If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim.

If a Covered Person or provider needs help filing a claim or information on the benefits provided under the Plan, he may contact the telephone number listed on the Covered Person's health plan identification card and speak with a Customer Service Representative.

All days mentioned in the previous section refer to "calendar days." All claims for benefits must be submitted within 365 days from the incurred date of service to be eligible for benefits under this Plan.

The Plan is authorized to make payments directly to Providers who have performed Covered Services for you. The Plan also reserves the right in some circumstances to make payment directly to you in the event you receive Covered Services from a Non-Network Provider. When this occurs, you must pay the Provider the amounts you may owe to the Provider. You cannot assign your right to receive payment to anyone else, nor can you authorize someone else to receive your payments for you, including your Provider.

DECISION ON SUBMITTED CLAIMS/PRE-AUTHORIZED SERVICES

Claims for benefits are defined as Pre-Service Claims or Post-Service Claims. Response time may vary according to the type of claim. Pre-Service Claims may be considered "urgent" or "concurrent." An Adverse Benefit Determination includes any decision to deny, reduce, terminate or refuse payment and includes eligibility denials and utilization review decisions. Upon written request, the Plan must explain any internal rules, guidelines or protocols, as well as disclose names of medical professionals who were consulted in the review process.

Pre-Service Claim: A Pre-Service Claim requires the Covered Person to pre-certify, notify or receive approval prior to receiving treatment. The Utilization Review Manager must give notice of the decision no later than 15 days after the request for services, with one 15-day extension permitted. An extension is permitted only for reasons beyond control of the Plan and requires the Covered Person be given written notification before the first 15-day period ends.

Urgent Claim: An urgent claim is any claim for medical care or treatment in which the Covered Person's health or life is seriously jeopardized without treatment or which would subject the patient to severe pain if treatment were

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delayed, as certified by a Physician. The Utilization Review Manager must respond to an urgent claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim.

Concurrent Claim: A concurrent claim is any claim that requires the approval of an ongoing course of treatment to be provided over a period of time or number of treatments (an example of a concurrent claim is physical therapy treatment). If the care is urgent, the Plan must respond to the Covered Person within 24 hours. When approved, if services are to be rendered over an extended period of time, the Covered Person shall be entitled to a review prior to reduction or termination of benefits.

Post-Service Claim: A Post-Service Claim is any claim that is not a Pre-Service Claim. Timely claim filing begins when the Claims Administrator receives a claim with re-priced information from any participating Network, if applicable. The Plan must give notice of approval within 30 days after a Post-Service Claim is received. A Post-Service Claim also allows a 15-day extension for reasons beyond Plan control if proper notice is given prior to the end of the first 30-day period.

No legal action for recovery of benefits allegedly due under any Company Sponsored benefit plan may be commenced by or on behalf of an employee or former employee against the Plan, the Plan Administrator, the Trustee, or successor of the same unless it is filed within one year after the date of the final determination noted in the appeals procedure of the relevant benefit Plan Document.

INCOMPLETE CLAIMS

Urgent Claims: If an urgent claim fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan shall notify the claimant as soon as possible, but not later than 24 hours following receipt of the incomplete claim, of the specific information necessary to complete the claim. The notification may be made orally to the claimant, unless the claimant requests written notice and it shall describe the information necessary to complete the claim. The claimant must submit the requested information as soon as possible, but not later than 48 hours after the claimant receives notice from the Plan of the incomplete claim. The Plan shall decide the claim as soon as possible but not later than 48 hours after the earlier of (a) receipt of the specified information, or (b) the due date for the requested information.

Pre-Service: If a Pre-Service Claim fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the claim will be treated as an incomplete claim and the Plan will notify the claimant that additional information is needed to process the claim. The notice shall include a description of the missing information and shall provide the claimant no more than 45 days in which the necessary information must be provided. The timeframe for deciding the claim shall be suspended from the date the notice is received by the claimant until the date the missing necessary information is provided to the Plan. If the requested information is provided, the Plan shall decide the claim no later than 15 days after the missing information is received by the Plan. If the requested information is not provided, the claim may be decided without such information.

Post-Service: If a Post-Service Claim fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the claim will be treated as an incomplete claim and the Plan will notify the claimant that additional information is needed to process the claim and it will be denied. The notice shall include a description of the missing information and shall provide the claimant no more than 180 days in which the necessary information must be provided. If the requested information is provided, the Plan shall decide the claim no later than 15 days after the missing information is received by the Plan.

ADVERSE BENEFIT DETERMINATIONS AND APPEAL PROCEDURES

If a benefit is denied, in whole or in part, it is considered an Adverse Benefit Determination, as defined. With the exception of Urgent Claims and Concurrent Claims, the Plan utilizes a two-level appeals process for all Adverse Benefit Determinations. Urgent Claims and Concurrent Claims are subject to a single level appeal process only. When an Adverse Benefit Determination is made, the claimant will receive written or electronic notification of the following:

1) The specific reason(s) for the Adverse Benefit Determination
2) Reference to relevant Plan provisions used in making the determination

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3) A description of additional information necessary for the claimant to perfect the claim and an explanation of why the additional information is necessary
4) A description of the Plan's appeal procedures applicable to the claim, including any applicable time limits
5) If the Adverse Benefit Determination reflected was based upon an internal rule, guideline or protocol, a copy of the rule, guideline or protocol will be provided free of charge upon written request. In addition, if the determination was based on a limitation or exclusion that the treatment was experimental or not medically necessary, an explanation of the scientific or clinical judgment relied upon will be sent free of charge upon written request
6) In the case of an Urgent Care Claim, an explanation of the expedited review methods available for such claims. Notification of the Plan's adverse decision on an urgent care claim may be provided orally, but written notification shall be furnished no later than three (3) days after the oral notice.

First-Level and Second-Level Appeals

If the Covered Person (or the Covered Person's authorized representative) is dissatisfied with a benefit determination, he has 180 days following receipt of an Adverse Benefit Determination to submit a written first-level appeal to the Plan Sponsor. Products included in the ACMS Rx Assistance Program are automatically submitted for First-Level benefit reconsideration.

Urgent Claims: If an appeal relates to an Urgent Care Claim, the Covered Person will be notified of the benefit determination on review as soon as possible, but not later than 72 hours after receipt of the appeal request. There is only one-level of appeal for Urgent Claims.

Pre-Service Claim: If a first-level appeal relates to a non-urgent Pre-Service Claim, the Covered Person will be notified of the benefit determination on appeal not later than 15 days after receipt of the first-level appeal request. The notice of the decision will be in writing. If the Covered Person's first-level of appeal is denied in whole or in part, the Covered Person will be notified in writing of the specific reasons for the decision, as outlined above. The Covered Person has 180 days to submit a second-level appeal after receiving notice of the decision. The Covered Person will be notified of the benefit determination on the second level-appeal not later than 15 days after receipt of the second-level appeal request.
Post-Service Claim: If a first-level appeal relates to a Post-Service Claim, the Covered Person will be notified of the benefit determination on appeal not later than 30 days after receipt of the first-level appeal request. If a medical professional was consulted for the initial denial, then an independent reviewer must be used for the appeal. If the Covered Person's first-level appeal is denied in whole or in part, the Covered Person will be notified in writing of the specific reasons for the decision, as outlined above. The Covered Person has 180 days to submit a second-level appeal after receiving notice of the decision. The Covered Person will be notified of the benefit determination on the second-level appeal not later than 30 days after receipt of the second-level appeal request.

The "Definitions" section contains definitions for Adverse Benefit Determination, Urgent Care Claim, Pre-Service Claim and Post-Service Claim.

As part of the appeal process, a full and fair review of each claim will be provided on an unbiased basis. Any individual involved in the initial determination may not participate in an appeal of the initial determination. Documents and other information relating to the claim may be submitted.

Upon written request (and free of charge), reasonable access to the Plan's Documents and information relevant to the appealed claim will also be provided. The Claims Administrator will review this report and a written report will be sent to the Plan Administrator. The Plan Administrator's decision on the appeal will be final, binding and conclusive and will be afforded maximum deference permitted by law. All appeal procedures specified in the Plan must be exhausted before any legal action is filed. No legal action can be filed more than two years after the decision on appeal.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

EXTERNAL REVIEW PROCESS (STATE OF OHIO)

Standard External Review Procedures

A Covered Person may make a written request to the Plan for an external review no later than one-hundred eighty (180) days after the date in which a Covered Person receives notice of the final internal adverse benefit determination.

A Covered Person shall have the right to an external review provided:

(a) The denial involves a medical judgment or is based on medical information (i.e., determined not to be medically necessary); or
(b) the denial indicates that the service is experimental or investigational and the treating physician certifies one of the following: (i) standard health care services have not been effective; (ii) standard health care services are not medically appropriate; and (iii) there is no available standard health care services covered by the plan that are more beneficial than the requested service; or
(c) denial is based on a contractual issue not involving a medical judgment or medical information; or
(d) denial indicates that emergency services did not meet definition of emergency and the decision has been upheld through external review by an independent review organization ("IRO"); and
(e) The Covered Person has exhausted the Plan's internal appeal process.

If the Plan denies an external review request due to failure to exhaust the Plan's internal appeals process, the Covered Person may request an explanation and the Plan shall provide an explanation no later than ten (10) days after the request. The Covered Person may request review by the Ohio Department of Insurance of the Plan's explanation. If the Ohio Department of Insurance affirms the Plan's explanation, the Covered Person may re-submit and pursue the Plan's internal appeal process no later than ten (10) days after the Covered Person receives notice from the Ohio Department of Insurance.

Immediately following the date of receipt of the external review request, the Plan must complete a preliminary review of the request to determine whether the request is complete and eligible for external review. Immediately after completion of the preliminary review, the Plan must issue a notification in writing to the Covered Person of whether the claim is complete and is eligible for external review.

If a request for an external review is complete, but not eligible for external review, the Plan must issue a notification in writing to the Covered Person stating the reasons for the ineligibility and informing the Covered Person that the denial may be appealed to the Ohio Department of Insurance. If the Ohio Department of Insurance determines that the request is eligible for external review, the request shall be referred for external review.

If a request for an external review is incomplete, the Plan must issue a notification in writing to the Covered Person that describes the information or materials needed to complete the request.

If a request for an external review is complete (and the Covered Person is entitled to exercise that option), the Plan must immediately initiate the external review process. The Plan must forward all documents and related information used in making the final adverse benefit determination to the Ohio Department of Insurance or IRO within five (5) days after the external review is requested.

The IRO will provide written notice to the Covered Person, to the Ohio Department of Insurance and to the Plan of the final external review decision with thirty (30) days after the IRO receives the request for the external review. If an IRO reverses the Plan's decision, the Plan must immediately provide the requested coverage or pay the claims at issue.

The IRO's notice will contain:

(a) A general description of the reason for the external review, including information sufficient to identify the claim;
(b) The date the IRO received the assignment to conduct the external review, the date the external review was conducted and the date of the IRO's decision;
(c) References to the evidence or documentation the IRO considered in reaching its decision;
(d) A discussion of the principal reason(s) for the IRO's decision, including what, if applicable, evidence-based

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

standards were a basis for its decision and the rationale for its decision.

Expedited External Review Procedures

A Covered Person may request an expedited external review at the time the Covered Person receives:

(a) An initial adverse benefit determination if (i) the treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the Covered Person if treatment is delayed until after the time of expedited internal appeal or standard external review and (ii) the Covered Person requests an expedited internal review; or
(b) A final internal adverse benefit determination if (i) the treating physician certifies that adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function if treated after the time period for a standard external review or (ii) the final adverse benefit determination concerns an admission, availability of care, continued stay or health care service for which the Covered Person received emergency services, but has not yet been discharged.

Immediately upon receipt of a request for an expedited external review, the Plan must determine whether the request satisfies the reviewability requirements, described above, for a standard external review and immediately send a notice of the Plan's eligibility determination.

If the Plan determines that the claim is eligible for an expedited external review:

(a) The Plan must immediately initiate the external review process;
(b) The Plan must immediately provide all necessary documents and information to the IRO in an expeditious manner (e.g., e-mail, fax, phone);
(c) The IRO must consider the following in reaching its decision, to the extent the information or documents are available and to the extent the IRO considers them appropriate:

  (i) The Covered Person's medical records;
  (ii) The attending health care professional's recommendation;
  (iii) Consulting reports from the appropriate health care professionals and other documents submitted by the health carrier, Covered Person or Covered Person's treating physician;
  (iv) The terms of coverage under the Plan;
  (v) The most appropriate practice guidelines, which shall include evidence based standards, and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards and associations;
  (vi) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse benefit determinations; and
  (vii) The opinion of the IRO's clinical reviewers after considering (i) – (vi), above, to the extent the information and documents are available and the clinical reviewer(s) consider appropriate.

The IRO must provide a notice of the final external review decision as expeditiously as the Covered Person's medical condition or circumstance require, but in no event more than 72 hours after the IRO receives the request for an expedited external review.

An expedited external review may be requested by a Covered Person by oral or by electronic means. If made by oral or electronic means, the Covered Person must provide written confirmation of the request to the Plan not later than five (5) days after the initial request was made.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

COORDINATION OF BENEFITS

The Coordination of Benefits provision applies when a person has health care coverage under more than one Plan. "Plan" for the purpose of the Coordination of Benefits provisions is defined below.

This Plan has been designed to help meet the cost of Illness or Injury. The amount of benefits payable under this Plan will take into account any coverage under other Plans and be coordinated with the benefits of the other Plans. The objective is to make sure the combined payments of all Plans are no more than your actual expenses.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

This Plan will always pay either its regular benefits in full if it is determined to be the Primary Plan (Plan primarily responsible for payment) or, if the Plan is determined to be the Secondary Plan, a reduced amount which, when added to the benefits payable by the Primary Plan, will equal no more than the Allowable Benefit under This Plan.

When you or your family members are covered by another group Plan in addition to this one, This Plan will follow Ohio Coordination of Benefits rules to determine which Plan is the Primary Plan and which Plan is the Secondary Plan. You must submit all bills first to the Primary Plan. The Primary Plan must pay its full benefits as if you had no other coverage. If the Primary Plan denies the claim or does not pay the full bill, you may then submit the balance to the Secondary Plan.

This Plan pays for health care only when you follow This Plan's rules and procedures. If This Plan's rules conflict with those of another Plan, it may be impossible to receive benefits from both Plans, and you will be forced to choose which Plan to use.

DEFINITIONS

Plan. For purposes of the Coordination of Benefits provisions, the term Plan includes any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no Coordination of Benefits among those separate contracts.

Plan includes: group and nongroup insurance contracts, health insuring corporation contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; some supplemental coverages; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplemental policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage above is a separate Plan. If a Plan has two parts and Coordination of Benefits rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan. "This Plan" means the part of healthcare Plan offered by the Employer providing the health care benefits to which the Coordination of Benefits provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one Coordination of Benefits provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another Coordination of Benefits provision to coordinate other benefits.

The "order of benefit determination rules" (see below) are used to determine whether This Plan is a primary Plan or a secondary Plan when a person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

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

The following are examples that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.

2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursements or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

4. The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

5. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary Plan to determine its benefits.

Custodial Parent. The parent awarded custody by a court decree, or in the absence of a court decree, is the parent with whom the child resides for more than one half of the calendar year excluding any temporary visitation.

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

ORDER OF BENEFIT DETERMINATION RULES – Which Plan is Primary?

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

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

B. Except as provided in Paragraph C. below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

C. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written

in connection with a Closed Panel Plan to provide out-of-network benefits.

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

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

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

2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan, the order of benefits is determined as follows:

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

(1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(2) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan;

(3) However, if one spouse's Plan has some other coordination rule (for example a "gender rule" which says that the father's Plan is always primary), the rules of that Plan will be followed.

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

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage, and the Plan of that parent has actual knowledge of those terms, the Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(2) If a court decree states that: (a) both parents are responsible for the dependent child's health care expenses or health care coverage, or (b) the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a. above shall determine the order of benefits; or

(3) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) The Plan covering the custodial parent;

(b) The Plan covering the spouse of the custodial parent;

(c) The Plan covering the non-custodial parent; and then

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(d) The Plan covering the spouse of the non-custodial parent.

c. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of subparagraphs a. or b. above shall determine the order of benefits as if those individuals were the parents of the child.

3. Active Employee or Retired or Laid-Off Employee. The Plan that covers a person as an active employee is the Primary Plan. The Plan covering the same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule regarding dependents and non-dependents can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person, whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law, is covered under another Plan, the Plan covering the person as a employee, member, subscriber or retiree, or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or other continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the rule regarding dependents and non-dependents can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is the Primary Plan and the Plan that covered the person for the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

7. With regard to any Covered Person eligible to elect Medicare, except an actively-at-work eligible employee age sixty-five (65) or older, or an eligible covered dependent spouse of an active eligible employee who is within the same age bracket, Medicare benefits will be considered as having been paid whether or not the Covered Person has applied for Medicare coverage or submitted a claim for Medicare benefits. It is the Covered Person's responsibility to apply for and maintain Parts A, B and D of Medicare coverage. If Medicare is elected primary, Medicare requires that This Plan not provide any benefits that supplement Medicare for active employees for whom coverage under This Plan would be primary to Medicare if such coverage were elected.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for the claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage. This Plan will not pay more than it would have paid had it been the Primary Plan.

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

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RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these Coordination of Benefit rules and to determine benefits payable under This Plan and other Plans. The Claims Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Claims Administrator any facts it needs to apply these rules and determine benefits payable.

PAYMENT TO OTHERS / RIGHT OF RECOVERY

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, the Claims Administrator may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. The Claims Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services. If the amount of the payments made by the Claims Administrator is more than it should have paid under these Coordination of Benefits provisions, the Claims Administrator may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION DISPUTES

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting the Claims Administrator:

CareFactor
8760 Orion Place Suite 204
Columbus, Ohio 43240
(614) 766-5800
www.mycarefactor.com (website).

Additional claims information may be found under the heading "Claims Procedures-Adverse Benefit Determinations and Appeal Procedures".

If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Ohio Department of Insurance website at http://insurance.ohio.gov.

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RECOVERY PROVISION

INTRODUCTION

The Plan has the right to recover in full the medical benefits (and disability benefits if provided by the Plan) paid for injuries caused by the act or omission of any party. The Plan's right of recovery, as explained below, may be from the Covered Person, the third party, any liability or other insurance covering the third party, the Covered Person's own uninsured motorist benefits, underinsured motorist benefits or any medical pay or no-fault benefits which are paid or payable to the Covered Person from any source whatsoever. The Plan's right to any monies recovered (through either reimbursement or subrogation) takes priority over any other party's right (including that of the Covered Person) to monies recovered, regardless of whether the amount recovered constitutes a partial or full recovery of the benefits paid by the Plan.

RIGHT OF REIMBURSEMENT

To the extent of the payment of benefits by the Plan, the Covered Person shall reimburse the Plan from money recovered by or on behalf of the Covered Person from any source, including, but not limited to, any third party, any liability or other insurance covering the third party, the Covered Person's own uninsured motorist benefits, underinsured motorist benefits or any medical pay or no-fault automobile benefits. The Covered Person's obligation to make restitution to the Plan applies whether the Covered Person has received partial or complete recovery and whether or not the Covered Person is made whole. Accordingly, the Plan hereby expressly disclaims the make-whole doctrine.

Out of the first payment(s) or recovery of compensation or benefits by a third party, the full amount of compensation benefits paid by the Plan must be repaid to the Plan, regardless of the ultimate amount of any recovery, up to and including the amount that such payment(s) or recovery equals the amounts paid by the Plan. The Plan's right of reimbursement is a first-priority right to monies recovered by the Covered Person by way of any settlement of the Covered Person's claim, a judgment in any court proceeding or otherwise. The Plan's recovery rights shall apply to any funds, regardless of how these funds were categorized. Any amounts recovered by the Covered Person shall be held in trust for the exclusive benefit of the Plan, until the Plan's rights, as set forth in this section, have been fully resolved.

The Plan will not pay or share in any attorneys' fees, expenses or costs associated with any claim or lawsuit brought by or on behalf of any Covered Person. Specifically, the Plan does not permit a deduction in any amount to which it is subrogated or to which it is entitled to reimbursement for attorneys' fees, costs or expenses expended by or on behalf of a Covered Person to obtain a settlement, payment, judgment or other recovery.

SUBROGATION

Whether or not the Covered Person pursues recovery from the liable third party or the Covered Person's individual policies, the Plan is subrogated to the rights of the Covered Person and may pursue the claim on its own. The Plan's right to subrogation applies regardless of whether the Covered Person has received partial or complete recovery and regardless of whether or not the Covered Person has been made whole. The Covered Person agrees to cooperate with the Plan's representative who is pursuing the subrogation recovery. The Plan may, but is not obligated to, take legal action against the third party, any liability insurer covering the third party or the Covered Person's own insurer to recover the benefits the Plan has paid. The Covered Person's failure to comply with the requirements of this section may, at the Plan Administrator's discretion, result in a forfeiture of benefits under the Plan.

IN GENERAL

The Covered Person further agrees that he will not release any third party or his insurer without prior written approval from the Plan and will take no action that prejudices the Plan's recovery right. The Covered Person agrees to include the Plan's name as a co-payee on any settlement check. The Covered Person agrees to refrain from characterizing any settlement in any manner so as to avoid repayment of the Plan's recovery lien.

Payment of any claims to or on behalf of the Covered Person may be delayed, withheld or denied unless the Covered Person cooperates fully and enters into any requested reimbursement/subrogation agreement.

The Covered Person is obligated to inform his attorney of the right of reimbursement/subrogation lien and to make no distributions from any settlement or judgment which will in any way result in the Plan receiving less than the full amount of its lien without the written approval of the Plan.

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CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under South Central Ohio Insurance Consortium (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Employer is Bloom Carroll Local Schools. COBRA continuation coverage for the Plan is administered by CareFactor, 8760 Orion Place Suite 204, Columbus ,Ohio 43240, (614) 766-5800. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

There may be other options available when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, Spouse, or Dependent child of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not

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a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993, as amended ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

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- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the Employee,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below

Bloom Carroll Local Schools

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement.**

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan.

(5) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. South Central Ohio Insurance Consortium Health Benefit Plan is the benefit plan of South Central Ohio Insurance Consortium (SCOIC), the Plan Administrator also called the Plan Sponsor. An individual or committee may be appointed by SCOIC to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, SCOIC shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage,

Docusign Envelope ID: 15E3E8AF-160C-408A-A4B0-7C4B006BD75C

provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

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(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

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CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

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GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

South Central Ohio Insurance Consortium Health Benefit Plan

PLAN NUMBER: n/a

TAX ID NUMBER: 311770705

PLAN EFFECTIVE DATE: Revised July 1, 2024 (originally established January 1, 2007)

PLAN YEAR ENDS: June 30th

EMPLOYER INFORMATION

Bloom Carroll Local Schools
5420 Plum Road NW
Carroll, Ohio 43112

PLAN ADMINISTRATOR

South Central Ohio Insurance Consortium
c/o Bloom Carroll Local Schools
5420 Plum Road NW
Carroll, Ohio 43112

CLAIMS ADMINISTRATOR

CareFactor
8760 Orion Place Suite 204
Columbus, Ohio 43240
(614) 766-5800

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BY THIS AGREEMENT, South Central Ohio Insurance Consortium Health Benefit Plan for Employees of Bloom Carroll Local Schools – Medical Benefits is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Bloom Carroll Local Schools on or as of the day and year first below written.

Signed by:

By Travis Bigam
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Bloom Carroll Local Schools

Date 10/1/2024