



STARK COUNTY SCHOOLS

**Comprehensive Major Medical (CMM)
Preferred Provider Organization (PPO)
Dental Coverage
Prescription Coverage
Vision Coverage**

HEALTH BENEFITS PLAN

for

**STARK COUNTY SCHOOLS
COUNCIL OF GOVERNMENTS**

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Section I

Introduction

It has always been the intent of Stark County Schools to provide its Employees with the most comprehensive health care plan available at a reasonable price.

In order to utilize your premium dollars to the best advantage and secure prompt, efficient claims service, Stark County Schools has elected to "Self-Fund" your health Plan and retain Medical Mutual Services Company of Cleveland, Ohio and AultCare to perform the necessary claims processing and administrative services.

Summary Plan Description

This booklet provides you with a "Summary Plan Description" of your new Health Benefit Plan.

You will notice that a brief description of your benefits is provided for your convenience. Should you have further or more detailed questions regarding the Plan, you are urged to contact your Plan Administrator.

Section II

Schedule of Benefits

Traditional Comprehensive Major Medical Schedule of Benefits (CMM)

(not available to new enrollees after 8/1/09)

Overall Lifetime Maximum Benefits.....	Unlimited
Calendar Year Deductible Amount (p.21)	
Individual.....	\$100.00
Family	\$200.00
Co-payment (after the deductible is satisfied) (p.22)	80%
Calendar Year Maximum Out of Pocket Amount (p.22)	
Individual.....	\$500.00
Family	\$1,000.00
(maximum out of pocket excludes the deductible)	

After the deductible has been met, the following are considered a Covered Expense each calendar year:

- One Routine Pap Test
- One Routine Mammogram
- One Routine Prostate Screening
- \$1,000 Maximum for Well-Child Care (to age 9)
- Colon Cancer Screening

Outpatient Psychiatric Treatment (not biologically based mental illness)

Calendar Year Maximum 15 visits per year
(covered under medical after 7-1-2010)

Outpatient Substance Abuse Treatment (not biologically based mental illness)

Calendar Year Maximum 15 visits per year
(covered under medical after 7-1-2010)

Inpatient psychiatric and substance abuse care is limited to 31 days per calendar year. (covered under medical after 7-1-2010)

Biologically Based Mental Illness Services – Any applicable Deductible, Coinsurance or Copayment corresponds to the type of service received and is payable on the same basis as any other illness.

Preferred Provider Organizations (PPO)

Schedule of Benefits

Overall Lifetime Maximum Benefits..... Unlimited

Calendar Year Deductible Amount

	In Network	Out of Network
Individual	\$100.00	\$200.00
Family	\$200.00	\$400.00

Calendar Year Out of Pocket Amount

	In Network	Out of Network
Individual	\$ 500.00	\$1,000.00
Family	\$1,000.00	\$2,000.00

Co-payment (after the deductible is satisfied) (p.22).....	90%	80%
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PREVENTIVE CARE

Routine Physical Exam	100% up to \$200 per calendar year	Not Covered
Routine GYN/Pap Exam	100%	Not Covered
(one per calendar year)		
Routine Mammography.....	100%	80% UCR**
(one per calendar year)		
Prostate Screening	100%	80% UCR**
Well Baby Care	100%	80% UCR**
(including immunizations up to 9 years of age)	(up to \$1,000 per calendar year)	

PHYSICIANS OFFICE

Allergy Testing/Injections.....	90%	80% UCR**
Visits for Illness	90%	80% UCR**
Emergency Care	90%	80% UCR**
Minor Surgery	90%	80% UCR**
Diagnostic Testing	90%	80% UCR**

	In Network	Out of Network
Speech/Occupational..... Therapy (illness/injury related)	90%	80% UCR**
Physician/Rehabilitative Therapy (illness/injury related)	90%	80% UCR**
Respiratory Therapy.....	90%	80% UCR**

AFFILIATES

Chiropractors	90%	80% UCR**
Podiatrists	90%	80% UCR**

MENTAL HEALTH (not biologically based mental illness)

Outpatient Psychotherapy.....	90% (up to 30 visits per year)	80% UCR** (up to 15 visits per year)
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(covered under medical after 7-1-2010)

**ALCOHOL/SUBSTANCE
ABUSE**

Outpatient Psychotherapy.....	90% (up to 30 visits per calendar year)	80% UCR** (up to 15 visits per year)
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(covered under medical after 7-1-2010)

MENTAL HEALTH/ALCOHOL (not biologically based mental illness)/SUBSTANCE ABUSE

Inpatient Care	90% (up to 45 days per calendar year)	80% UCR** (up to 31 days per calendar year)
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(covered under medical after 7-1-2010)

Routine Colonoscopy 90% 80% UCR**
(Age 50 – every 10 years)

Beginning at age 50, men and women who are at average risk for developing colorectal cancer should have 1 of the 5 screening options below:

- A fecal occult blood test (FOBT)* or fecal immunochemical test (FIT)* every year**, OR
- Flexible sigmoidoscopy every 5 years, OR

- An FOBT* or FIT* every year plus flexible sigmoidoscopy every 5 years**, OR

(Of these first 3 options, the combination of FOBT or FIT every year plus Flexible sigmoidoscopy every 5 years is preferable.)

- Double-contrast barium enema every 5 years**, OR
- Colonoscopy every 10 years

* For FOBT or FIT, the take-home multiple sample method should be used.

**Colonoscopy should be done if the FOBT or FIT shows blood in the stool, if sigmoidoscopy results show a polyp, or if double-contrast barium enema studies show anything abnormal. If possible, polyps should be removed during the colonoscopy.

****The level of benefits payable under these Plans depends upon whether you choose to obtain medical care from an In-Network or Out-of-Network Provider. The plan encourages you to utilize Network Providers in order to receive the highest level of benefits payable. Network Providers will not hold you responsible for amounts exceeding the negotiated amounts.**

Dental Expense Benefits

Calendar Year Deductible Amount

Individual (p.32)	\$25.00
Family (p.32)	\$75.00

Co-payment (After Deductible Amount is Satisfied)

**Preventative and Diagnostic Services (p.33)	100% of R & C
Basic Restorative Services (p.33)	80% of R & C
Major Restorative Services (p.34)	80% of R & C
**Orthodontic Services (p.35)	60% of R & C

****The Dental Deductible amount is waived for Preventive and Diagnostic Services and Orthodontic Services**

Overall Calendar Year

Maximum Benefit (p.32) \$2,500.00 per person

Orthodontic Lifetime

Maximum Benefit (p.32) \$1,200.00 per person

Vision Expense Benefits

Eye Examinations

One regular eye examination in each 12 consecutive month period by an ophthalmologist, optician or optometrist is provided for each person covered under the program. The maximum payment is \$40.00 per exam.

Lenses

One pair in each 12 consecutive month period is covered. Payment is made for the actual charge for one or two lenses or contact lenses, but not more than:

	Per Lens	Per Pair
Single Vision	\$ 20.00	\$ 40.00
Bifocals	\$ 30.00	\$ 60.00
Trifocals	\$ 40.00	\$ 80.00
Lenticular	\$100.00	\$200.00
Contact Lenses (cosmetic)	\$ 35.00	\$ 70.00
Contact Lenses (medically necessary)	\$200.00	\$400.00

*NOTE: The amount for a single lens is fifty percent (50%) of the amount for a pair of lenses.

The allowance for medically necessary contact lenses will be paid only if: (a) the lenses are necessary following cataract surgery; (b) visual acuity cannot be correct to 20/70 in either eye with other lenses, but can be correct to at least 20/70 in either eye with contact lenses; or (c) the lenses are necessary for the treatment of anisometropia for keratoconus.

Should an individual select contact lenses instead of conventional lenses, when the latter is all that is needed, the program will pay the amount equal to the single lenses plus the frames toward the cost of the contact lenses.

Maximum

The plan will pay the actual charge for the services and supplies up to the maximum, the difference will be added to the maximum amount applicable to any other service or supply for which a charge is incurred within sixty days.

Frames

One set of frames is covered every 24 consecutive month period provided the frames are used with lenses prescribed after an eye examination. Frame allowance: \$30.00. When new frames are not required, the payment allowed for frames may be applied toward the cost of lenses.

Limitations and Exclusions

Services for which vision care coverage does not provide benefits include:

- Sunglasses, whether or not a prescription is required.
- Drugs or medication
- Employer furnished services or supplies or those covered under Worker's Compensation laws, occupational disease laws or similar legislation
- Services and supplies rendered or furnished as a result of loss, theft, or breakage of lenses, contact lenses or frames for which benefits were paid under the Group Contract and Certificate
- Orthoptics or vision training
- Aniseikonic lenses
- Coated lenses

Vision care does not provide full benefits for cosmetic vision needs. This distinction applies particularly to frames and contact lenses.

Section III

Prescription Drug Expense Coverage

Your prescription drug benefit is administered by Caremark.

	Retail	Mail Order
When to use your benefit:	For immediate or short-term medications	For maintenance or long-term** medications
Where:	To locate a CVS Caremark participating retail network pharmacy in your area, simply click on “Find a Local Pharmacy” at www.caremark.com or call a Customer Care representative toll-free at 1-888-202-1654	Simply mail your original prescription and the mail service order form to CVS Caremark. Your medicines will be sent directly to a location of your choice.
Your Copay:	<p>20% of the cost of the medication for generics and brand drugs without a generic.</p> <p>100% of the cost of brand drugs if a generic is available.</p> <p>100% of the cost of long-term** drugs that are filled at a retail pharmacy more than 2 times.</p> <p>You must present your I.D. number at the Caremark Pharmacy and may <u>not</u> submit a paper claim for primary coverage. Failure to do so will result in a 100% copay.</p>	
Refill Limits:	One initial fill plus 1 refill for long-term medications**	
Days Supply:	34 Days	90 Days

**A long-term medicine is taken regularly for chronic conditions or long-term therapy. A few examples include medicines for managing high blood pressure, asthma, diabetes, or high cholesterol.

When you need to take your maintenance medicine right away, ask your doctor for two prescriptions:

1. The first for up to a 34-day supply at retail and one refill at retail
2. The second for up to a 90-day supply at mail order with refills when clinically appropriate.

Have the short-term supply filled immediately at a CVS Caremark participating retail pharmacy and send the 90-day supply prescription to the CVS Caremark Mail Service Pharmacy.

Getting Your Short-Term Prescription Filled at a Retail Pharmacy

Day Supply Limit

You can get up to a 34-day supply of medicine each time you have a prescription filled at a participating retail pharmacy. Ask your doctor to write a prescription for up to a 34-day supply plus refills, when clinically appropriate. Keep in mind; if you are taking long-term medications each one must be filled at CVS Caremark's mail order facility after the initial fill plus 1 refill.

If You Use a Non-Caremark Pharmacy

You must pay 100 percent of the prescription price. You will then need to submit a paper claim form along with the original prescription receipt(s) to CVS Caremark for reimbursement of covered expenses. You can download and print a claim form when you log in to www.caremark.com or call the Customer Care toll-free number (available 24/7) on your benefit I.D. card. You must have met your deductible to be reimbursed the 80%.

If You Use a Caremark Pharmacy

If you use a Caremark Pharmacy but do not identify yourself as a member of your school's health plan program (present your I.D. card or Member I.D. number), you may **not** file a paper claim for reimbursement for primary coverage.

For Reimbursement under the Medical Plan

You do not need to file a claim with the medical plan in order for your prescription costs to be credited toward your out-of-pocket maximum. Prescription drug information is sent by CVS Caremark to the medical plans on a weekly basis. The medical plans process the claims. If your out of pocket maximum has been met, you will be reimbursed in accordance with your plan parameters.

Getting Your Prescription Filled Through CVS Caremark's Mail Order Program

To ensure your safety, CVS Caremark's mail service pharmacies are staffed by registered pharmacists. Just like your neighborhood pharmacist, CVS Caremark's pharmacists check each prescription to make sure it is filled correctly. In addition, your prescription history is reviewed to identify any possible problems with new medicines you may be prescribed.

Day Supply Limit

You can get up to a 90-day supply of medicine when you get your prescription filled through the CVS Caremark Mail Service Pharmacy. Ask your doctor to write a prescription for a 90-day supply plus refills, when clinically appropriate.

Please Note: *By law, CVS Caremark must fill your prescription for the exact quantity of medicine prescribed by your doctor, up to the 90-day supply limit.*

Payment Options

While checks and money orders are accepted, CVS Caremark's preferred method of payment is by credit card. For credit card payments, simply include your VISA®, Discover®, MasterCard® or American Express® number and expiration date in the space provided on the enclosed mail service order form.

Convenient Home Delivery

You can expect your medicine to arrive approximately 10 calendar days after CVS Caremark receives your prescription. Your package will include a new mail service order form and an invoice, if applicable. You will also receive the same type of information about your prescribed medicine that you would receive from a retail pharmacy.

Eligibility

Prescription drug coverage is available to the employee and any dependents who are "primary" under the employee's coverage. For definition of "primary" see (page 38) Coordination of Benefits.

Secondary Coverage

To file a claim for secondary coverage, you will need to submit a **paper claim form** along with the original prescription receipt(s) and primary coverage Explanation of Benefits or receipt to AultCare or Medical Mutual for reimbursement of covered expenses.

Specialty Drugs

For Specialty medications, please contact CVS Caremark at 800-237-2767

Non-Covered Services

- Over the Counter drugs or supplies
- Anorexiant (diet pills)
- Medical devices or supplies
- Contraceptive Devices
- Rogaine
- Retin A over age 26
- Growth Hormones
- Cosmetic
- Diabetic Supplies – unless enrolled in diabetic wellness program
- Non insulin needles and syringes
- Specialty Drugs that are not obtained through CVS Caremark's Specialty Pharmacy
- Long-Term medications filled at a retail pharmacy beyond the initial fill plus 1 refills
- Brand drugs that have a generic equivalent
- Drugs purchased at Caremark Retail Pharmacy when insurance I.D. is not used for primary coverage (no reimbursement for paper claim).

Section IV

Pre-certification

Pre-Admission Certification and Concurrent Review administered by Medical Mutual Services and AultCare includes three separate components designed to ensure that you continue to receive quality medical care and that your hospital related care is provided in the most cost-effective manner possible.

Pre-certification procedures Do NOT apply to those participants for whom Stark County Schools COG coverage is secondary insurance.

Pre-certification will monitor the cost-effectiveness of your health care through its Pre-Admission Certification/Concurrent Review, Second Surgical Opinion and Case Management Program described below.

Under the Pre-Admission Certification/Concurrent Review Program, your doctor's recommendation for non-emergency hospitalization is reviewed and "pre-certified" before you are admitted to the hospital. Any elective non-emergency hospital stay (including maternity, psychiatric, and substance abuse admissions) must be pre-certified.

Pre-certification ensures that a hospital admission is necessary for the care recommended and that the efficient scheduling of service occurs. The result is less costly and more effective use of hospital services and less inconvenience for you and your family.

Here's how it works: If your doctor recommends that you or a covered family member enter the hospital for a non-emergency reason, the doctor will contact Pre-certification approximately two weeks before the anticipated admission.

At that time, your doctor will indicate the treatment involved and the anticipated length of stay in the hospital.

If your doctor forgets to contact Pre-certification, the information can be called in by the physician's staff to Medical Mutual

Services or AultCare at the toll free numbers listed on page 16. You or a family member may call the Pre-cert Hotline to begin the process. A nurse reviewer will then contact your doctor for the necessary information.

In the case of an emergency admission, your doctor should notify the Pre-Certification office of the hospitalization within one working day of admission. The review of the course of treatment during hospitalization is called “concurrent review.” Concurrent review verifies that hospital confinement already in progress does not exceed the number of days that are medically required.

The Pre-admission certification and concurrent review procedures required for full benefit under your health plan are described more fully below:

- A registered nurse reviewer familiar with the hospital procedures will review the number of days your physician recommended for hospitalization. Usually that recommendation is approved without question. In those cases where it appears that length of the hospital stay could be less than your physician has recommended, a Pre-cert physician will contact your doctor to discuss the need for the extended stay.
- Your physician and the hospital will be notified in writing of the initial number of days that have been approved for reimbursement under your medical plan.
- During a hospital stay, a nurse reviewer will contact the hospital. If the hospital stay exceeds or is expected to exceed the approved number of days, a nurse reviewer will contact your physician to verify the medical necessity of the additional days.

NOTE: FAILURE TO FOLLOW THE PRE-ADMISSION PROCEDURE MAY RESULT IN THE PATIENT PAYING THE FIRST \$200 OF ROOM AND BOARD CHARGES.

CASE MANAGEMENT

Case management is an economical, common sense approach to health care benefits. Sometimes patients who can safely be treated at home or in another setting, remain hospitalized because relatively

inexpensive and practical alternative care or equipment does not appear to be covered by health insurance. The Case Management Program is designed to help in these instances.

HOW CASE MANAGEMENT WORKS

In the process of the Concurrent Review Program described above, the Pre-cert nurse will identify cases that may be appropriate for care in an alternative site. The nurse reviewer will contact the patient's attending physician to discuss the alternative, support care and equipment which might make discharge from the hospital possible. For example, a ramp built in the home of a patient confined to a wheelchair may make it possible for the patient to return home rather than continuing to stay in the hospital. In this case, the nurse reviewer would discuss that alternative and obtain authorization for reimbursement for the ramp from the Plan. Case management would also provide assistance to families of terminally ill patients regarding hospice care. The Case Management Program is designed to identify the best possible care options for each individual patient and meet that individual's unique needs.

CALL PRE-CERTIFICATION HOTLINE ABOUT CASE MANAGEMENT

If you or a family member are hospitalized, you may call the Pre-cert Hotline listed below to discuss possible alternatives to hospitalization with a nurse consultant.

Case Management works because quality care can be more cost-effective when care is personally and professionally managed.

PRE-CERTIFICATION SUMMARIZED

Pre-certification does not limit or restrict your choice of hospital or physician.

Pre-certification does not apply where Medicare or any other coverage is your primary insurance.

WHAT NEEDS TO BE DONE

Notify your physician that your Medical Plan includes participation in a Pre-certification program.

REMEMBER — Your physician **MUST** call the Pre-Cert Hotline

before admission when elective hospitalization is anticipated or within one working day of any emergency admission.

Contact the nurse at Pre-certification if elective surgery has been recommended or if you have any questions.

Preview Pre-certification Hotline 1-800-258-2873
(For Traditional or SuperMed Plus) 8:00 am - 4:30 pm
Medical Mutual Services

Pre-certification Hotline 1-800-344-8858
(For AultCare) or
1-330-363-6397
7:30 am - 5:00 pm

Calls before or after these hours will be recorded and returned.

Section V

Eligibility

When Does Coverage Begin?

Each employee (see definition) will be eligible on their first day of active employment. If the employee is not actively at work or available for work on the day he would normally become eligible, he will be eligible on the day he returns to active work.

Coverage will become effective on the date the employee becomes eligible provided the employee has enrolled for coverage within 30 days of their initial date of eligibility.

Dependents (see definition) will be eligible on the date the employee becomes eligible except for a child at birth or dependents confined to a hospital or other covered institution.

Newborn dependent child will be eligible on the date of birth provided that dependent has been enrolled within 30 days of birth.

Dependents confined to a hospital or other covered institution will be eligible upon discharge.

Coverage for dependents will become effective on the date the employee's coverage becomes effective provided the employee has enrolled for dependent coverage within 30 days of the dependents date of eligibility.

If dependents are added after the employee's effective date, and the employee had no dependents previously, they will be covered on the date that they become an eligible person provided the election of coverage is made within 30 days of the date of eligibility.

If additional dependents are added while the individual has dependent coverage, they will be covered on the date that they become eligible provided the election of coverage is made within 30 days of the date of eligibility.

Late Enrollees

Employees and dependents who do not enroll for coverage when first eligible will be late enrollees. Late enrollees who subsequently wish to enroll for coverage may do so during the Open Enrollment Period. The Open Enrollment Period will be November 1 through November 30 for a coverage effective date of January 1.

Late enrollees who subsequently wish to enroll for coverage due to the involuntary termination of other coverage will be covered on the date the other coverage terminated provided the employee has enrolled within 30 days of the date the other coverage ceases. Health Insurance Portability and Accountability Act (HIPPA) allows for crediting time a person was covered under a previous carrier if the previous coverage was continuous with not more than a 63 day gap in coverage prior to the effective date of the new coverage.

If dependents are added after the employee's effective date, and the employee had no dependents previously, they will be covered, on the date that they become an eligible person provided they have been enrolled within 30 days of eligibility.

If additional dependents are added while the individual has dependent coverage, they will be covered on the date that they become eligible provided they have been enrolled within 30 days of eligibility.

In the case of a newborn child, coverage will become effective on the newborn child's date of birth provided the newborn child is enrolled within 30 day's from the date of birth.

Termination of Coverage

An employee's coverage will terminate on the earliest of: (1) the date the Plan terminates; (2) the last day of the month the employee ceases to be an eligible employee; (3) the date all coverage or certain benefits are terminated for the employee due to modification of the Plan; (4) the date the employee becomes a full-time member of the Armed Forces of any country; (5) the date the employee fails to make any required contribution.

A dependent's coverage will terminate on the earliest of: (1) the date the Plan terminates; (2) the date the employee's coverage terminates; (3) the date the dependent becomes a full-time member of the Armed Forces of any country; (4) the date the dependent fails to make any required contribution; or (5) the end of the month in which the dependent no longer meets the Plan's definition of dependent.

Continuation of Benefits (COBRA)

On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) was enacted. This law gives you and your beneficiaries the opportunity to receive the same options for health care benefits that you currently have at the group rate should your status with the company change or if there is a change in your relationship with your family. (COBRA also makes Medicare secondary to employer-sponsored health plans for all employees and their spouses regardless of age.)

You can become eligible for continued health care benefits by purchasing them at the group rate if you or your beneficiaries fall into one of the following categories. The duration of coverage depends on the condition of eligibility.

CONDITION OF ELIGIBILITY	DURATION OF COVERAGE OFFERED
Widowed spouse and dependent children (up to age 26).	36 months
Employees, their spouses and dependent children who have been terminated (voluntary or involuntary except for reason of gross misconduct.	18 months
Employees, their spouses and dependent children, if their hours have been reduced resulting in lost coverage.	18 months
Divorced or legally separated spouse and their dependent children.	36 months
Medicare ineligible spouses.	36 months
Dependent children who no longer meet the Plan's definition of eligibility.	36 months

You will be responsible for paying both the employer and the employee contributions to receive this continued coverage, plus up to 2 percent to cover administrative costs.

Your eligibility for coverage may end earlier if:

1. You receive health insurance through another employer or Medicare.

2. The premium for continuation of coverage is not paid on time.
3. The company no longer sponsors group health coverage for any of its employees.

If you are terminated, your hours are reduced to part time, or you become a widowed spouse of an employee, you will be notified that you are eligible for continued coverage under COBRA. Should a person become eligible for any other reason, it is his or her responsibility to notify the Personnel Department of the qualifying event.

Section VI

Description of Medical Expense Benefits

Your Medical Plan shares the cost of your health care expenses with you. This section explains what services are covered, what portion of the cost of these services is payable by the Plan and what portion of the cost of these services is payable by you.

The medical plan pays for covered services rendered by hospitals, physicians, and other providers. Covered services are those for which medical necessity has been established. The fact that your physician may prescribe, recommend or provide treatment does not necessarily mean that the treatment is medically necessary. To be medically necessary, your tests, treatments, services and supplies must:

- be consistent with the symptoms, diagnosis and treatment of your illness or injury;
- be given to you as an inpatient only when the services cannot be safely provided as an outpatient;
- not be provided solely for the convenience of your physician, hospital, other provider, or you.

Deductible Amount

Before the Plan will pay, the calendar year deductible amount must be met. This means that the first dollar benefits of covered Major Medical expenses submitted will be applied to the satisfaction of the deductible amount.

The Family deductible will be met when any combination of family members meet the family deductible amount. Please refer to Schedule of Benefits on pages (3-8) for deductible amounts which apply to your benefit plan.

If during the last three months of a calendar year a Covered Person/Family incurs Major Medical expenses applicable to the deductible, such expense shall also be applicable to the deductible for the next succeeding calendar year. This is often referred to as "Carry-over-Deductible."

If two or more covered persons in the same family are injured in a common accident, the deductible applicable in the calendar year of the common accident shall be limited to a single deductible amount for the calendar year for covered expenses, related to that accident, which are incurred by all family members.

Co-Payment

After the individual/family deductible amount is satisfied, the Traditional Plan will pay 80% of the R & C charges in excess of the deductible amount until the individual/family maximum out-of-pocket amount is satisfied. The PPO plans will pay 90% in-network and 80% out-of-network of the negotiated fee amounts. All Plans will pay: 100% of Covered Expenses (PPO) or 100% of Covered Expenses at R & C (Traditional or non-network) incurred after the maximum out-of-pocket amount has been satisfied.

Maximum Out-Of-Pocket Amount

This provision limits the maximum amount which an individual will have to pay in a calendar year. The maximum amount which a family will have to pay is indicated in the Schedule of Benefits.

The Out-Of-Pocket amount includes the co-payment amount not paid by the Plan but excludes the deductible amount and any non-covered amounts.

Covered Comprehensive Major Medical Expenses

1. Charges made by a hospital for semiprivate room and board and miscellaneous services (including Special Care Unit charges). Private room charges will be limited to the hospital's semiprivate room charge unless certified as medically necessary by the attending physician.

NOTE: Please refer to Section IV for information regarding the requirements for precertifying hospital confinements.

2. Charges made by an inpatient rehabilitation institution for room and board and miscellaneous services while confined as an inpatient.
3. Charges made by a physician for diagnosis, treatment and surgery (except as specifically excluded under Exclusions

and Limitations). This includes follow-up therapy in the treatment of allergies and routine newborn care while baby is confined as an inpatient.

4. Charges made by a registered nurse (R.N.), or a Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.) for private duty nursing, provided such services are certified as medically necessary by the attending physician and are not rendered by a person who is related to the covered person by blood or marriage. Such services shall include a registered nurse, mid-wife acting within the scope of her license. Private duty-nursing services are covered either in a hospital, an extended care facility, or the covered person's home.
5. The following medical services or supplies that are ordered by a physician:
 - a. Anesthetics, including the charge for administration;
 - b. X-ray examination, microscopic and laboratory tests and other diagnostic services;
 - c. Radiation therapy and chemotherapy;
 - d. Blood and blood plasma (if not replaced) and other fluids to be injected into the circulatory system;
 - e. Physical therapy;
 - f. Braces, crutches, casts, splints, trusses and surgical dressings;
 - g. The initial artificial limb, or a replacement if occasioned by the natural growth and development of a covered person.
 - h. The rental or purchase, whichever is the least expensive, of hospital type equipment, including wheelchairs, hospital beds, iron lungs, and other medical equipment used exclusively for therapeutic treatment.
 - i. Drugs and medicines requiring the written prescription of a physician.
 - j. One routine pap test per calendar year.
 - k. One routine mammogram per calendar year (unless additional mammogram(s) are deemed medically necessary).

- l. Routine prostrate screening, once per calendar year.
 - m. The exam associated with items j, k, or l as shown above.
 - n. Magnetic Resonance Imagery (MRI) testing is covered if medical necessity has been determined by the Medical Review Process. You may contact customer service to begin this process.
 - o. Second Surgical Opinion Services are covered if the examination or consultation is performed by a physician who is not affiliated with the attending physician. Second Surgical Opinions are recommended but not mandatory.
6. Charges made by a professional ambulance service for transportation to or returning from the nearest hospital or other covered institution equipped to provide the medical treatment recommended by the attending physician.
 7. Charges made by a hospital, ambulatory care center, emergency care center or a physician's office for supplies and services in connection with:
 - a. surgical procedures;
 - b. emergency accident care;
 - c. acute medical emergency care;
 - d. X-ray exams, microscopic and laboratory tests and other diagnostic services.
 8. The Plan will pay the eligible charges made by an Extended Care Facility for room and board and miscellaneous services. The Covered Person must be under a physicians' continuous care and the physician must certify that the Covered Person requires 24-hours-a-day nursing care.
 9. Charges made by a hospice for room and board and other services to a terminally ill Covered Person whose life expectancy is six months or less, as certified by a physician.
 10. The Plan will pay eligible charges for home health care provided such services are certified as medically necessary by the attending physician. Services must be performed by a Home Health Agency.
 11. Charges for maternity care will be eligible the same as for any other illness. Charges for sterilization procedures and abortions will also be eligible the same as any other illness.

Charges on behalf of the newborn child (well-baby care) will be eligible the same as any other illness, provided the newborn child is a Covered Person under the Plan and confined as an inpatient. All provisions of the Plan will apply separately from that of the mother.

Well baby care is limited to routine nursery charges and charges relating to circumcision.

12. Chiropractic Therapy/Physical Therapy — After the 25th visit, your Physician must certify that additional treatments are medically necessary.
13. Orthopedic shoes and braces provided the shoes are attached to the braces.

Lifts or supports that are added to the shoes will be considered as covered expenses provided that these expenses are determined to be medically necessary by the attending physician.

14. **Child Health Supervision Services (Well Baby Care)**

Regardless of Medical Necessity, we will provide benefits for child health supervision services for eligible Dependent children to age 9.

Child health supervision services include a review performed in accordance with the recommendations of the American Academy of Pediatrics. This review includes a history, complete physical examination and developmental assessment. This review also includes anticipatory guidance, laboratory tests and appropriate immunization.

Benefits will be limited to a maximum payment of \$1,000 per calendar year.

15. **Clinical Trial Programs**

Benefits are provided for routine patient care administered to a Covered Person participating in any stage of an eligible cancer clinical trial, if that care would be covered under the Plan if the Covered Person was not participating in a clinical trial.

“Eligible cancer clinical trial” means a cancer clinical trial that meets all of the following criteria:

- A purpose of the trial is to test whether the intervention potentially improves the trial participant’s health outcomes;
- The treatment provided as part of the trial is given with the intention of improving the trial participant’s health outcomes;

- The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology; and
- The trial does one of the following:
 - Tests how to administer a health care service, item, or drug for the treatment of cancer;
 - Tests responses to a health care service, item, or drug for the treatment of cancer;
 - Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
 - Studies new uses of a health care service, item, or drug for the treatment of cancer;
 - The trial is approved by one of the following entities:
 - The national institutes of health or one of its cooperative groups or centers under the United States Department of Health and Human services;
 - The United States Food and Drug Administration;
 - The United States Department of Defense; or
 - The United States Department of Veterans' Affairs.

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

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

No benefits are payable for the following:

- A health care service, item, or drug that is the subject of the cancer clinical trial;
- A health care service, item, or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
- An Experimental or Investigational drug or device that has not been approved for market by the United States Food and Drug Administration;

- Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
- An item or drug provided by the cancer clinical trial sponsors free of charge for any patient; and
- A service, item, or drug that is eligible for reimbursement by a person other than Plan Administrator, including the sponsor of the cancer clinical trial.

16. Embryo Transplants

The Plan will provide coverage for embryo transplants on a self-donor basis. This coverage will include all stages of the transplant procedure.

The Plan will continue to exclude coverage for embryo transplants in the case of “other” donor.

17. A program to manage diabetes shall be made available to both insulin and non-insulin dependent diabetics.

Section VII

Exclusions and Limitations Applicable to Medical Expense Benefits

The following charges/fees/expenses are excluded under the Plan:

1. Charges which are not specifically included as Eligible Expenses.
2. Charges incurred prior to the effective date of coverage under the Plan.
3. Charges incurred after the termination date of coverage under the Plan.
4. Charges not medically necessary for the diagnosis or treatment of an active illness or injury except as specifically included as eligible expenses.
5. Charges in excess of the Reasonable & Customary (R & C) or negotiated amount.
6. Charges not prescribed or recommended by a physician.
7. Charges for which benefits may be claimed under the Workers' Compensation act or similar legislation, or which are due to the treatment of an illness or injury arising out of or in the course of any occupation or employment for wage or profit.
8. Charges for surgery, therapy, treatment or drugs considered to be experimental or investigative in nature.
9. Charges for treatment provided or furnished by the United States Government or the government of any other country.

10. Charges for services or supplies that cannot reasonably be expected to lessen the patient's disability or to enable him to live outside of an institution.
11. Charges for care or treatment resulting from war, an act of war (declared or undeclared) or arising out of a Covered Person's participation in a riot.
12. Charges for the care or treatment as a result of being engaged in an illegal occupation or commission of or attempted commission of a felony or assault.
13. Charges for care or treatment while a member of the armed forces of any state or country.
14. Charges by persons who ordinarily reside in the same household with the Covered Person or who are related by blood or marriage or legal adoption to the Covered Person.
15. Charges for which the Covered Person is not legally required to pay or which would not have been made if no coverage had existed.
16. Charges for custodial care.
17. Charges for personal convenience items including, but not limited to TV and telephone, guest trays, guest beds, admission kits and reading material.
18. Charges for embryo transplants; artificial insemination, and invitro fertilization except as defined on page 27.
19. Charges for vaccinations, inoculations and preventive shots, except as defined on page 25, No. 14.
20. Charges for routine pap tests; except for one routine pap per calendar year.
21. Charges for hearing aids, glasses, eye examinations, or the fitting thereof, except as specifically included as Eligible Expenses.
22. Charges for cosmetic surgery except as the charges relate to such surgery to correct a congenital defect in a newborn child, to repair the effects of an injury or for reconstructive breast surgery.
23. Charges for the treatment of corns, calluses, or toenails, unless the charges are for the removal of nail roots or in conjunction with the treatment of a metabolic or peripheral vascular disease.

24. Charges for any care or treatment of teeth, gums, alveolar process, or gingival tissues (including the prevention or correction of teeth irregularities and malocclusion of the jaw by wire appliances, braces or other mechanical aids) unless such charges are for the professional services of a Physician or qualified oral surgeon in rendering any of the following treatments.
 - a. treatment to repair the effects of an injury to sound natural teeth which occurred while the individual is covered under the Plan.
 - b. treatment for the excision of impacted unerupted teeth or of a tumor or cyst, or the incision and drainage of an abscess or cyst.
 - c. treatment or excision of a tooth root (without extraction of entire tooth) but not including root canal therapy.
 - d. surgical treatment of temporal mandibular joint syndrome. Therapy charges incurred due to TMJ shall be allowed as a Major Medical Benefit provided that sufficient documented medical evidence complies with guidelines.
 - e. surgical treatment to correct a congenital defect in a new born child.
25. Charges for transportation except as specifically included as Eligible Expenses.
26. Charges for drugs except as specifically included as Eligible Expenses.
27. Charges for sterilization reversal or any complications thereof.
28. Charges for sexual conversion surgery, or any other services related to gender reassignment or disturbances of gender identification, or any complications thereof.
29. Charges for biofeedback training.
30. Charges for marital counseling.
31. Charges for hair replacement, transplant, or removal.
32. Charges for weight reduction procedures, surgical or otherwise, or any complications thereof.
33. Charges for the completion of claim forms, medical reports, or certifications required by the Plan.
34. Charges for diagnostic X-ray exams and laboratory tests, ECG's, EKG's, and other diagnostic tests not related to a

specific injury or sickness or a definite set of symptoms except as specifically included as Eligible Expense.

35. Charges for a hospital admission when the primary reason for admission is to perform diagnostic X-ray exams and other diagnostic tests which could have been performed on an outpatient basis unless certified as "medically necessary" by the attending physician.
36. Charges for routine physical examinations and health check-ups except as specifically included as Eligible Expenses.
37. Charges for hearing or vision therapy and any related diagnostic testing, except if treatment is due to congenital defect or accidental injury.

Section VIII

Description of Dental Expense Benefits

If a Covered person incurs eligible Dental Expenses for the treatment of a Covered disease or injury to the teeth, the Plan will pay, after satisfaction of the Deductible Amount, the percentage indicated in the Schedule of Benefits of the lesser of the Scheduled Amount or Reasonable and Customary (R & C) Amount for such eligible expenses.

Maximum Amount

The overall Calendar Year Maximum Dental Benefit is \$2,500 per person.

The Orthodontic Lifetime Maximum Benefit is \$1,200 per person.

Calendar Year Deductible Amount

Before the Plan will pay, the Calendar Year Deductible Amount must be met. This means that the first \$25 per person/\$75 per family in eligible expenses submitted will be applied to the satisfaction of the Deductible Amount.

If during the last three months of a Calendar Year a Covered person incurs Dental Expenses applicable to the Deductible Amount, such expense shall also be applicable to the Deductible Amount for the next succeeding Calendar Year.

The Dental Deductible Amount is waived for Preventive and Diagnostic Services.

Co-Payment

The Plan will pay eligible expense (R & C) at the percentage indicated in the Schedule of Benefits.

Eligible Expenses

The following charges/fees/expenses are eligible under the Plan. Covered Dental Expenses are divided into four major categories, each subject to the Deductible Amount and Co-Payment indicated. The following identifies each of the four categories and indicates the specific type of treatment or services covered under each category.

PREVENTIVE AND DIAGNOSTIC SERVICES

(Payable at 100% — No Deductible)

1. Routine oral examinations (including diagnosis) twice per calendar year.
2. Prophylaxis (scaling and polishing) twice per calendar year.
3. Topical application of stannous fluoride twice per calendar year. (No age limitation)
4. Space maintainers including installation and fitting.
5. Emergency treatment to relieve pain.
6. Dental X-rays
 - Supplementary bitewing X-rays twice per calendar year.
 - Full mouth X-rays once in any period of thirty-six (36) consecutive months.
 - Other X-rays as required in connection with the diagnosis of a specific condition requiring treatment.
7. Tests and laboratory examinations including bacteriologic cultures, pulp vitality test and diagnostic cast (study models).

BASIC RESTORATIVE SERVICES

(Payable at 80% — After Deductible)

1. Oral surgery including necessary pre-operative treatment during hospital confinement and customary post-operative treatment furnished in connection with oral surgery.
 - Extraction of one or more teeth, except when done in connection with or in preparation for orthodontic services.
 - Alveoplasty (surgical reparation of ridge for dentures) and tooth replantation.
 - Treatment of fractures and reduction of dislocation of the jaw, and other cutting procedures in the oral cavity, except periodontic and endodontic surgery.

2. Charges for amalgam, silicate, acrylic, synthetic porcelain, and composite restorative materials are payable when placed within the anterior arches to restore diseased or fractured teeth.
3. General anesthesia and the administration thereof when Medically Necessary and administered in connection with oral or dental surgery.
4. Endodontic treatment including root canal therapy.
5. The injection of antibiotic drugs and application of desensitizing medicaments by the attending Dentist or Physician.
6. The repair or recementing of crowns, inlays, onlays, bridge-work or dentures, or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any period of thirty-six (36) consecutive months.
7. The treatment of periodontal and other diseases of the gums and tissues of the mouth including gingivectomy and osseous surgery.

MAJOR RESTORATIVE SERVICES

(Payable at 80% — After Deductible)

1. Inlays, onlays, gold fillings or crown restorations to restore diseased or fractured teeth, but only when the tooth, as a result of extensive caries or fracture cannot be restored to proper function with an amalgam, silicate, acrylic, synthetic porcelain or composite restoration.
2. The initial installation of removable partial or complete denture.
3. The initial installation of fixed partial denture (bridgework — including inlays and crowns as abutments).
4. Replacement of an existing removable partial or complete denture or fixed partial denture by a new removable or fixed partial denture, or the addition of teeth to an existing removable partial denture or to a fixed partial denture, but only if (1) the replacement or addition of teeth is required to replace one or more teeth extracted after the existing removable partial denture or fixed partial denture was installed, or (2) the existing removable denture or fixed partial denture cannot be made serviceable and, if such a denture was installed at least five years prior to its replacement, or (3) the existing denture is an immediate temporary denture which cannot be

made permanent, and replacement by a permanent removable denture takes place within 12 months from the date of initial installation of the immediate temporary denture.

5. If an in-serviceable removable partial denture is replaced with a fixed partial denture and a professionally satisfactory result cannot be achieved by replacement with another removable denture, the charge will be a covered dental expense, but only to the extent of the Reasonable and Customary charge which would have been made if the replacement had been accomplished by a partial removable denture and benefits will be determined as if the removable denture had in fact been installed. The appliance must be a minimum of five (5) years old.

ORTHODONTIC SERVICES

(Payable at 60% — After Deductible)

1. Orthodontic procedures and treatment consisting of surgical therapy, appliance therapy, and functional/myofunctional therapy (including related oral examinations, surgery and extractions).

Payment will be made on a monthly basis as follow:

Twenty percent (20%) of the total charge for the initial down payment, payable at the coinsurance percentage, with the balance divided over the remaining course of treatment.

Incurred Date

A charge is incurred on:

the date the impression is taken, in the case of dentures or fixed bridges;

the date the preparation of the tooth is begun, in the case of crown work;

the date the work on the tooth is begun, in the case of root canal therapy;

the date the initial appliance is installed, in the case of orthodontic treatment; or

the date the treatment is performed in the case of any other work.

Section IX

Exclusions and Limitations Applicable to Dental Expense Benefits

The following charges/fees/expenses are excluded under the Plan:

1. Charges which are not specifically included as Eligible Expenses;
2. Charges incurred prior to the effective date of coverage under the Plan;
3. Charges incurred after the termination date of coverage under the Plan;
4. Charges in excess of the lesser of the Scheduled Amount or the Reasonable and Customary (R & C) amount;
5. Charges, for which benefits may be claimed under the Workers' Compensation act or similar legislation, or which are due to the treatment of an illness or injury arising out of or in the course of any occupation or employment for wage or profit;
6. Charges for treatment provided or furnished by the United States Government or the government of any other country;
7. Charges for care or treatment while a member of the armed forces of any state or country;
8. Charges by person who ordinarily reside in the same house hold with the Covered Person or who are related by blood or marriage or legal adoption to the Covered Person;
9. Charges for which the Covered Person is not legally required to pay or which would not have been made if no coverage had existed;

10. Charges for procedures or services rendered or supplies furnished by other than a legally qualified Dentist, or another Physician, acting within the scope of his license, except for charges for procedures performed by a licensed dental hygienist acting within the scope of his license and under the supervision and direction of a legally qualified Dentist or another Physician;
11. Charges for facing on pontics or crowns posterior to the second bicuspid;
12. Charges for sealants and for education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene, or dental plaque control;
13. Charges for procedures, services, or supplies which do not meet accepted standards of dental practice, including charges for procedures, services, or supplies which are experimental in nature;
14. Charges for procedures, services or supplies furnished on account of an injury or disease or dental defect resulting from war or any act of war, whether declared or undeclared, which war or act of war occurs while the individual is insured under this coverage.
15. Charges for any duplicate prosthetic device or any other duplicate dental appliance within five years of the insertion or placement of the original prosthetic device or dental appliance;
16. Charges for the replacement of a lost, missing, or stolen prosthetic device, or any other dental appliance;
17. Charges for implantology, including tooth implantation or transplantation and surgical insertion of fabricated implants;
18. Charges for periodontal splinting of teeth except for provisional intracoronal stabilization of mobile teeth;
19. Charges for precision attachments except when they represent the sole method of completing a course of treatment.
20. Charges for drug and/or medicaments, including prescriptions, other than injection of antibiotics and application of desensitizing medicaments by attending dentist;
21. Charges for Alternative Treatment in excess of what is recognized as adequate and appropriate;
22. Charges for dental care payable under Medical Expense Benefits.

Section X

Miscellaneous Provisions

Coordination of Benefits

The health care benefits otherwise provided under this Plan are subject to Coordination of Benefits so that the total benefits payable will not exceed 100% of the Eligible Expenses incurred. All benefits provided under this Plan are subject to the Coordination of Benefits provision.

If in addition to this Plan, any Covered Person is covered by one or more of the Plans listed below, benefits paid by the Plan will be coordinated with the other plans.

- Any group blanket or franchise insurance plan.
- Any hospital or medical, or dental service plan (i.e., Blue Cross/Blue Shield) or any group practice or prepayment.
- Any union-welfare or labor-management trustee insurance plans.
- Any government insurance plan coverage required by law (i.e., Medicare/Medicaid).
- Any insurance plan required by a Motor Vehicles Accident Reparation Act (no-fault auto plan) or similar law.
- Student insurance plans sponsored by or provided through an education institution (Exception: school accident insurance plans covering grammar and high school students and paid for totally by the parent or student are NOT coordinated with this benefit plan).

In coordinating benefits, one benefit plan is considered the primary plan and the other plan or plans become the secondary plan.

If a Covered Person has eligible expenses related to an injury and/or illness, your benefit plan will pay benefits as outlined in

this booklet. If you have additional group coverage, the additional healthcare plan(s) will pay the difference (or a portion of the difference) between the benefits paid by the primary plan and the amount charged by the medical services and/or items. The amount paid by the secondary plan will be determined by its maximum benefit level.

The group program which determines its benefit payment first and pays its full allowance is called the primary plan.

The benefit plan which determines its benefit payment after the other plan(s) is called the secondary plan. Secondary plan benefit payments are limited so that the total amount from all group plans will not be more than the actual amount of eligible expenses incurred by the Covered Person.

In NO event will a Covered Person receive benefit payments greater than the actual cost of the medical expense.

If both the husband and the wife are employed by the school, both may be covered as employees and both may be covered as dependents of each other along with any dependent children.

Order of Payment

If a Covered Person is eligible under two group plans and both plans have a provision for Coordination of Benefits, the order of payment (Primary and Secondary) will be determined as follows:

1. The benefits of a Plan which covers a person as an Employee are determined before those of a Plan which covers the person as a Dependent.
2. Dependent Children — Parents Not Separated or Divorced
The benefits of a Plan which covers a child as a Dependent of a parent whose birthday (month/day) falls earlier in the year are determined before those of a Plan of the parent whose birthday falls later in the year. A Person's year of birth is not used in applying this rule.

If the other Plan does not follow this rule, but instead has a rule based on the gender of the parent, and as a result the Plans do not agree on the order of payment, then the rule in the other Plan will determine the order of payment.
3. Dependent Children — Parents Separated or Divorced
The benefits of a Plan which covers a child as a Dependent of divorced or separated parents are determined in the following order:

- a. the benefits of the Plan of the parent with custody of the child are determined first;
- b. the benefits of the Plan of the spouse of the parent with custody of the child (the step-parent) are determined second;
- c. the benefits of the Plan of the parent without custody are determined next; and
- d. the benefits of the Plan of the spouse of the parent without custody of the child (step-parent) are determined last.

If, however, there is a court decree which would otherwise establish financial responsibility for the healthcare expense of the child, the benefits of the Plan which covers the parent with financial responsibility are determined before any other Plan.

4. The benefits of a Plan which covers a person as an Employee (or a Dependent of such person) who is not laid off or retired are determined before the benefits of a Plan which covers such person (or a Dependent of such person) as a laid off or retired employee.

If the other Plan does not have this rule, and as a result the Plans do not agree on the order of payment, this rule does not apply.

5. If none of the above rules determine the order of payment, then the benefits of the Plan which has covered the person for the longer period of time are determined before those of a Plan which has covered the person for the shorter period of time.

When only one of the Plans has a Coordination of Benefits provision, then the benefits of the Plan without such a provision are determined before those of a Plan which contains a Coordination of Benefits provision.

Medicare Elections

Federal Law requires that the Plan offer to active employees (age 65 and over), the same benefits as are available to other active employees and their dependents. In addition, the Plan must offer employees and their eligible dependents who are under age 65 but still eligible for Medicare due to disability, the same benefits as are available to other active employees and their dependents.

This Plan Primary

As an active employee over 65 you would then receive the same coverage as an employee under age 65. If you elect this option, Medicare will supplement this Plan by becoming your secondary coverage until you retire or terminate your employment, whichever occurs first.

Medicare Primary

If you are age 65 or older and retired, Medicare is your primary Plan. The only medical coverage you would have would be Medicare (unless you arrange for some other individual coverage to supplement Medicare).

If applicable, the election of the employee will also apply to his dependents.

Section XI

Definitions

Ambulatory Care Center

A public or private establishment with an organized staff of doctors and with permanent facilities equipped mainly to do surgery. It does not provide services or accommodations for patients to stay overnight, but it has the services of a doctor or a registered nurse at all times when a patient is present.

Biologically Based Mental Illness - schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association.

Calendar Year

A period of one year beginning with January 1.

Charges/Fees/Expenses

The actual expense incurred for medical care excluding the amount of (a) a service or supply not generally accepted in medical practice as needed in the diagnosis or treatment of the patient, even if ordered by a physician, (b) repeated tests which are not needed, even if ordered by a physician, or (c) more than what is reasonable and customary in the locale where incurred.

Chiropractic Services

The actual expense incurred for spinal manipulation therapy, defined as the manual manipulation of the spine, and/or the musculoskeletal system to restore mobility to the joints and to allow vertebrae to assume their normal position. The physician must certify, at reasonable intervals, the medical necessity of continued treatment.

Community Mental Health Facility

A facility which is approved by a regional health planning agency or which provides services under a community mental health and retardation board. Such a board must be established in accordance with Ohio law and where such a board provides direct mental health services, the specific program of such services must be approved by Ohio's Mental Health Commissioner.

Co-Payment

After the individual Deductible Amount is satisfied, the Plan will pay eligible expense (R & C) in excess of the Deductible Amount at the percentage indicated in the Schedule of Benefits.

Confinement

The period of time during which an individual is an inpatient in a hospital or other covered institution. Successive periods of confinement which are due to the same or related causes are considered as one period of confinement if they are not separated by a return to active work of three (3) consecutive months.

Covered Person

An employee and/or dependent who enrolls and becomes covered under the Plan.

Custodial Care

Charges for room and board and other institution or nursing services which are provided for a person due to his or her mental or physical condition mainly to aid the person in daily living.

Charges for medical services which are given merely as care to maintain the person's present state of health and which cannot be expected to improve a medical condition to a great extent.

Deductible Amount

The amount of eligible expenses as shown in the Schedule of Benefits, which must be incurred by a Covered Person during each calendar year, before benefits become payable under the Plan.

Dependents

Each of the following constitute a dependent:

- a) spouse of the employee not divorced or legally separated;
- b) unmarried dependent children from birth to age 19, (to age 26 if full time student) provided the child is dependent upon the employee for support and maintenance in accordance with the Internal Revenue Service dependent guidelines.
- c) unmarried dependent children who are mentally retarded or physically handicapped. Proof of such incapacity and dependency must be furnished to the Plan within 31 days of the date they are first eligible for coverage. The administrator may require, at reasonable intervals, subsequent proof of the child's incapacity and dependency. The Plan reserves the right to have such dependent examined by a physician of the Plan's choice to determine the existence of such incapacity.

The term "unmarried dependent children" will include; (1) natural children; (2) step-children; (3) legally adopted children, or (4) any other children who live with the employee in a parent-child relationship and is solely dependent on the employee for support and maintenance in accordance with the Internal Revenue Service dependent guidelines.

Emergency Accident

An accidental injury or accidental poisoning which is caused by external force and which is sudden, unexpected, and unforeseen.

Emergency Care Center

A public or private establishment with an organized staff of doctors and with permanent facilities equipped mainly to provide immediate emergency accident care and non-acute medical care.

Employee

A person who is regularly scheduled to work the number of hours specified in the respective bargaining unit agreements. Contact the school office for eligibility information.

If both husband and wife are employed by the school, both may be covered as employees and both may be covered as dependents of each other along with any dependent children.

Extended Care Facility

A legally constituted and operated institution (other than a hospital) that furnishes a room and board and skilled nursing services for medical care, has one or more licensed nurses on duty at all times under the 24-hour supervision of Registered Nurse (R.N.) or a physician, and has available at all times the services of a physician. The institution must be licensed, registered or approved by the appropriate authority of the jurisdiction in which it is located and it must be accredited by the American Hospital Association (A.H.A.). It also must keep daily medical records on all patients.

This term does not include an institution or part of one, used mainly for (a) rest care, (b) care of the aged, (c) care of drug addicts/alcoholics, (d) custodial care or (e) education care.

He, Him, His

Whenever the masculine pronoun is used in this document, it shall include the feminine gender unless the context clearly indicates otherwise.

Home Health Agency

A public or private agency or organization, or part of one, that mainly provides skilled nursing and other therapeutic services. It must be legally qualified in the state or locality in which it operates. It must keep critical records on all patients. The services must be supervised by a doctor or registered nurse, and they must be based on policies set by associated professionals, which include at least one doctor and one registered nurse.

Hospice

A legally constituted healthcare program which provides a coordinated set of services rendered at home or in an outpatient or institutional setting for individuals suffering from an illness or condition with a terminal prognosis of six (6) months or less.

Hospital

An institution for care of the sick or injured which is properly licensed or permitted legally to operate as such, and which has licensed graduate Registered Nurses on duty twenty-four hours a day, a physician on call at all times and facilities for diagnosis of

illness and for major surgery. The definition of "Hospital" shall be expanded for purposes of in-patient psychiatric benefits, if any, to include, any facility operating legally as a psychiatric hospital and licensed as such by the state in which the facility operates. The definition of Hospital shall also be expanded to include facilities for the treatment of drug addiction and alcoholism, if the facility is licensed by the state in which the facility operates and is operating legally within the scope of its license.

Illness

Any sickness or disease which manifests treatable symptoms and which requires treatment by a Physician.

Incurred Date

A charge is incurred on the date the services are performed or the date the purchase is made.

Injury

Any bodily injury sustained while the individual is covered under the Plan, and which requires treatment by a Physician.

Inpatient

The period of time during which a Covered Person is treated at a hospital or other covered institution as a registered bed patient.

Inpatient Rehabilitation Institution

An institution (other than a hospital) established to care for and treat those who need inpatient medical care including but not limited to mental or emotional disorders or substance abuse. The institution must have permanent facilities on the premises for inpatient medical care. The institution must be licensed, registered or approved by the appropriate authority of the jurisdiction in which it is located or it must be accredited by the American Hospital Association. It must keep daily medical records on all patients.

This term does not include an institution or part of one, used mainly for (a) rest care (b) nursing care (c) care of the aged or (d) custodial care.

Medically Necessary

A service or supply must be necessary and appropriate for the diagnosis and treatment of an illness or injury based on generally accepted current medical practice. A service or supply will not be considered as medically necessary if (a) it is provided only as a convenience to the covered person or (b) it is not appropriate treatment for the covered person's diagnosis or symptoms, or (c) it exceeds (in scope, duration, or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

The fact that any particular physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make that service medically necessary.

Medicare

Title XVIII (Health Insurance for the Aged) of the United States Social Security Act as amended by Social Security Amendment of 1965 or as later amended.

Miscellaneous Services

Charges made by a hospital or other covered institution for other than room and board and general nursing care including, but not limited to amounts charged for necessary services, medicines, supplies or services for diagnosis or treatment of an illness or injury (except services of a physician and drugs or supplies not consumed or used in the hospital) while the Covered Person is confined as an inpatient.

Outpatient

A Covered Person shall be considered to be an Outpatient if treated in a hospital or other covered institution on a basis other than as a registered bed patient. Outpatient care includes services, supplies and medicines provided under the direction of a Physician. Outpatient care shall also include covered services rendered in the physician's office, laboratory or X-ray facility, or in the patient's home.

Physician

A person acting within the scope of his license and holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry

(D.P.M.), Doctor of Chiropractic (D.C.) or a Psychologist (Ph.D) or licensed Physical Therapist provided they are licensed in the political jurisdiction where practicing and are acting within the scope of their license and are performing services order by a Doctor of Medicine or Doctor of Osteopathy.

Pre-Admission Testing

The actual charge incurred for diagnostic laboratory tests and X-ray exams required in connection with a scheduled surgery and performed on an out-patient basis. Charges will include all such tests performed within 14 days of the hospital admission and as a result of having these tests performed, the Covered Person must not be admitted to the hospital prior to the actual date of service.

Reasonable and Customary Charges (R & C)

The normal and necessary charges made for similar services by the providers of medical services with like experience, education and training in the same geographic (zip code) area. Determination of whether or not a charge is R & C shall be made by the Claims Administrator based on nationally obtained and recognized survey data.

Room and Board

Charges made by a hospital or other covered institution for the cost of the room, general duty nursing care, and other services routinely provided to all inpatients.

Semi-Private Charge

The charge made by a hospital for a room containing two (2) or more beds but does not include Special Care Unit Charges.

Special Care Unit

A specific hospital unit which provides concentrated special equipment and highly skilled personnel for the care of critically ill patients requiring immediate, constant and continuous attention. This term will include charges for intensive care, coronary care, acute care units of a hospital but does not include care in a surgical recovery or post-operative room. The unit must meet the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Sudden and Serious Illness

A condition or symptom which becomes so acute in nature and which is of such severity that it does in fact constitute an extremely hazardous medical condition which would result in jeopardy to the person's life or causes serious harm to their health if not treated immediately by a doctor.

Total Disability

A Covered Person shall be considered totally disabled if he is prevented, solely because of a non-occupational injury or non-occupation disease, from engaging in his regular or customary occupation and is performing no work of any kind for compensation or profit; or in the case of a dependent, is prevented, solely because of a non-occupational injury or non-occupation disease, from engaging in all of the normal activities of a person of like age and sex in good health. Certification of total disability must be made by a physician.

Section XII

Claims Appeal Process

In the event that you do not agree with how your claim has been paid, or you simply do not understand the Explanation of Benefits (EOB), you may request a review of your claim. It is recommended that you first call your customer service representative. If, after this, you still are unsatisfied, you may file a requestor review. This should be done by filing a written request with the Claims Administrator, Medical Mutual Members Appeals Unit, MZ: 01-4B-4809, P.O. Box 94580, Cleveland, Ohio 44101-4580, FAX: 216-687-7990, or AultCare, P.O. Box 6910, Canton, Ohio 44706-0910 stating in clear and concise terms the reason or reasons for the disagreement with the handling of this claim. You may also submit for consideration any additional information or documentation (medical records, etc.) which you feel supports your claim. To submit an appeal electronically, go to Medical Mutual's Web site, **www.MedMutual.com**, under Members' section.

The request for review should be directed to the Claims Administrator within sixty (60) days after the claims payment date or the date of the notification of denial of benefits.

Under normal circumstances you will be notified of the final decision within sixty (60) days of the date your request for review is received. If there are special circumstances requiring delay, you will be notified that additional time may be needed.

Section XIII

External Review Process Under The Patient Protection Act of 1999

This Plan intends to comply with the Patient Protection Act of 1999 as it applies to public employee benefit plan (Ohio Revised Code §§3923.75 to 3923.79), as amended from time to time.

The Patient Protection Act adds a separate and additional process for review of a denied claim following a Covered Person's exhaustion of the plan's internal claims appeal process. The Covered Person must use all the Plan's established steps for internal appeal of a denied claim before invoking a review under the Patient Protection Act. Due to the comprehensive nature of the Patient Protection Act of 1999, the following is intended only as a summary of the law as it applies to public employee benefit plans.

Review of Claim Denial for Service Not Covered

The Ohio Department of Insurance will review written requests from Covered Persons who have been denied coverage on the grounds that service is not covered under the contractual terms of the Plan.

If the Plan or Carrier denies the service because it is not a covered service, a Covered Person may request a review from the Ohio Department of Insurance.

The Ohio Department of Insurance shall notify the Covered Person and the Plan of its determination, or that it is not able to make a determination because the determination requires the resolution of a medical issue.

If the determination requires the resolution of a medical issue, the Plan shall afford the Covered Person an opportunity for external review by an independent review organization. If the Ohio Department of Insurance notifies the Plan that the health care service is not a covered service, then the Plan is not required to cover the service or afford the Covered Person an external review.

External Review of Coverage Denial

The Plan will afford the Covered Person an external review of a coverage denial when requested if the Plan has determined that the health care service is not medically necessary and the proposed service, plus any ancillary services and follow-up care, will cost the Covered person more than five hundred dollars (\$500).

An external review must be requested in writing. If the Covered Person has a condition that requires expedited review, the review may be requested orally or by electronic means. Written confirmation of the request must be submitted to the Plan not later than five (5) days after an oral or electronic request is made.

Except in the case of an expedited review, a request for an external review must be accompanied by written certification that the proposed service, plus any ancillary services and follow-up care, will cost more than five hundred dollars (\$500). A Covered Person shall not be required to pay for any part of the cost of any external review.

A request for an external review shall be denied if the request is received by the Plan or Carrier later than sixty (60) days after the Covered Person received notice from the Ohio Department of Insurance or Carrier that making the determination requires the resolution of a medical issue. The provider or health care facility may not request a review without the prior content of the Covered Person.

Expedited Review of Coverage Denial

For an expedited review, the Covered Person's provider must certify that the Covered Person's condition could, in the absence of immediate medical attention, result in any of the following:

- (a) Placing the health of the Covered Person, with respect to a pregnant woman, the health of the Covered Person or the unborn child, in serious jeopardy;
- (b) Serious impairments to bodily functions; of
- (c) Serious dysfunction of any bodily organ or part.

In the case of an expedited review, the independent review organization shall issue a written decision not later than seven (7) days after the filing of the request for review. In all other cases, the independent review organization shall issue a written decision not later than thirty (30) days after the filing of the request. The independent review organization shall send a copy of its decision to the Plan and the Covered Person. If the provider rendering health care services requested the review, the independent review organization shall also send a copy of its decision to the provider.

The independent review organization shall base its decision on the information submitted. In making its decision, the independent review organization shall consider safety, efficacy, appropriateness, and cost effectiveness.

The Plan shall provide any coverage determined by the independent review organization's decision to be medically necessary, subject to the other terms, limitations, and conditions of the Plan.

External Review of Coverage Denial for Experimental Treatment of Terminal Conditions

The Plan will afford an external review regarding experimental treatment to examine the Plan's coverage decision for a Covered Person who meets all of the following criteria:

- (a) The Covered Person has a diagnosed terminal condition that has a high probability of causing death within two years;
- (b) The Covered Person requests a review not later than sixty (60) days after receipt by the Covered Person of notice from the Ohio Department of Insurance or Carrier that making a determination requires resolution of a medical issue;

- (c) The Covered Person's physician certifies the terminal condition, and that standard therapies have not been effective in improving the condition, and that standard therapies are not medically appropriate;
- (d) The Covered Person's physician has recommended treatment that the physician certifies, in writing, is likely to be more beneficial to the Covered Person, in the physician's opinion, than standard therapies, or the Covered Person has requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition;
- (e) The Covered Person has been denied coverage by the Plan for treatment recommended or requested, and has exhausted all internal appeals; and
- (f) The treatment, for which coverage has been denied, would be a covered health care service except for the Plan's determination that the treatment is experimental or investigational.

A review shall be requested in writing, except that if the Covered Person's physician determines that a therapy would be significantly less effective if not promptly initiated, the review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request shall be submitted to the Plan or Carrier not later than five (5) days after the oral or written request is submitted. For an expedited review, the Covered Person's provider must certify that the requested or recommended therapy would be significantly less effective if not promptly initiated.

A Covered Person shall be notified by the Plan or Carrier of the opportunity for external review of a denied claim for experimental treatment of a terminal illness within thirty (30) business days after the Plan denies coverage.

The opinion of the majority of the experts on the external review panel is binding on the Plan with respect to that Covered Person. If the opinions of the experts on the panel are evenly divided as to whether the therapy should be covered, the Plan's final decision shall be in favor of coverage. If less than a majority of the experts on the panel recommend coverage of the therapy, the Plan may, in its discretion, cover the therapy. However, any

coverage is subject to the terms, limitations, and conditions of the Plan. The Plan will annually file a certificate with the Ohio Department of Insurance certifying the Plan's compliance with this section.

Section XIV

How to Use Your Benefits

If You Need Hospital Care

Present your Health Benefit Plan identification Card when you enter the hospital. You may not need to fill out claim forms or report any hospital charges to the Claims Administrator. The hospital may instead bill the Claims Administrator directly and all covered services will be paid for you.

If You Need Physician Care

Show the physician your Health Benefit Identification Card, provide him with a claim form (which you can obtain from your employer or claims Administrator) and ask him to bill the Claims Administrator for all of his services to you which are payable under this Plan — whether at his office, your home or in the hospital — indicating diagnosis, date of service, and fees.

When to File a Claim

You should file a claim as soon as you receive charges for services covered by your Plan. Claim forms may be obtained from your Personnel Office. In situations where charges incurred may be of a nominal nature, it is suggested that you accumulate them until they are sufficient to satisfy the cash deductible. In situations where the deductible has already been satisfied, accumulating smaller bills will simplify everyone's record-keeping by reducing the number of checks issued to you and your Dependents.

All claims relating to payment for a benefit covered by the Plan must be filed within the twelve-month period following the date the benefit is received. A claim shall not be considered filed unless and until all required information relating to the service or

benefit for which the claim is filed has been provided to the Claims Administrator.

How to File a Claim for Other Health Services

Sometimes the provider of healthcare does not bill the Claims Administrator directly, but bills you for such services.

Make sure that your bill from the provider of service contains all of the following information:

- a. patient's name;
- b. description of each service rendered;
- c. date(s) of each service rendered;
- e. diagnosis (if more than one diagnosis, indicate which diagnosis refers to each specific service rendered); and
- f. name, address and tax identification number of the provider of service.

Make a photocopy of the billing you receive from the provider of health service for your records and send the billing (if paid by you, make sure the bill so indicates this) with a completed claim form to your Claims Administrator:

Medical Mutual Services Company	AultCare
P.O. Box 6018	or P.O. Box 6910
Cleveland, Ohio 44101-1018	Canton, Ohio 44706-0910

1. A separate claim form must be submitted for each family member for whom a claim is being made. The Plan maintains separate payment and deductible records on you and each of your Dependents. It is necessary to submit another form with billings for subsequent service. If you have made payment to the provider, be sure the bill is marked paid or is accompanied by a paid receipt.
2. Please review the claim form carefully and follow the instructions it contains. It is not always necessary to complete every section. You need only complete those sections applicable to the claim being filed. For example, if no accident is involved, you need not complete the Accident Section. If the claim is on you, it is not necessary to complete the Dependent Section, etc.

Method of Payment

All payments will be made directly to you unless you specifically request otherwise.

Other Group Coverage

Since this Plan contains a Coordination of Benefits provision, it is important that you advise the Claims Administrator of any other group health plan covering you or your Dependents. You should complete the appropriate section of your claim form in full.

NOTE: When another plan covers the claimant, send exact duplicates of all bills being submitted with a claim to each carrier involved to assist them in coordinating benefits without a lengthy delay. To help you to understand what Coordination of Benefits is and how it affects you, refer to "Coordination of Benefits Provision".

Incomplete Claim Forms

Your Claims Administrator has simplified procedures for handling your Health and Welfare Benefits by providing you with a claim form which contains the information necessary to process your claim. When a claim form is submitted without completion of all of these items, it is necessary for the Claims Administrator to request the information. This can cause unnecessary delays in providing you with your eligible benefits.

Late Submission of Claim

Important: Claims submitted more than 12 months from date of service may be denied. You can assist your Claims Administrator by submitting your claims promptly and by following the claim filing instructions.

Right of Subrogation

The Plan shall be subrogated to the extent of any payments under this Plan of health coverage to all of the Plan Member's right of recovery irregardless of the entity or individual from whom the recovery may be due. The Plan will have the right, at its discretion and Plan Administrator's sole instigation, to take legal action on behalf of the insured or on behalf of the Plan itself. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan

any rights the Covered Person may have to recover payments from any third party or insurer. As a condition to the Plan making payments for any medical or dental charges, the Plan Member must assign to the Plan his or her rights to any recovery arising out of or related to any act or omission that caused or contributed to the Injury or Sickness for which such benefits are to be paid. Any amounts so recovered, however designated, shall be apportioned as follows: this Plan shall be fully reimbursed to the extent of its payments under this plan of health coverage. This Plan shall have priority over the Plan Member to the funds recovered and this Plan shall have priority over the Plan Member to any full or partial recovery. If any balance then remains from such recovery, it shall be applied to reimburse the Plan Member and any other policy providing benefits to the Plan Member as their interest may appear.

Reimbursement

If the Plan Member recovers damages from any party or through any coverage named above, he must hold in trust for the Plan the proceeds of the recovery, and must reimburse the Plan to the extent of payment made. The Plan is entitled to be completely compensated for any and all funds expended as a result of the Plan Member's sickness or injury regardless if the Plan Member is fully or only partially compensated. The Plan takes priority over the Plan Member for both full and partial recovery.

The Plan maintains both a contractual right of reimbursement and a separate right of subrogation to any funds recovered by you. You acknowledge that the Plan's subrogation and reimbursement rights shall be considered the first priority claim against any third party or your own automobile or liability carrier, to be paid before any other claims which may exist are paid, including claims by you for general damages or attorney fees or other costs.

— NOTES —

Plan administered by:



MEDICAL MUTUAL SERVICES

Medical Mutual Services Company

Customer Service Hotline — 1-800-228-6472

Preview Hotline — 1-800-258-2873

Dental Customer Service Hotline — 1-800-833-7027

**Traditional
Comprehensive &
PPO Plans**



AultCare

PPO Plans

Customer Service Hotline - 1-800-344-8858

1-330-363-6360

Pre-certification Hotline - 1-800-344-8858

1-330-363-6397