PPO Medical Plan

What Your Plan Covers and How Benefits are Paid

Plan Effective Date: 1/1/2020

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Introduction and Important Plan Information

The medical benefits described in this Summary Plan Description or SPD are a benefit program offered by Your Employer. Your Employer has selected these medical plan benefits to be offered as a component of the OhioHealth Corporation Welfare Benefits Plan. These benefits are not insured with OhioHealthy or any of its affiliates, but will be paid from the Employer's funds. OhioHealthy will provide certain administrative services under the OhioHealthy Medical Plan (referred to as the "Plan") in this SPD.

OhioHealthy has an agreement with Your Employer to provide administrative services in accordance with the conditions, rights, and privileges in this SPD.

The SPD describes Your rights and obligations, what the Plan covers, and how benefits are paid for that coverage starting on the Plan's effective date. It is Your responsibility to understand the terms and conditions in this SPD. Your SPD also includes the Summary of Benefits with Your out-of-pocket Deductible and Coinsurance amounts.

Employer: **OhioHealth Corporation, including its related entities as applicable**
Effective Date: **January 1, 2020**

Health Expense Coverage for You and Your Dependents

Benefits are payable for covered health care expenses that are incurred by You or Your Dependents while coverage is in effect. An expense is "incurred" on the day You receive a health care service or supply.

Coverage under this Plan is non-occupational. Only Non-Occupational Injuries and Non-Occupational Illnesses are covered.

Refer to the *What The Plan Covers: Medical Benefits* and *What The Plan Covers: Pharmacy Benefits* sections of the SPD for more information about Your medical and pharmacy benefits.

Treatment Outcomes of Covered Services

OhioHealthy is not a provider of health care services and therefore is not responsible for, and does not guarantee any results or outcomes of the covered health care services and supplies You receive. Except for OhioHealthy, providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of OhioHealthy or its affiliates.

OhioHealthy PPO Summary of Benefits

This document is a summary of benefits and services available through the Plan. If there are any differences between this summary and the rest of this Summary Plan Description (SPD), the provisions of the SPD documents will prevail for all benefits, conditions, limitations and exclusions. There are two benefit columns. One column lists the Copay and the percent Coinsurance You[1] will pay for In-Network Benefits from In-Network Providers. The other column lists the percent Coinsurance You will pay for Out-of-Network Benefits from Out-of-Network Providers. Some benefits require Pre-Authorization before You receive them. For details about Pre-Authorization, Covered Services, and non-Covered Services please read Your entire Summary Plan Description document carefully.

DEDUCTIBLE AND COINSURANCE INFORMATION

	In-Network Benefits[4] Coinsurance	Out-of-Network Benefits[5] Coinsurance
Deductibles per calendar year[3]	**$500 Associate Only $750 Associate + 1 $1,000 Family**	**$1,800 Associate Only $2,800 Associate + 1 $3,600 Family**
Out-of-pocket maximum (includes deductible)	**$2,500 Associate Only $3,750 Associate + 1 $5,000 Family**	**There Is No Maximum For Out-Of-Network Benefits**

Note: Your total out-of-pocket maximum amount is the Deductible amount for Your coverage plus the Coinsurance and Copayments you pay, up to the dollar amounts shown for Your coverage. If You have Associate only coverage once the individual out of pocket maximum has been met, eligible costs are covered for the rest of the Plan Year. If You have Associate +1 or Family coverage when an individual within Your family reaches the individual out-of-pocket amounts, that family member's eligible costs are covered for the rest of the Plan Year.

CIN is an acronym for Clinically Integrated Network. Our clinically integrated network provides more access to care and helps reduce healthcare costs. It is your decision as to which provider you choose to use for your healthcare. Should you choose to use an OhioHealthy CIN provider, you may pay a lower copay. More information is available at www.ohiohealthyplans.com/ohiohealth

PHYSICIAN SERVICES

	In-Network Benefits Copay/Coinsurance[2]	Out-of-Network Benefits Coinsurance[2]
Primary Care Physician (PCP) Office Visit	$20 copay	After calendar year Deductible You pay 50%
Specialist Office Visit	CIN Providers: $25 copay All other In-Network Providers: $50 copay	After calendar year Deductible You pay 50%
Virtual office visit provided by MDLIVE	$10 Copay	Not Covered

Summary of Benefits: Medical Benefits

PREVENTIVE CARE [7,8,9]		
Pages 4-6 of this Summary of Benefits lists major categories of covered preventive care. You can see a complete list of ACA Recommended Preventive Care Services at the links below: **http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/** **http://www.hrsa.gov/womensguidelines/** **https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html** **Some preventive care services may be administered under Your Prescription Drug benefit on pages 15-18 in this SPD.**		
	In-Network Benefits Coinsurance[2]	**Out-of-Network Benefits Coinsurance[2]**
Bone Density Measurement Screening Maximum tests per 2 consecutive year period for covered females age 65 and over: 1 test For covered females age 55 through 64:1 baseline test Combined In-Network or Out-of-Network	Covered at 100% No calendar year Deductible applies.	After calendar year Deductible You pay 50%
Breast Pumps & Supplies Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the SPD for limitations on breast pumps and supplies.	Covered at 100% No calendar year Deductible applies.	After calendar year Deductible You pay 50%
Colonoscopy Age 50 and over	First colonoscopy per calendar year: Covered at 100% No calendar year Deductible applies. All subsequent colonoscopies: After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Colorectal Cancer Screening Screenings listed below for colorectal cancer starting at age 50 years and continuing until age 75 years		
Depression screening: adolescents screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years.	Covered at 100% No calendar year Deductible applies.	After calendar year Deductible You pay 50%
Depression screening: adults Screening for depression in the general adult population, including pregnant and postpartum women.	Covered at 100% No calendar year Deductible applies.	After calendar year Deductible You pay 50%
Diabetic Counseling	Covered at 100% No calendar year Deductible applies.	After calendar year Deductible You pay 50%
Digital Rectal Exam - Routine For covered males age 45 and over: 1 test Combined In-Network or Out-of-Network	Covered at 100% No calendar year Deductible applies.	After calendar year Deductible You pay 50%

Summary of Benefits: Medical Benefits

	In-Network Benefits Coinsurance[2]	Out-of-Network Benefits Coinsurance[2]
Exercise Consultation Exercise Consultation Maximum visits per calendar year: 3 visits	Covered at 100% No calendar year Deductible applies for services for diagnoses related to diabetes, obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor. All other diagnoses After calendar year Deductible You pay 20%	Not Covered
Family Planning - Female Voluntary Sterilization Inpatient or Outpatient	Covered at 100% No calendar year Deductible applies.	After calendar year Deductible You pay 50%
Family Planning Services Female Contraceptive Counseling Services	Covered at 100% No calendar year Deductible applies.	After calendar year Deductible You pay 50%
Family Planning Services: Female Contraceptive identified on the OptumRx Preventive care list. www.optumrx.com/enroll/ohiohealth	Covered at 100% per Prescription or refill No calendar year Deductible applies.	You pay the difference between the Recognized Charge and the amount you paid out of pocket
Fecal Immuno Chemical Test For Covered Persons age 50 and over. Maximum tests per calendar year: 1 test Combined In-Network or Out-of-Network	Covered at 100% No calendar year Deductible applies.	After calendar year Deductible You pay 50%
Fecal Occult Blood Test For Covered Persons age 50 and over. Maximum tests per calendar year: 1 test Combined In-Network or Out-of-Network	Covered at 100% No calendar year Deductible applies.	After calendar year Deductible You pay 50%
Female Contraceptive Devices Covered under Your Plan's Prescription Drug benefit.	Covered at 100% per Prescription or refill No calendar year Deductible applies.	After calendar year Deductible You pay 50% per Prescription or refill.
Gynecological Exam - Routine Maximum exams per calendar year: 1 exam Combined In-Network or Out-of-Network	Covered at 100% No calendar year Deductible applies.	After calendar year Deductible You pay 50%
Lactation Support and Counseling Services - Comprehensive Lactation Counseling Services Facility or Office Visits Lactation Counseling Services Maximum visits either in a group or individual setting: 6 visits per 12 months Note: Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under traditional provider office visits.	Covered at 100% No calendar year Deductible applies.	After calendar year Deductible You pay 50%

Summary of Benefits: Medical Benefits

	In-Network Benefits Coinsurance[2]	Out-of-Network Benefits Coinsurance[2]
Mammography - Routine Maximum tests per calendar year For covered females age 40 and over: 1 test For covered females age 35 through 39: 1 baseline mammogram Combined In-Network or Out-of-Network	Covered at 100% No calendar year Deductible applies.	After calendar year Deductible You pay 50%
Nutritional Counseling	Covered at 100% No calendar year Deductible applies (first 3 visits per calendar year) for services for diagnoses related to diabetes, obesity, cardiovascular disease risk factors, or being overweight with an additional cardiovascular disease risk factor. All subsequent visits per calendar year and all other diagnoses: After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Pap Smears - Routine Maximum tests per calendar year: 1 test Combined In-Network or Out-of-Network	Covered at 100% No calendar year Deductible applies.	After calendar year Deductible You pay 50%
Physical Exams – Routine Adults only. Includes coverage for immunizations. Maximum exams per calendar year Adults age 18 and over : 1 exam combined In-Network or Out-of-Network	Covered at 100% No calendar year Deductible applies.	After calendar year Deductible You pay 50%
Preventive Vision Services Coverage includes one examination every 24 months.	Covered at 100% No calendar year Deductible Applies	Covered at 100% No calendar year Deductible Applies
Prostate Specific Antigen Test For covered males age 45 and over. Maximum tests per calendar year: 1 test Combined In-Network or Out-of-Network	Covered at 100% No calendar year Deductible applies.	After calendar year Deductible You pay 50%
Sigmoidoscopy **Age 50 and over**	Covered at 100% No calendar year Deductible applies.	After calendar year Deductible You pay 50%
Tobacco Cessation Screening, Counseling and Interventions	Covered at 100% No calendar year Deductible applies.	Not Covered
Well Child Exams Includes coverage for immunizations. Maximum exams Under age 3 first 12 months of life: 7 exams 13th-24th months of life: 3 exams 25th-36th months of life: 3 exams Maximum exams per calendar year For age 3 to 18: 1 exam Combined In-Network or Out-of-Network	Covered at 100% No calendar year Deductible applies.	After calendar year Deductible You pay 50%

OUTPATIENT THERAPY AND REHABILITATION SERVICES		
	In-Network Benefits Coinsurance[2]	Out-of-Network Benefits Coinsurance[2]
Cardiac Rehabilitation	After calendar year Deductible You pay 20%	After calendar year DeductibleYou pay 50%
Physical Therapy, Occupational Therapy and Speech Therapy[7] Physical, Occupational and Speech Therapy are limited to a maximum combined benefit with In-Network and Out-of-Network Benefits and for all places of service of 50 visits per calendar year.	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Pulmonary Rehabilitation Vascular Rehabilitation Vestibular Rehabilitation Pre-Authorization is required.[6]	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Other Outpatient Treatments		
	In-Network Benefits Coinsurance[2]	Out-of-Network Benefits Coinsurance[2]
Allergy Testing and Treatment including injections	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Chemotherapy Radiation Therapy IV Therapy Inhalation Therapy	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Injectable and Infused Medications[6] Includes injectable and infused medications, biologics, and IV therapy medications that require Pre-Authorization. Coinsurance applies when medications are provided in a Physician's office, an outpatient facility, or in the Member's home as part of Skilled Home Health Care Services benefit. Coinsurance is in addition to any applicable office visit or outpatient facility Coinsurance.	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
OUTPATIENT DIALYSIS SERVICES		
	In-Network Benefits Coinsurance[2]	Out-of-Network Benefits Coinsurance[2]
Dialysis Services Coinsurance applies at any place of service.	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%

OUTPATIENT SURGERY		
	In-Network Benefits Coinsurance[2]	Out-of-Network Benefits Coinsurance[2]
Outpatient Surgery Pre-Authorization is required.[6] Coinsurance applies to services provided in a freestanding ambulatory Surgery Center or Hospital outpatient surgical facility.	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%

Summary of Benefits: Medical Benefits

OUTPATIENT DIAGNOSTIC PROCEDURES		
	In-Network Benefits Coinsurance[2]	**Out-of-Network Benefits Coinsurance[2]**
Diagnostic Laboratory Testing	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Diagnostic Procedures	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Diagnostic X-Rays **Ultrasound** **Doppler Studies**	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%

OUTPATIENT ADVANCED IMAGING AND TESTING PROCEDURES[6]		
	In-Network Benefits Coinsurance[2]	**Out-of-Network Benefits Coinsurance[2]**
Complex Imaging and Testing including: **Magnetic Resonance Imaging (MRI)** **Magnetic Resonance Angiography (MRA)** **Positron Emission Tomography (PET Scans)** **Computerized Axial Tomography (CT Scans)** **Computerized Axial Tomography Angiogram (CTA Scans)** **Sleep Studies** **Genetic Testing** **Pre-Authorization is required for all procedures except MRS, SPECT and Nuclear Cardiology.[6]** Coinsurance applies to procedures done in a Physician's office, a freestanding outpatient facility, or a Hospital outpatient facility.	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Magnetic Resonance Guided Focused Ultrasound Surgery (MRgFUS)	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%

MATERNITY CARE		
	In-Network Benefits Coinsurance[2]	**Out-of-Network Benefits Coinsurance[2]**
Maternity Care[8, 9] Includes prenatal, delivery, postpartum services, and home health visits. Coinsurance is in addition to any applicable inpatient Hospital Coinsurance. Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, You will need to complete a change form and return it to Your Employer within the 31-day enrollment period.	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%

Summary of Benefits: Medical Benefits

INPATIENT SERVICES		
	In-Network Benefits Coinsurance[2]	**Out-of-Network Benefits Coinsurance[2]**
Inpatient Hospital Services **Pre-Authorization is required.[6]** Room and Board (including maternity). Transplants are covered at contracted facilities only.	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Skilled Nursing Facilities/Services[7] **Pre-Authorization is required.[6]** Following inpatient Hospital care or in lieu of Hospitalization. Covered Services include up to 120 days combined in and out-of-network per calendar year that in the Plan's judgment requires Skilled Nursing Facility Services.	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
AMBULANCE SERVICES		
	In-Network Benefits Coinsurance[2]	**Out-of-Network Benefits Coinsurance[2]**
Elective Transportation Services Ambulance Services **Pre-Authorization is required for non-emergent transportation only.[6]** Includes air, ground or water Ambulance for Emergency transportation, or non-emergent transportation that is Medically Necessary and Pre-Authorized by the Plan. Coinsurance is applied per transport each way.	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
EMERGENCY SERVICES		
	In-Network Benefits Copay/Coinsurance[2]	**Out-of-Network Benefits Coinsurance[2]**
Emergency Services **Pre-Authorization is not required.** Includes Emergency Services, Physician, and ancillary services provided in an emergency department facility.	After calendar year Deductible You pay 20% + $200 copay	
URGENT CARE CENTER SERVICES		
	In-Network Benefits Copay/Coinsurance[2]	**Out-of-Network Benefits Coinsurance[2]**
Non-Urgent Use of Urgent Care Provider Routine medical care and preventive care services not covered at Urgent Care Provider, except for flu shots at OhioHealth urgent care.	Not covered	Not covered
Urgent Medical Care Services **Pre-Authorization is not required.** Includes Urgent Care Services, Physician services, and other ancillary services received at a non-Hospital freestanding Urgent Care facility. If You are transferred to an emergency department from an urgent care center, You will pay the Emergency Services Deductible, Coinsurance, and Copay	$40 copay	After calendar year Deductible You pay 50%

Summary of Benefits: Medical Benefits

MENTAL/BEHAVIORAL HEALTH & SUBSTANCE USE DISORDER TREATMENT		
	In-Network Benefits Copay/Coinsurance[2]	**Out-of-Network Benefits Coinsurance[2]**
Behavioral Health Counseling	CIN Providers: $25 copay All Other In-Network Providers: $50 copay	After calendar year Deductible You pay 50%
Behavioral Health Counseling Virtual Consults provided by MDLIVE	$10 copay	Not Covered
Inpatient Services **Pre-Authorization is required for all inpatient services.[6]**	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Outpatient Services **Pre-Authorization is required for Intensive Outpatient Program (IOP), Partial Hospitalization services and electro-convulsive therapy.[6]**	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Diabetes Supplies and Equipment		
	In-Network Benefits Coinsurance[2]	**Out-of-Network Benefits Coinsurance[2]**
Diabetic Education Including in-person outpatient self-management training and education including medical nutrition therapy diabetic education by a registered dietician or pharmacist.	Covered at 100%. No calendar year Deductible applies.	After calendar year Deductible You pay 50%
Diabetic Testing Supplies **Insulin, Needles, and Syringes** Testing supplies includes test strips, lancets, lancet devices, blood glucose monitors and control solution. Diabetic Prescription Benefits	The plan will pay 100% of the cost for approved In-network diabetic testing supplies if the condition management requirements are met. Failure to meet the condition management requirements means that You will pay 20% of the cost for these approved diabetic testing supplies. Insulin, needles, and syringes should be picked up at the pharmacy.	For non-contracted pharmacies outside of the OptumRx network: After calendar year Deductible You pay 20% of the Negotiated Charge plus the difference between the Recognized Charge and the Negotiated Charge.
Insulin Pumps **Pre-Authorization is required. [6]**	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Pump Infusion Sets and Supplies **Pre-Authorization is required. [6]**	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%

Summary of Benefits: Medical Benefits

OTHER COVERED SERVICES		
	In-Network Benefits Coinsurance[2]	Out-of-Network Benefits Coinsurance[2]
Acupuncture services[7] **Pre-Authorization is required.**[6] Only services performed by a certified acupuncturist are covered limited to the relief of migraines or back/neck pain. Maximum Benefit: 15 visits per calendar year combined In-Network or Out-of-Network.	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Bariatric Surgery[7] **Pre-Authorization is required.**[6] Coverage for the treatment of Morbid Obesity through gastric bypass surgery or other methods recognized by the National Institutes of Health as effective for the long-term reversal of Morbid Obesity. Maximum benefit $30,000 per lifetime combined with In-Network and Out-of-Network benefits for all OhioHealth plans.	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Chiropractic Care/ Spinal manipulation[7] Only services performed by a chiropractor, MD or DO are covered. Spinal manipulation maximum 20 visits per calendar year.	After calendar year Deductible You pay 50%	After calendar year Deductible You pay 50%
Clinical Trials **Pre-Authorization is required.**[6] Coverage of Routine patient costs for phase I, II and III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening disease or condition.	Associates are responsible for any applicable Copay, Coinsurance or Deductible depending on the type and place of treatment or service listed on the Summary of Benefits.	Associates are responsible for any applicable Coinsurance or Deductible depending on the type and place of treatment or service listed on the Summary of Benefits.
Durable Medical Equipment (DME) and Supplies **Orthopedic Devices and Prosthetic Appliances** **Pre-Authorization is required for single items over $750.**[6] **Pre-Authorization is required for all rental items.**[6] **Pre-Authorization is required for repair and replacement.**[6] Covered Services include Durable Medical Equipment, orthopedic devices, prosthetic appliances, colostomy, iliostomyileostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement. Coverage is limited to one item of equipment, for the same or similar purpose and the accessories needed to operate the item.	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%

Summary of Benefits: Medical Benefits

OTHER COVERED SERVICES		
	In-Network Benefits Coinsurance[2]	Out-of-Network Benefits Coinsurance[2]
Family Planning: Other Voluntary termination of pregnancy Voluntary sterilization for males	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Home Health Care Skilled Services **Pre-Authorization is required.**[6] You will pay a separate outpatient therapy Coinsurance amount for physical, occupational, and speech therapy visits received at home. Therapy visits received at home will count toward Your Plan's annual outpatient therapy benefit limits. You will pay a separate outpatient Rehabilitation Services Coinsurance amount for cardiac, pulmonary, vascular, and vestibular rehabilitation visits received at home. Rehabilitation visits received at home will count toward Your Plan's annual outpatient rehabilitation benefit limits.	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Hospice Care **Pre-Authorization is required.**[6] Includes Facility Expenses (Room and Board) Other expenses during the day and any Hospice Care outpatient visits. No maximum benefit limit or day limit per lifetime.	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Infertility: Diagnostic Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the Infertility only.	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Infertility: Treatment and Assisted Reproductive Technologies[7] Includes In Vitro Fertilization, Artificial Insemination and other ART procedures. Maximum benefit $10,000 per lifetime combined with In-Network and Out-of-Network benefits for all OhioHealth plans.	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Jaw Joint Disorder Treatment also known as TMJ	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth) Includes limited surgical and non-surgical treatment of infections or diseases of the mouth, jaw joints, or supporting tissues.	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%

Summary of Benefits: Medical Benefits

OTHER COVERED SERVICES		
	In-Network Benefits Coinsurance[2]	Out-of-Network Benefits Coinsurance[2]
Outpatient Obesity Treatment Non-Surgical NOTE: The Plan provides coverage for the Medical Weight Treatment Program at the McConnell Heart Health Center.	After calendar year Deductible You pay 20%	Services are not covered Out-of-Network.
Prosthetics and Components Pre-Authorization is required.[6] Services include coverage for Medically Necessary prosthetic devices. This also includes repair, fitting, replacement, and components. Definitions: "Component" means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device. "Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot. "Prosthetic device" means an artificial device to replace, in whole or in part, a limb. Prosthetic device coverage does not mean or include repair and replacement due to Member neglect, misuse, or abuse. Coverage also does not mean or include prosthetic devices designed primarily for an athletic purpose.	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%
Wigs[7] Coverage includes wigs for loss of hair due to Illness or disease. Coverage is limited to one wig per calendar year.	After calendar year Deductible You pay 20%	After calendar year Deductible You pay 50%

SUMMARY OF BENEFITS NOTES

All benefits are subject to the terms and conditions in this Summary Plan Description (SPD). Words that are capitalized are defined terms listed in the *Definitions* section of this SPD, unless otherwise defined in the Summary chart.

Children are covered up to the end of the month in which they turn age 26. This Plan does not have pre-existing condition exclusions. This is a group Plan sponsored by Your Employer. Your Employer will pay the costs for providing these benefits to Us on Your behalf. Your Employer will tell You how much You must contribute, if any, to the costs of these benefits.

OhioHealthy has an internal claims appeal process, and an external appeal review process. Please see *Pre-Authorization, Utilization Management, And Claims Procedures* and *How To Appeal An Adverse Benefit Determination* sections in this SPD.

1. You and Your Dependents are responsible for payment of all required Copayment and Coinsurance amounts up to the maximum Coinsurance.

2. **Copayment and Coinsurance** are out of pocket amounts You pay directly to a Provider for a Covered Service. A Copayment is a flat dollar amount. A Coinsurance is a percent of OhioHealthy's **Allowable Charge** for the Covered Service You receive. Your Coinsurance amounts are listed on the Summary of Benefits. You pay Coinsurance directly to an In-Network or Out-of-Network Provider after You have met any Deductibles You owe. For example, if the Plan's Negotiated Charge for a service is $100 and You've met Your Deductible, Your Coinsurance payment of 20% would be $20.
   a. In-Network Providers accept the Plan's Negotiated Charge amount as payment in full.
   b. Medically Necessary Covered Services provided by an Out-of-Network Provider during an Emergency at a plan facility, or during an authorized admission to a plan facility, will be covered under In-Network Benefits. All other Covered Services received from Out-of-Network Providers will be covered under Your Out-of-Network Benefits.
   c. When You receive Out-of-Network Benefits from Out-of-Network Providers the Negotiated Charge may be a negotiated rate; or if there is no negotiated rate Negotiated Charge is OhioHealthy's In-Network contracted rate for the same service performed by the same type of provider or the provider's actual charge for the service, whichever is less. Out-of-Network Providers may not accept this amount as payment in full. If You use an Out-of-Network Provider who charges more than our negotiated amount the provider may balance bill You for the difference. You will have to pay the difference to the provider in addition to Your Coinsurance amount. Charges from Out-of-Network Providers will be higher than the Plan's Negotiated Charge so You will usually pay more out-of-pocket when You use Out-of-Network Providers.

3. **Deductible** means the dollar amount You must pay out of pocket each calendar year for Covered Services before the Plan begins to pay for Your benefits. Your Plan may have separate Deductible amounts You have to meet for In-Network Covered Services and for Out-of-Network Covered Services. Amounts applied to an In-Network Deductible will apply toward the Plan's In-Network Maximum Out of Pocket Limit. If You have individual coverage You must satisfy the individual Member coverage Deductible before coverage begins. This Plan has an embedded individual Deductible within the associate plus one and the family Deductible. That means if one covered family member meets the individual Member Deductible his or her benefits will begin. Once the total family (or Associate + 1) coverage Deductible is met benefits are available for all covered family members. The Deductible does not apply to Preventive Care Visits and Screenings, Prescription Drugs, and some benefits that require a Copayment (except as noted) You receive from In-Network Plan Providers. Cost sharing amounts You pay for some Covered Services will not count toward any Deductible. Deductibles will not be reimbursed under the Plan.

4. Coinsurance amounts that You pay for most In-Network Covered Services will count toward Your Out-of-pocket maximum for In-Network Benefits. If a service does not count toward Your Out-of-pocket maximum You must continue to pay Your Coinsurance for these services after Your Out-of-pocket maximum has been met. Coinsurance or any other charges for the following will not count toward Your Out-of-pocket maximum for In-Network Benefits:
   1. Amounts You pay for services or charges not covered under Your Plan;
   2. Amounts You pay for services after a benefit limit has been reached;
   3. Except for Emergency Services, amounts You pay for Out-of-Network Services;
   4. Balance billing amounts from Out-of-Network Providers;
   5. Employee contribution amounts.

Summary of Benefits: Medical Benefits

Your total out-of-pocket maximum amount is the Deductible amount for Your coverage plus the Coinsurance and Copayments you pay, up to the dollar amounts shown for Your coverage. If You have Associate only coverage once the individual out of pocket maximum has been met, eligible costs are covered for the rest of the Plan Year. If You have Associate +1 or Family coverage when an individual within Your family reaches the individual out-of-pocket amounts, that family member's eligible costs are covered for the rest of the Plan Year.

5. There is no out-of-pocket maximum when You receive Out-of-Network Benefits.

6. This benefit requires Pre Authorization before You receive services. Your benefits for Covered Services may be reduced or denied if You do not comply with the Plan's Pre-Authorization requirements.
7. Coverage for this benefit or service is limited as stated. The Plan will not cover any additional services after the limits have been reached. You will be responsible for payment for all services after a benefit limit has been reached. Amounts You pay for any services after a benefit limit has been reached are not Covered Services and will not count toward Your Out-of-pocket maximum Limit.

8. Preventive Care includes the services listed below. Some services may be administered under Your Prescription Drug benefit under the Plan. Where no frequency or limits are indicated the Plan will use its normal medical care management processes to determine frequency and appropriate level of Covered Services under this benefit. Services covered under the Plan's outpatient Prescription Drug benefit will be limited to monthly supply or quantity limits that apply to all outpatient Prescription Drug benefits.

    A. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved;
    B. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this subdivision, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;
    C. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings in the Recommendations for Preventive Pediatric Health by the American Academy of Pediatrics and the Recommended Uniform Screening Panels by the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
    D. With respect to women, evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services include the following:
        - Breastfeeding support, supplies, and counseling in conjunction with each birth including: comprehensive lactation support and counseling from trained providers during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.
        - Contraceptive methods and counseling including: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include abortifacient drugs.
        - Screening and Counseling for domestic and interpersonal violence including annual screening and counseling for all women.
        - Screening for gestational diabetes including screening for women between 24 and 28 weeks pregnant, and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
        - Human Immunodeficiency Virus (HIV) including annual screening and counseling for sexually active women.
        - Human Papillomavirus (HPV) DNA Test including: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older.
        - Sexually Transmitted Infections (STI) including annual counseling for sexually active women.
        - Well-woman visits to obtain recommended preventive services for women. Visits will be provided at least annually. Additional visits are covered if needed to obtain all recommended preventive services.

9. You do not need Pre-Authorization from OhioHealthy or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Pre-Authorization for certain services, following a pre-

approved treatment plan, or procedures for making referrals. Look in this SPD in the *Pre-Authorization, Utilization Management, and Claim Procedures s*ection for more information on Pre-Authorization.

Outpatient Prescription Drug Summary of Benefits

This Summary of Benefits describes Your outpatient Prescription Drug coverage. All drugs must be FDA-approved and You must have a Prescription. You will need to pay Your Copay or Coinsurance when You fill Your Prescription at the Pharmacy. Some drugs require Pre-Authorization by Your Physician, and some quantities may be limited. **Step Therapy for certain Prescription Drugs is required.**

This Plan has a closed formulary and covers a specific list of drugs and medications. Drugs not included on the Plan's formulary will not be covered. Please use the following link to see a list of drugs on the Plan's formulary by signing on to the website at www.optumrx.com .

Your drug coverage also has specific Exclusions and Limitations so please read the next few pages carefully.

Copay		
For a single Copay You may receive up to a consecutive 30-day supply of a covered drug. A Copay is a set dollar amount that you pay for your prescription. Certain Prescription Drugs will be covered at a Generic product level established by the Plan. If a Generic product level has been established for a drug and You or Your prescribing Physician requests the Brand-Name drug or a higher costing Generic, You must pay the difference between the cost of the dispensed drug and the Generic product level in addition to the Copay charge.		
Generic and Brand- Name Prescription Benefits		
Plan Features	**In-Network**	**Out-of-Network**
Prescription Drug Plan Copay Diabetes and Asthma Rx Benefits	Tier 1: $5 copay (no deductible) 30 day supply Tier 1: $10 copay (no deductible) 31-60 day supply Tier 1: $12.50 copay (no deductible supply) 61-90 day supply Tier 2: 20% (no deductible) Tier 3: 30% (no deductible) Diabetes and Asthma Prescriptions Not covered out of network. The plan will pay 100% of the cost for approved In-network diabetic and asthmatic prescriptions after the condition management requirements are met. Failure to meet the condition management requirements means that you will pay the tiered copay for these approved prescriptions.	You pay the tiered copay plus the difference between the Recognized Charge and the copay.
Diabetic Testing Supplies Insulin, Needles, and Syringes Testing supplies include test strips, lancets, lancet devices, blood glucose monitors and control solution.	The plan will pay 100% of the cost for approved In-network diabetic testing supplies if the condition management requirements are met. Failure to meet the condition management requirements means that you will pay Tier 2 cost for these approved diabetic testing supplies.	You pay the tiered copay plus the difference between the Recognized Charge and the copay.

Summary of Benefits: Pharmacy Benefits

Generic and Brand- Name Prescription Benefits		
Plan Features	**In-Network**	**Out-of-Network**
Fertility Drugs Maximum benefit $2,000 per calendar year combined. The fertility drug calendar year maximum benefit is the most the Plan will pay for fertility drug covered benefits in a calendar year. The individual maximum applies separately to You and each of Your Dependents. The family maximum applies to You and Your Dependents combined.	You pay 40% of the Negotiated Charge (no deductible)	Not covered
Maintenance Medications	You can use either network Retail pharmacies including the OhioHealth owned pharmacies (RMB or Marion General Hospital Ambulatory), or OptumRx Home Delivery, to obtain a 90 day supply of maintenance medications	Not applicable
OptumRx Home Delivery for each 30 or 90 day supply	Tier 1: $5 copay (no deductible) 30 day supply Tier 1: $12.50 copay (no deductible) 90 day supply Tier 2: 20% (no deductible) Tier 3: 30% (no deductible	You pay the tiered copay plus the difference between the Recognized Charge and the copay.
Retail pharmacies for each 30 or 90 day supply	Tier 1: $5 copay (no deductible) 30 day supply Tier 1: $12.50 copay (no deductible) 90 day supply Tier 2: 20% (no deductible) Tier 3: 30% (no deductible)	You pay the tiered copay plus the difference between the Recognized Charge and the copay.
Riverside Medical Building (RMB) Pharmacy or Marion General Hospital Ambulatory Pharmacy: For each 30 or 90 day supply (retail)	Tier 1: $5 copay (no deductible) 30 day supply Tier 1: $12.50 copay (no deductible) 90 day supply Tier 2: 20% (no deductible) Tier 3: 30% (no deductible)	Not applicable
Specialty Care Drugs	20% (no deductible) $500 max copay	Not covered

Summary of Benefits: Pharmacy Benefits

Wellness Benefits and Preventive Care Services		
Family Planning Services: Female Contraceptive identified on the OptumRx Preventive care list. www.optumrx.com/enroll/ohiohealth	Covered at 100% per Prescription or refill No calendar year Deductible applies.	You pay the difference between the Recognized Charge and the amount you paid out of pocket
Female Contraceptives not identified on the OptumRx preventive care list	Tier 1: $5 copay (no deductible) 30 day supply Tier 1: $12.50 copay (no deductible) 90 day supply Tier 2: 20% (no deductible) Tier 3: 30% (no deductible)	You pay the tiered copay plus the difference between the Recognized Charge and the amount you paid out of pocket.
Tobacco Cessation Medications Available at retail, Mail Order, RMB and Marion General Hospital Ambulatory	Covered at 100% No calendar year Deductible applies.	You pay the tiered copay plus the difference between the Recognized Charge and the copay.

Some outpatient Prescription Drugs are available through the Plan's Mail Order Provider. This does not include Specialty Drugs described below. You may call OptumRx Home Delivery at; 1-844-368-7173, TTY 711 to find out if a drug is available. If Your drug is available, You may purchase up to a 90-day supply for the applicable copay amount.

Please remember that Riverside Medical Building (RMB) and Marion General Hospital Ambulatory Pharmacy provide coverage for a 90-day supply, and Retail pharmacies can be used for a 90 day supply of maintenance drugs.

Step Therapy for certain Prescription Drugs is required.

Coverage of Specialty Care Drugs

Specialty Care Drugs have unique uses and are generally prescribed for people with complex or ongoing medical conditions. Specialty Care Drugs typically require special dosing, administration, and additional education and support from a health care professional.

Specialty Care Drugs are available through BriovaRx at 855-427-4682.

Specialty Care Drugs include the following:

- Medications that treat certain patient populations including those with rare diseases;
- Medications that require close medical and Pharmacy management and monitoring;
- Medications that require special handling and/or storage;
- Medications derived from biotechnology and/or blood derived drugs or small molecules; and
- Medications that can be delivered via injection, infusion, inhalation, or oral administration.

Your Specialty Care Drug will be delivered to Your home address. If You have a question or need to find out if Your drug is considered a Specialty Care Drug please call Member Services at the number on Your Plan ID Card . You can also log onto www.optumrx.com for a list of Specialty Care Drugs.

Exclusions And Limitations And Other Coverage Terms

The following is a list of exclusions, limitations and other conditions that apply to Your drug benefit.

1. All compounded Prescriptions require Pre-Authorization and must contain at least one Prescription ingredient. Compound Prescription medications with ingredients not requiring a Physician's authorization by state or federal law are excluded from coverage.
2. All covered outpatient Prescription Drugs must have been approved by the Food and Drug Administration and require a Prescription either by state or federal law. Medications with no approved FDA indications are excluded from coverage.

3. Amounts You pay for any outpatient Prescription Drug after a benefit limit has been reached, or for any outpatient Prescription Drug that is excluded from coverage will not count toward any Plan Maximum Out-of-Pocket Amount.
4. Ancillary charges which result from a request for a Brand-Name outpatient Prescription Drug when a Generic drug is available are excluded from coverage and do not count toward any Plan Maximum Out-of-Pocket Limit.
5. Copay is Your out-of-pocket amount You pay directly to the Pharmacy provider for a covered Prescription Drug. A Copay is a set dollar amount based on the tiered drug.
6. Deductible means the dollar amount You must pay out-of-pocket each year for Covered Services before the Plan begins to pay for Your benefits.
7. Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are excluded from coverage.
8. Immunization agents, biological sera, blood, or blood products are excluded from coverage.
9. Injectables (other than those self-administered and insulin) are excluded from coverage under this benefit.
10. Intrauterine devices (IUDs), and cervical caps and their insertion are covered under the Plan's medical benefits.
11. Medication taken by or administered to the Member in the Physician's office is excluded from coverage under this benefit.
12. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is excluded from coverage under this benefit.
13. Medications for Cosmetic purposes only, including but not Limited to Retin-A for aging, are excluded from coverage.
14. Medications for Experimental indications and/or dosage regimens determined by the Plan to be Experimental are excluded from coverage.
15. Medications that do not meet the Plan's criteria for Medical Necessity are excluded from coverage.
16. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and Durable Medical Equipment not listed as covered are excluded from coverage.
17. Over-the-counter (OTC) medications that do not require a Physician's authorization by state or federal law and any Prescription that is available as an OTC medication are excluded from coverage except as specifically described in the *What The Plan Covers: Pharmacy Benefits* section.
18. Prescription or over-the-counter appetite suppressants and any other Prescription or over-the-counter medication for weight loss are excluded from coverage.
19. Prescriptions may be filled at a Plan Pharmacy or a non-participating Pharmacy that has agreed to accept as payment in full, reimbursement from the Plan at the same level as the Plan gives to participating pharmacies.
20. Some drugs require Pre-Authorization from the Plan in order to be covered. The Physician is responsible for obtaining Pre-Authorization. Benefits for Covered Services may be reduced or denied for not complying with the Plan's Pre-Authorization requirements.
21. The Plan will not cover any additional benefits after benefit limits have been reached. You will be responsible for payment for all outpatient Prescription Drugs after a benefit limit has been reached.
22. The Plan's Pharmacy and Therapeutics Committee is composed of Physicians and pharmacists. The committee looks at the medical literature and then evaluates whether to add or remove a drug from the preferred drug list. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration. The Pharmacy and Therapeutics Committee may establish monthly quantity limits for selected medications.
23. Therapeutic devices or appliances, including but not limited to support stockings and other medical/non-medical items or substances, regardless of their intended use are excluded from coverage.
24. You or Your means the Associate and each family member who is a Covered Person under the Plan.

Non-formulary requests: You have the right to request a non-formulary prescription drug if You believe that You need a prescription drug that is not on the Plan's list of covered drugs (formulary), or You have been receiving a specific non-formulary prescription drug for at least six months previous to the development or revision of the formulary and Your prescribing physician has determined that the formulary drug is inappropriate for Your condition or that changing drug therapy presents a significant health risk to You. Your physician must complete a medical necessity form and deliver it to the OptumRx pharmacy authorization department. After reasonable investigation and consultation with the prescribing physician, OptumRx will make a determination. OptumRx will act on such requests within one business day of receipt of the request. You will be responsible for all applicable Copayments, Coinsurance, or Deductibles depending upon which Tier a drug is placed in by the Plan.

Section 1 Who Can Be Covered and When Your Coverage Begins

Throughout this section You will find information on who can be covered under the Plan, how to enroll, what to do when there is a change in Your life that affects coverage, and when Your coverage begins. In this section, "You" means the Associate or other Covered Person.

Who Can Be Covered

Associates

To be covered by this Plan, the following requirements must be met:

- You will need to be in an "eligible class," as defined below; and
- You will need to meet the "eligibility date criteria" described below

Determining if You Are in an Eligible Class

You are in an eligible class if:

- You are a part-time or full-time Associate regularly scheduled to work at least 48 hours per bi-weekly pay period, or eligible per the affordable care act eligibility rules, as defined by Your Employer.

Coverage for Eligible Children

To be eligible for coverage, a child must be under 26 years of age.

An eligible child includes:

- Your biological children;
- Your stepchildren;
- Your legally-adopted children;
- Your foster children, including any children placed with You for adoption;
- Any children for whom You are responsible under court order;
- Your grandchildren in Your court-ordered custody;
- Any other child with whom You have a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

Determining When You Become Eligible

You become eligible for the Plan on Your eligibility date, which is determined as follows.

On the Effective Date of the Plan

If You are in an eligible class on the effective date of this Plan, Your coverage eligibility date is the effective date of the Plan if You elect and enroll in coverage by the Plan's effective date.

Obtaining Coverage for Eligible Dependents

Your Dependents can be covered under this Plan. You may enroll the following Dependents:

- Your spouse;
- Your eligible children;

OhioHealthy will rely upon Your Employer to determine whether or not a person meets the definition of a Dependent for coverage under this Plan. This determination will be conclusive and binding upon all persons for the purposes of this Plan. You cannot be enrolled as both an Associate and a Dependent or a Dependent of more than one Associate.

How and When to Enroll

Annual Enrollment

During the annual enrollment period, You will have the opportunity to review Your coverage needs for the upcoming year. During this period, You have the option to change Your coverage. The choices You make during this annual enrollment period will become effective the following year.

If You do not enroll yourself or a Dependent for coverage when You first become eligible, but wish to do so later, You will need to do so during the next annual enrollment period, unless You qualify under one of the Special Enrollment Periods, as described below.

If You Adopt a Child

Your Plan will cover a child who is placed for adoption. This means You have taken on the legal obligation for total or partial support of a child whom You plan to adopt.

Your Plan will provide coverage for a child who is placed with You for adoption if:

- The child meets the Plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 31 days of the placement; and
- Proof of placement is presented to Your Employer prior to the dependent's enrollment.

Initial Enrollment in the Plan

You will be provided with Plan benefit and enrollment information when You first become eligible to enroll. You will need to enroll in a manner determined by Your Employer. To complete the enrollment process, You will need to provide all requested information for yourself and Your eligible Dependents. You will also need to agree to make required contributions for any contributory coverage. Your Employer will determine the amount of Your Plan contributions, which You will need to agree to before You can enroll. Your Employer will advise You of the required amount of Your contributions and will deduct Your contributions from Your pay. Remember, Plan contributions are subject to change.

You will need to enroll within 30 days of Your eligibility date. If You miss the enrollment period, You will not be able to participate in the Plan until the next annual enrollment period, unless You qualify under a Special Enrollment Period, as described below.

If You do not enroll for coverage when You first become eligible, but wish to do so later, Your Employer will provide You with information on when and how You can enroll.

Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, You will need to complete a change form and return it to Your Employer within the 31-day enrollment period.

Late Enrollment

If You do not enroll during the initial enrollment period, You will not be able to enroll until a subsequent annual enrollment period or until You have a special enrollment qualifying event.

Loss of Other Health Care Coverage

You or Your dependents may qualify for a Special Enrollment Period if:

- You did not enroll yourself or Your dependent when You first became eligible or during any subsequent annual enrollments because, at that time You or Your dependents were covered under another group health plan or health insurance coverage ("other coverage");

- You or Your dependents are no longer eligible for the other coverage because of one of the following events:
    - The end of Your or Your dependent's employment;
    - A reduction in Your or Your dependent's hours of employment (for example, moving from a full-time to part-time position that impacts Your eligibility for coverage);
    - The ending of the other plan's coverage;
    - Death;
    - Divorce, annulment or legal separation;
    - Employer contributions toward that other coverage have ended;
    - COBRA coverage ends;
    - The employer's decision to stop offering the other group health plan to the eligible class to which You belong;
    - Any other change in status approved by the Plan and the Plan's governing documents.

You will need to enroll yourself or a dependent for coverage within 31 days of when other coverage ends.

Evidence of termination of other coverage must be provided to OhioHealth. If You do not enroll during this time, You will need to wait until the next annual enrollment period.

Medicaid and CHIP

You and/or Your dependents may qualify for a Special Enrollment Period if:

- You or Your dependents are eligible for but not enrolled in the Plan; and either

    - You or Your dependent become eligible for premium assistance, with respect to coverage under the group health Plan, under Medicaid or a CHIP plan; or
    - You or Your dependent lose eligibility for coverage under Medicaid or a CHIP plan.

You will need to enroll yourself or a dependent for coverage:

- Within 60 days of when coverage under Medicaid or a CHIP plan ends; or
- Within 60 days of the date You or Your dependents become eligible for Medicaid or CHIP premium assistance.

Evidence of eligibility for premium assistance or termination of eligibility for Medicaid or CHIP, as applicable, must be provided to OhioHealth. If You do not enroll during this time, You will need to wait until the next annual enrollment period.

New Dependents

You and Your dependents may qualify for a Special Enrollment Period if:

- You are eligible for coverage but not enrolled in the Plan; and
- You acquire an eligible dependent, as defined under the Plan (other than meeting the requirement to be enrolled in this Plan), through marriage, birth, adoption, or placement for adoption; and
- You elect coverage for yourself and Your dependent within 31 days of acquiring the dependent.

If You were already enrolled in the Plan when You acquire a dependent through marriage, birth, adoption, or placement for adoption, You can add that dependent to Your coverage if You enroll the dependent within 31 days of acquiring the dependent.

You will need to report any new dependents by completing a change form, which is available from Your Employer. The form must be completed and returned to Your Employer within 31 days of the change. If You do not return the form within 31 days of the change, You will need to make the changes during the next annual enrollment period.

Special Enrollment Periods

If You qualify under a Special Enrollment Period as defined below You may enroll before the next annual enrollment period.

When You Receive a Qualified Medical Child Support Order (QMCSO)

Your Plan will provide coverage for a child, who is covered under a QMCSO, if:

- The child meets the Plan's definition of an eligible dependent; and
- The order for coverage is determined to be a QMCSO.

Under a QMCSO, if You are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent. You can obtain a copy of the Plan's QMCSO procedures free of charge by requesting them from OhioHealth.

When Your Coverage Begins

Your Effective Date of Coverage

If You have met all the eligibility requirements and paid all required contribution amounts, Your coverage takes effect on the first day of the month following the last of:

- The date You are eligible for coverage; and
- The date Your enrollment information is received; and
- The date Your required contribution is received by Your Employer.

If Your completed enrollment information is not received within 31 days of Your eligibility date, the rules under the Special or Late Enrollment Periods section will apply.

Your Dependent's Effective Date of Coverage

Your dependent's coverage takes effect on the same day that Your coverage becomes effective, if You have enrolled them in the Plan and paid all required contribution amounts.

New dependents need to be reported to Your Employer within 31 days because they may affect Your contributions. If You do not report a new dependent within 31 days of his or her eligibility date, the rules under the *Special or Late Enrollment Periods* section will apply.

Section 2 How Your Medical Plan Works

It is important that You have the information and useful resources to help You get the most out of Your Plan. Please keep in mind that unless otherwise stated You or Your refers to the Covered Associate and Dependents. Your Plan pays benefits only for services and supplies described in this Summary Plan Description (SPD) as Covered Expenses and determined to be Medically Necessary. Please read this SPD carefully so You will understand how Your medical Plan works. This SPD includes the following:

- Definitions You need to know;
- How to access care, including procedures You need to follow;
- What expenses for services and supplies are covered and what limits may apply;
- What expenses for services and supplies are not covered by the Plan;
- How You share the cost of Your Covered Services and supplies; and
- Other important information such as eligibility, claims, complaints and appeals, termination of coverage, continuation of coverage, and general administration of the Plan.

Common Terms and Definitions

Many terms throughout this SPD are defined in the *Definitions* section at the back of this document. Understanding these terms will also help You understand how Your Plan works and provide You with useful information regarding Your coverage.

About Your Plan

This Plan provides coverage for a wide range of medical expenses for the treatment of Illness or Injury. It does not provide benefits for all Illnesses and Injuries, such as those that are occupational in nature.

The Plan also provides coverage for certain preventive and wellness benefits. With Your Plan, You can directly access any In-Network or Out-of-Network Physician, Hospital or other health care provider for Covered Services and supplies under the Plan. The Plan pays benefits differently when services and supplies are obtained through Network Providers or Out-of-Network Providers under this Plan.

The Plan will pay for Covered Expenses up to the maximum benefits shown on the Summary of Benefits in this SPD.

Coverage is subject to all the terms, policies and procedures outlined in this SPD. Not all medical expenses are covered under the Plan. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the *What The Plan Covers: Medical Benefits, What Is Not Covered (Medical Benefit Exclusions and Limitations),* sections and the Summary of Benefits to determine if medical services are covered, excluded or limited.

This Plan provides access to covered benefits through a broad network of health care providers and facilities. This Plan is designed to lower Your out-of-pocket costs when You use Network Providers for Covered Expenses. Your Coinsurance or Payment Percentage will generally be lower when You use Network Providers and facilities.

You also have the choice to access licensed providers, Hospitals and facilities outside the network for Covered Services and supplies. Your out-of-pocket costs will generally be higher when You use Out-of-Network Providers because the Coinsurance Payment Percentage that You are required to pay is usually higher when You utilize Out-of-Network Providers. Out-of-Network Providers have not agreed to accept the Negotiated Charge and may balance bill You for charges over the amount OhioHealthy pays under the Plan.

Some services and supplies may only be covered through Network Providers. Refer to the *What The Plan Covers: Medical Benefits* and Your Summary of Benefits to determine if any services are limited to network coverage only.

Your out-of-pocket costs may vary between Network and Out-of-Network Benefits. Read Your Summary of Benefits carefully to understand the cost sharing charges applicable to You.

Section 2 How Your Medical Plan Works

Accessing In-Network Providers and In-Network Benefits

- You may select a PCP or other direct access In-Network Providers by searching the online provider Directory at www.ohiohealthyplans.com/ohiohealth. Providers outside of the Greater Columbus Ohio Service Area use the same online provider Directory for PHCS providers at www.ohiohealthyplans.com/ohiohealth. You can also search for names and locations of In-Network Physicians, Hospitals and other In-Network health care providers and facilities. You can change Your PCP at any time.

- If a service or supply You need is covered under this Plan but not available from an In-Network Provider in Your area, please contact Member Services by email or at the toll-free number on Your Member ID card for assistance.

- Certain health care services such as Hospitalization, outpatient surgery and certain other outpatient services, require Pre-Authorization with OhioHealthy to verify coverage for these services. You do not need to Pre-Authorize services provided by an In- Network Provider. In-Network Providers will be responsible for obtaining necessary Pre-Authorization for You. Pre-Authorization is the provider's responsibility, there are no additional out-of-pocket costs to You as a result of an In-Network Provider's failure to Pre-Authorize services. Refer to the *Pre-Authorization, Utilization Management, And Claims Procedures* section for more information on Pre-Authorization and what to do if a request for Pre-Authorization is denied.

- You will not have to submit medical claims for treatment received from In-Network health care professionals and facilities. Your In-Network Provider will take care of claim submission. OhioHealthy will directly pay the In-Network Provider or facility less any cost sharing required by You. You will be responsible for Deductibles, and Coinsurance Payment Percentage, if any.

- You may be required to pay some In-Network Providers at the time of service. When You pay an In-Network Provider directly, You will be responsible for completing a claim form to receive reimbursement of Covered Expenses from OhioHealthy. You must submit a completed claim form and proof of payment to OhioHealthy. Refer to the *General Provisions* section of this SPD for a complete description of how to file a claim under this Plan.

- You will receive an Explanation of Benefits (EOB) notification of what the Plan has paid toward Your Covered Expenses. It will indicate any amounts You owe toward Your Deductible, and Coinsurance Payment Percentage or other non-Covered Expenses You have incurred. You may elect to receive this notification by e-mail, or through the mail. Call Member Services at 1-844-200-OHHY (1-844-200-6449) if You have questions regarding Your EOB.

Accessing Out-of-Network Providers and Out-of-Network Benefits

- Certain health care services such as Hospitalization, outpatient surgery and certain other outpatient services, require Pre-Authorization with OhioHealthy to verify coverage for these services. When You receive services from an Out-of-Network Provider, You are responsible for obtaining the necessary Pre-Authorization from OhioHealthy. Your provider may Pre-Authorize the services for You. However, You should verify with OhioHealthy prior to the service, that the provider has obtained Pre-Authorization from OhioHealthy. If the service is not Pre-Authorized, the benefit payable may be significantly reduced or may not be covered. This means You will be responsible for the unpaid balance of any bills. You must call the Pre-Authorization toll-free number on Your Member ID card to Pre-Authorize services. Refer to the *Pre-Authorization, Utilization Management, and Claim Procedures* section for more information on the Pre-Authorization process and what to do if Your request for Pre-Authorization is denied.

- When You use Out-of-Network Providers, You may have to pay for services at the time they are rendered. You may be required to pay the full charges and submit a claim form to OhioHealthy for reimbursement. You are responsible for completing and submitting claim forms for reimbursement of Covered Expenses that You paid directly to an Out-of-Network Provider. Call Member Services at the number on Your ID card if You have questions or need a claim form.

- When You pay an Out-of-Network Provider directly, You will be responsible for completing a claim form to receive reimbursement of Covered Expenses from OhioHealthy. You must submit a completed claim form and proof of payment to OhioHealthy. Refer to the *General Provisions* section of this SPD for a complete description of how to file a claim under this Plan.

- You will receive notification of what the Plan has paid toward Your Covered Expenses. It will indicate any amounts You owe towards any Deductible, or Payment Percentage amounts or other non-Covered Expenses You have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if You have questions regarding Your statement.

Cost Sharing For In-Network Benefits

When You or Your eligible dependents become covered under this Plan, You have access to a unique network of Primary Care Physicians (PCP), Specialists and health care facilities. OhioHealth Corporation and OhioHealthy have joined forces to create an expanded network of health care providers. In many cases, You will receive the Plan's maximum level of coverage when You receive care from a participating In-Network Provider. Read Your *Summary of Benefits* carefully to understand the cost sharing charges applicable to You.

- In-Network Providers have agreed to accept the Negotiated Charge. OhioHealthy will reimburse You for a Covered Expense, incurred from an In-Network Provider, up to the Negotiated Charge and the maximum benefits under this Plan, less any cost sharing required by You such as Deductibles, Copays, and Coinsurance Payment Percentage. Your Coinsurance Payment Percentage is based on the Negotiated Charge. You will not have to pay any balance bills above the Negotiated Charge for that Covered Service.

- You must satisfy any applicable Deductible before the Plan will begin to pay for Covered Services. Deductibles do not apply to all services.

- Deductibles, Copays, and Coinsurance Payment Percentages are usually lower when You use In-Network Providers than when You use Out-of-Network Providers.

- For certain types of Covered Services, You will be responsible for any Deductibles, Copays, and/or Coinsurance amounts shown in Your *Summary of Benefits* depending on the type of service and whether You obtain Covered Services from a provider who is a Specialist or Non-Specialist. You will be subject to the PCP Copay shown on the *Summary of Benefits* when You obtain Covered Services from any PCP who is an In-Network Provider. If the provider is an In-Network Specialist, then the Specialist Copay will apply.

- After You satisfy any applicable Deductible, You will be responsible for any applicable Payment Percentage for Covered Expenses that You incur. You will be responsible for Your Payment Percentage up to the Payment Limit applicable to Your Plan.

- For In-Network Benefits Your total out-of-pocket maximum amount is the Deductible amount for Your coverage plus the Coinsurance and Copayments you pay, up to the dollar amounts shown for Your coverage. If You have Associate only coverage once the individual out of pocket maximum has been met, eligible costs are covered for the rest of the Plan Year. If You have Associate +1 or Family coverage when an individual within Your family reaches the individual out-of-pocket amounts, that family member’s eligible costs are covered for the rest of the Plan Year.

- For Out-of-Network Benefits there is no Maximum Coinsurance amount or out-of-pocket maximum.

- Certain designated out-of-pocket expenses may not apply to the Payment Limits in-network only. Refer to Your *Summary of Benefits* for information on what Covered Expenses do not apply to the Payment Limits and for the specific Payment Limit amounts that apply to Your Plan.

- The Plan will pay for Covered Expenses, up to the benefit maximums shown in the *What The Plan Covers: Medical Benefits* section or the *Summary of Benefits*. You are responsible for any expenses incurred over the maximum limits outlined in the *What The Plan Covers: Medical Benefits* or the Summary of Benefits.

- You may be billed for any Deductible or Coinsurance Payment Percentage amounts, or any non-Covered Expenses that You incur.

Cost Sharing for Out-of-Network Benefits

- Out-of-Network Providers have not agreed to accept the Negotiated Charge. OhioHealthy will reimburse You for a Covered Expense, incurred from an Out-of-Network Provider, up to the Recognized Charge and the maximum benefits under this Plan, less any cost-sharing required by You such as Deductibles and Coinsurance Payment Percentage. The Recognized Charge is the maximum amount OhioHealthy will pay for a Covered Expense from an Out-of-Network Provider. Your Payment Percentage is based on the Recognized Charge. If Your Out-of-Network Provider charges more than the Recognized Charge, You will be

responsible for any expenses incurred above the Recognized Charge. Except for Emergency Services, OhioHealthy will only pay up to the Recognized Charge.

- You must satisfy any applicable Deductible before the Plan begins to pay benefits.
- Coinsurance Payment Percentages are usually higher when You use Out-of-Network Providers than when You use Network Providers.
- After You satisfy any applicable Deductible, You will be responsible for any applicable Coinsurance Payment Percentage for Covered Expenses that You incur.
- The Plan will pay for Covered Expenses, up to the benefit maximums shown in the *What The Plan Covers: Medical Benefits* section or the Summary of Benefits. You are responsible for any expenses incurred over the maximum limits outlined in the *What The Plan Covers: Medical Benefits* section or the *Summary of Benefits*.

Ongoing Reviews

OhioHealthy conducts ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are Covered Expenses under this SPD. If OhioHealthy determines that the recommended services or supplies are not Covered Expenses, You will be notified. You may appeal such determinations by contacting OhioHealthy to seek a review of the determination. Please refer to *How to Appeal An Adverse Benefit Determination* section of this SPD.

Primary Care Physicians:

To access In-Network Benefits, You are encouraged to select a Primary Care Physician (PCP) from the network of providers at the time of enrollment. Each covered family member may select his or her own PCP. If Your Dependent is a minor, or otherwise incapable of selecting a PCP, You should select a PCP on their behalf. You may select a pediatrician as Your child's PCP.

You may search online for the most current list of In-Network Providers in Your area by using the online provider Directory at www.ohiohealthyplans.com/ohiohealth. Providers located outside of the Greater Columbus Ohio Service Area use the same online provider Directory for PHCS providers at www.ohiohealthyplans.com/ohiohealth. You can choose a PCP based on geographic location, group practice, medical specialty, language spoken, or Hospital affiliation.

A PCP may be a general practitioner, family Physician, internist, or pediatrician. Your PCP provides routine preventive care and will treat You for Illness or Injury.

A PCP coordinates Your medical care, as appropriate either by providing treatment or may direct You to other In-Network Providers for other Covered Services and supplies. The PCP can also order lab tests and X-rays, prescribe medicines or therapies, and arrange Hospitalization.

Specialists and Other In-Network Providers

You may directly access Specialists and other In-Network Providers for Covered Services and supplies listed in this SPD. Refer to the *Summary of Benefits* at the beginning of this SPD for Your out-of-pocket costs.

Section 3 Pre-Authorization, Utilization Management and Claim Procedures

This section explains how the Plan will determine Medical Necessity for payment of a claim. We use the following review processes to make coverage decisions and determine Medical Necessity on Pre-Service, Post-Service, Concurrent, and Urgent Care claims:

- Pre-Authorization;
- Concurrent Review;
- Retrospective Review; and
- Case management.

Compliance with any of the review processes is not a guarantee of benefits or payment under the Plan.

Adverse Benefit Determinations

You have certain rights if We deny a request for Pre-Authorization or make other Adverse Benefit Determinations. We will provide written notice of Adverse Benefit Determinations. For Urgent Claims notification may be provided orally and then confirmed in writing up to three days after the oral notice. If coverage is being rescinded You will receive written notice 30 days prior to the rescission. Written notification will include the following:

- A description of the Plan's appeal process and applicable time limits. For Urgent Care Claims it will include a description of the expedited appeals process;
- A statement describing any additional material or information necessary to complete the claim and why such information is necessary;
- A statement regarding the availability of and contact information for any applicable entity established by federal law to assist individuals with the claims and appeals process;
- Information to confirm the identity of the claim at issue, including the date of service, provider's name and claim amount;
- Reference to the specific Plan provisions on which the determination is based; and
- The specific reason or reasons for the Adverse Benefit Determination, including any denial code and its corresponding meaning.

You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and all other information relevant to the claim for benefits. This includes copies of any internal rule, guideline, protocol, or other criteria relied upon in making the Adverse Benefit Determination and any diagnosis and treatment codes (and their corresponding meanings) applicable to the claim. For denials due to Medical Necessity, Experimental treatment, or similar exclusion or limit, You are entitled to receive, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Member's medical circumstances. Please also see *How to Appeal an Adverse Benefit Determination* section of this SPD.

Concurrent Review And Approval Of Care Involving An Ongoing Course Of Treatment

If We decide to reduce or end care We will notify the Covered Person or provider before the care is reduced and early enough to allow for an appeal of our decision.

In-Network Providers must follow certain procedures to make sure that if a previously approved course of treatment needs to be extended, the extension is requested in time to minimize disruption of needed services. We will notify the Covered Person of a coverage decision within 24 hours of the request. Notification will include information on how to appeal an Adverse Benefit Determination prior to services being discontinued. Requests for extensions of therapy or rehabilitative treatment plans must be made 7 days prior to the end of the authorized timeframe to avoid disruption of care or services.

Expedited Pre-Authorization Decisions For Urgent Care Claims

We will notify the Covered Person/provider of our decision not later than 72 hours from receipt of the request for service. If We require additional information to make a decision We will notify the Covered Person/Physician within 24 hours of receipt of the request. We will include the specific information that is missing and the applicable timeframes within which to respond to Us.

Pre-Authorization

Some services require Pre-Authorization before You receive them. Your Physician or other provider is responsible for getting Pre-Authorization. We have instructions and procedures in place for providers to obtain Pre-Authorization.

Pre-Authorization is an evaluation process We use to assess the Medical Necessity and coverage of proposed treatment. It also checks to see that the treatment is being provided at the appropriate level of care. Pre-Authorizations are approved or denied based on current medical practice and guidelines and not on incentives or bonus structures. Pre-Authorization is certification by the Plan of Medical Necessity and not a guarantee of payment by the Plan. Payment by the Plan for Covered Services is contingent on the Covered Person being eligible for Covered Services on the date the Covered Service is received by the Covered Person.

On Your *Summary of Benefits* We tell You what services require Pre-Authorization before You receive them. You can also look in the *What The Plan Covers: Medical Benefits* section of this document or call Member Services to find out about Pre-Authorization. Generally the following types of services require Pre-Authorization:

- Acupuncture for treatment for the relief of migraines or back or neck pain
- Advanced Imaging and Testing including MRI, CT, PET, MRA, CTA, Sleep studies
- All Inpatient admissions (Medical & Mental Health)
- All Outpatient surgeries
    - All rental items
    - All repair or replacements
- All Skilled Nursing Facilities
    - Artificial limbs
- Biofeedback
- Clinical Trials and studies
- DME/DME Supplies & Prosthetic Appliances:
    - Single item over $750.00
- Elective Transportation Services
- Electro-convulsive Therapy
- Genetic Testing
- Home Health Care
- Home IV Therapy
- Hospice Services
- Intensive Outpatient Programs (IOP) Mental Health
- Medications listed requiring Pre-Authorization
- Penile Implants
- Pulmonary, Vascular, and Vestibular Rehabilitation
- Transplants

Pre-Service Claims Decisions.

We make decisions on Pre-Service Claims within 15 days from receipt of request for the service. We may extend this period for another 15 days if We determine We need more time because of matters beyond our control. If We extend the period We will notify the Covered Person/provider before the end of the initial 15 day period. If We make an extension because We do not have enough information to make a decision We will notify the Covered Person/provider of the specific information missing and the timeframe within which the information must be provided. We will make a decision within 2 business days of receiving all the required medical information needed to process the Claim.
When the Plan has made a decision We will send the Covered Person/treating Physician written notice.

Retrospective Review Of Post-Service Claims.

We will make coverage decisions on Post-Service Claims within 30 calendar days from receipt of request for the service. We may extend this period for another 15 days if We determine it to be necessary because of matters beyond our control. If an extension is necessary, the Covered Person will be notified prior to the end of the initial 30 day period. If the extension is necessary due to Us not having enough information to make the initial coverage decision, the Covered Person/provider will be notified of the specific information missing and the timeframe within which the information must be provided.

We will make our decision within 2 business days of receiving the medical information needed to process the claim. The Plan will provide the Covered Person and Physician written notice of its decision.

Section 4 What the Plan Covers Medical Benefits

This section explains what services are covered under the Plan. Please also refer to the *Summary of Benefits* in the front of this SPD for more information about the Plan's Covered Services. All Covered Services must be prescribed or performed by an appropriately licensed provider or facility, and must be Medically Necessary. All services and supplies are subject to the exclusions, limitations, and conditions of Your Plan.

Some services may require Pre-Authorization by the Plan before You receive them. Your Physician is responsible for Pre-Authorization of services. You can read more about Pre-Authorization in *Pre-Authorization, Utilization Management and Claims Procedures* in this SPD.

You must pay all of Your Deductible amounts out-of-pocket before the Plan will pay for benefits. You will also be responsible for a Coinsurance depending on the type and place of service. You will usually have to pay Your Deductible or Coinsurance when services are received. Your Coinsurance and Deductibles are listed on the Summary of Benefits.

Preventive Care Services, Exams, and Screenings

This section on Preventive Care describes the Covered Expenses for services and supplies provided when You are well. Recommended Preventive Care will be covered with no cost-sharing when received from In-Network Providers. However, You may still have to pay Your office visit Coinsurance amount in certain circumstances described below. **You can see a complete list of ACA Recommended Preventive Care Services at the links below:**

http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

http://www.hrsa.gov/womensguidelines/

https://www.cdc.gov/vaccines/schedules/index.html

Some preventive care services may be administered under Your Prescription Drug benefit administered separately by OptumRx.

1. You will pay an office visit Copay amount if Your preventive care item or service is billed separately, or is tracked as individual encounter data separately from the office visit.

2. You should not pay a Copay amount for an office visit if an item or service is not billed separately or is not tracked as individual encounter data separately from the office visit, and the primary purpose of the office visit is the delivery of the preventive item or service.

3. You will pay an office visit Copay amount if an item or service is not billed separately, or is not tracked as individual encounter data separately from the office visit and the primary purpose of the office visit is not the delivery of the preventive item or service.

4. You will pay all Out-of-Network Coinsurance amounts and Deductibles for preventive care items and services and office visits from Out-of-Network Providers.

Bone Density Measurement Screening

Covered Expenses include coverage for bone density measurement screening for the prevention and diagnosis of osteoporosis as follows.

- 1 baseline bone density screening for women age 55-64; and
- 1 bone density screening every two years for women age 65 and over.

Comprehensive Lactation Support and Counseling Services

Covered Expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the postpartum period by a certified lactation support provider. The "postpartum period" means the one-year period directly following the child's date of birth.

Covered Expenses incurred during the postpartum period also include the rental or purchase of breast feeding equipment as described below.

Lactation support and lactation counseling services are Covered Expenses when provided in either a group or individual setting. Benefits for lactation counseling services are subject to the visit maximum shown in Your Summary of Benefits**.**

Breast Feeding Durable Medical Equipment

Coverage includes the rental or purchase of breast feeding Durable Medical Equipment for the purpose of lactation support (pumping and storage of breast milk) as follows:

Breast Pump

Covered Expenses include the following:

- If an electric breast pump was purchased within the previous three year period, the purchase of an electric or manual breast pump will not be covered until a three year period has elapsed from the last purchase of an electric pump.
- The purchase of:
    - An electric breast pump (non-hospital grade). A purchase will be covered once every three years; or
    - A manual breast pump. A purchase will be covered once every three years.
- The rental of a hospital-grade electric pump for a newborn child following delivery upon the documented recommendation of the patient’s lactation consultant, obstetrician, pediatrician or primary care physician. Such a recommendation must be obtained again at 3, 6, 9, and 12 months, with a maximum benefit of 12 months’ rental; without such recommendation the pump must be returned within 10 business days of the rental period.

Breast Pump Supplies

Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

OhioHealthy reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of Optima Health.

Depression Screening Adolescents and Adults

Covered Expenses include:

- Screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years;
- Screening for depression in the general adult population, including pregnant and postpartum women.

Family Planning Services -Female Contraceptives-Voluntary Female Sterilization

For females with reproductive capacity, Covered Expenses include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this benefit must be approved by the U.S. Food and Drug Administration (FDA).

The following contraceptive methods are Covered Expenses under this benefit:

Voluntary Sterilization

Covered Expenses include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

Contraceptives

Covered Expenses include charges made by a Physician for:

- Female contraceptives that are Brand- Name and Generic Prescription Drugs;
- Female contraceptive devices including the related services and supplies needed to administer the device.

Generic and Brand- Name Prescription Drugs, and contraceptive devices are covered under Your Plan's Prescription Drug benefit.

Family Planning Services - Other

Covered Expenses include charges for certain family planning services, even though not provided to treat an Illness or Injury.

- Voluntary sterilization for males
- Voluntary termination of pregnancy

Vision Care Services

Covered Expenses include charges made by a legally-qualified ophthalmologist or optometrist for the following services:

- Routine eye exam: The Plan covers expenses for a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam. The Plan covers charges for one routine eye exam in any 24 consecutive month period.

Routine Physical Exams

Covered Expenses include charges made by Your Physician for routine physical exams. A routine exam is a medical exam given by a Physician for a reason other than to diagnose or treat a suspected or identified Illness or Injury, and also includes:

- Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- Routine hearing screenings; and
- Screening for Gestational Diabetes; and
- Testing for Tuberculosis; and
- X-rays, lab and other tests given in connection with the exam.

Covered Expenses for children from birth to age 18 also include:

- An initial Hospital checkup and well child visits in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians.

Routine Cancer Screenings

Covered Expenses include charges incurred for routine cancer screening as follows:

- 1 baseline mammogram for covered females age 35 to 39;
- 1 digital rectal exam and 1 prostate specific antigen (PSA) test per calendar year for covered males age 45 and older;
- 1 fecal immuno chemical test per calendar year if age 50 or older; and
- 1 fecal occult blood test per calendar year;
- 1 gynecological exam per calendar year;
- 1 mammogram per calendar year for covered females age 40 and over;
- 1 Pap smear per calendar year.

The following tests are Covered Expenses if You are age 50 and older when recommended by Your Physician:

- 1 Colonoscopy every 10 years for persons at average risk for colorectal cancer; or
- Sigmoidoscopy every 5 years for persons at average risk.

Physician Services

Anesthetics

Covered Expenses include charges for the administration of anesthetics and oxygen by a Physician, other than the operating Physician, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

Physician Visits

Covered medical expenses include charges made by a Physician during a visit to treat an Illness or Injury. The visit may be at the Physician's office, in Your home, in a Hospital or other facility during Your Stay or in an outpatient facility. Covered Expenses also include:

- Allergy testing, treatment and injections; and
- Immunizations;
- Supplies, radiological services, X-rays, and tests provided by the Physician.

Surgery

Covered Expenses include charges made by a Physician for:

- Consultation with another Physician to obtain a second opinion prior to the surgery;
- Performing Your surgical procedure; and
- Pre-operative and post-operative visits.

Walk-In Clinic Visits

Covered Expenses include charges made Walk-in Clinics for the following:

- Unscheduled, non-Emergency Illnesses and Injuries;
- The administration of certain immunizations administered within the scope of the clinic's license.

Virtual Consults
Virtual Consults will be covered when furnished by providers, such as MDLIVE, who are approved by OhioHealthy to provide services.

Hospital Expenses

Covered Expenses include services and supplies provided by a Hospital during Your Stay.

Room and Board

Covered Expenses include charges for Room and Board provided at a Hospital during Your Stay. Private room charges that exceed the Hospital's Semi-Private Room Rate are not covered unless a private room is required because of a contagious Illness or immune system problem.

Covered Expenses include charges made by a Hospital for services and supplies furnished to You in connection with Your Stay. Covered Expenses include Hospital charges for other services and supplies provided, such as:

- Administration of blood and blood products, but not the cost of the blood or blood products;
- Ambulance services;
- Discharge planning;
- Intensive or special care facilities;

- Intravenous (IV) preparations;
- Medications;
- Operating and recovery rooms;
- Oxygen and oxygen therapy;
- Physicians and surgeons;
- Radiation therapy;
- Radiological services, laboratory testing and diagnostic services;
- Speech therapy, physical therapy and occupational therapy.

Room and Board charges also include:

- Admission and other fees;
- General and special diets; and
- Services of the Hospital's nursing staff;
- Sundries and supplies.

Other Services and Supplies

Outpatient Hospital Expenses

Covered Expenses include Hospital charges made for Covered Services and supplies provided by the outpatient department of a Hospital.

Coverage for Emergency Medical Conditions

Covered Expenses include charges made by a Hospital or a Physician for services provided in an emergency room to evaluate and treat an Emergency Medical Condition.

The Emergency Medical Condition benefit covers:

- Emergency room Physician services;
- Hospital nursing staff services;
- Radiologists and pathologists services; and
- Use of emergency room facilities.

Please contact Your Physician after receiving treatment for an Emergency Medical Condition.

Coverage for Urgent Conditions

Covered Expenses include charges made by a Hospital or Urgent Care Provider to evaluate and treat an Urgent Condition.

Your coverage includes:

- Nursing staff services
- Physician services;
- Radiologists and pathologists services.
- Use of emergency room facilities when network urgent care facilities are not in the Service Area and You cannot reasonably wait to visit Your Physician; and
- Use of urgent care facilities.

Please contact Your PCP after receiving treatment of an Urgent Condition.

If You visit an Urgent Care Provider for a non-Urgent Condition, the Plan will not cover Your expenses, as shown in the *Summary of Benefits*.

Alternatives to Hospital Stays

Outpatient Surgery and Physician Surgical Services

Covered Expenses include charges for Magnetic Resonance Guided Focused Ultrasound Surgery (MRgFUS).

Covered Expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- A Physician or Dentist for professional services;
- A Surgery Center; or
- The outpatient department of a Hospital.

Covered Expenses include charges for Transcranial Magnetic Stimulation (TMS).

Magnetic Resonance Guided Focused Ultrasound Surgery (MRgFUS)

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a Surgery Center or Hospital; and
- The surgery is not normally performed in a Physician's or Dentist's office.

The following outpatient surgery expenses are covered:

- Services and supplies provided by the Hospital, Surgery Center on the day of the procedure;
- Services of another Physician for related post-operative care and administration of anesthesia. This does not include a local anesthetic; and
- The operating Physician's services for performing the procedure, related pre-and post-operative care, and administration of anesthesia.

Transcranial Magnetic Stimulation (TMS)

Birthing Center

Covered Expenses include charges made by a Birthing Center for services and supplies related to Your care in a Birthing Center for:

- Delivery;
- Prenatal care; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.

See *Pregnancy Related Expenses* for information about other Covered Expenses related to maternity care.

Home Health Care

Covered Expenses include charges for home health care services when ordered by a Physician as part of a Home Health Care Plan and provided You are:

- Homebound
- Transitioning from a Hospital or other inpatient facility, and the services are in lieu of a continued inpatient Stay; or

Covered Expenses include only the following:

- Home health aide services, when provided in conjunction with Skilled Nursing Services that directly support the care. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits.
- Medical social services, when provided in conjunction with Skilled Nursing Services by a qualified social worker.
- Skilled Nursing Services that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of four hours or less, with a daily maximum of three visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure Your proper care, which means they are not on site for more than four hours at a time. If You are discharged from a Hospital or Skilled Nursing Facility after an inpatient Stay, the intermittent requirement may be waived to allow coverage for up to 12 hours (three visits) of continuous Skilled Nursing Services. However, these services must be provided within 10 days of discharge.

Benefits for home health care visits are payable up to the home health care maximum. Each visit by a nurse or therapist is one visit.

In figuring the calendar year maximum visits, each visit of up to four hours is one visit.

This maximum will not apply to care given by an R.N. or L.P.N. when:

- Care is provided within 10 days of discharge from a Hospital or Skilled Nursing Facility as a full-time inpatient; and
- Care is needed to transition from the Hospital or Skilled Nursing Facility to home care.

When the above criteria are met, Covered Expenses include up to 12 hours of continuous care by an R.N. or L.P.N. per day.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or Custodial Care service does not cause the service to become covered. If the Covered Person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

Skilled Nursing Facility

Covered Expenses include charges made by a Skilled Nursing Facility during Your **Stay** for the following services and supplies, up to the maximums shown in the Summary of Benefits, including:

- Medical supplies;
- Other medical services and general nursing services usually given by a Skilled Nursing Facility (this does not include charges made for private or special nursing, or Physician's services);
- Oxygen and other gas therapy;
- Physical, occupational, or speech therapy;
- Radiological services and lab work;
- Room and Board, up to the Semi-Private Room Rate. The Plan will cover up to the private room rate if it is needed due to an infectious Illness or a weak or compromised immune system; and
- Use of special treatment rooms.

Hospice Care

Covered Expenses include charges made by the following furnished to You for Hospice Care when given as part of a Hospice Care Program.

Facility Expenses

The charges made by a Hospital, Hospice Facility or Skilled Nursing Facility for:

- Room and Board and other services and supplies furnished during a Stay for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to You on an outpatient basis.

Outpatient Hospice Expenses

Covered Expenses include charges made on an outpatient basis by a Hospice Care Agency for:

- Consultation or case management services by a Physician;
- Dietary counseling; and
- Medical social services under the direction of a Physician. These include but are not limited to:
    - Assessment of Your social, emotional and medical needs, and Your home and family situation;
    - Identification of available community resources; and
    - Assistance provided to You to obtain resources to meet Your assessed needs.
- Medical supplies;
- Part-time or intermittent home health aide services to care for You up to eight hours a day;
- Part-time or intermittent nursing care by an R.N. or L.P.N. for up to eight hours a day;
- Physical and occupational therapy;
- Prescription Drugs;
- Psychological counseling.

Charges made by the providers below are covered if they are not an associate of a Hospice Care Agency; and such Agency retains responsibility for Your care:

- A Physician for a consultation or case management;
- A physical or occupational therapist;
- A Home Health Care Agency for:

    - Dietary counseling
    - Medical supplies;
    - Part time or intermittent home health aide services for Your care up to eight hours a day;
    - Physical and occupational therapy;
    - Prescription Drugs; and
    - Psychological counseling.

Other Covered Health Care Expenses

Acupuncture Services

Covered Expenses include acupuncture services listed below, performed by any certified acupuncturist, limited to the treatment or relief of migraines, or back or neck pain. Services are limited to a maximum benefit of fifteen (15) visits per calendar year and are subject to Deductible and Coinsurance requirements for each Covered Member.

- Acupuncture, one (1) or more needles; with electrical stimulation, initial fifteen (15) minutes of personal one on one contact with the patient.
- Acupuncture, one (1) or more needles; without electrical stimulation, initial fifteen (15) minutes of personal one on one contact with the patient.
- Acupuncture, one (1) or more needles; without electrical stimulation, initial fifteen (15) minutes of personal one on one contact with the patient, with re-insertion of the needle(s).
- Acupuncture, one (1) or more needles; with electrical stimulation, each additional fifteen (15) minutes of personal one on one contact with the patient, with re-insertion of needles(s).

Ambulance Service

Covered Expenses include charges made by a professional Ambulance, as follows:

Ground Ambulance

Covered Expenses include charges for transportation:

- From home to Hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to Your medical condition. Transport is limited to 100 miles.
- From Hospital to home or to another facility when other means of transportation would be considered unsafe due to Your medical condition.
- From one Hospital to another Hospital in a medical Emergency when the first Hospital does not have the required services or facilities to treat Your condition.
- To the first Hospital where treatment is given in a medical Emergency.
- When during a covered inpatient Stay at a Hospital, Skilled Nursing Facility or acute rehabilitation Hospital, an Ambulance is required to safely and adequately transport You to or from inpatient or outpatient Medically Necessary treatment.

Air or Water Ambulance

Covered Expenses include charges for transportation to a Hospital by air or water Ambulance when:

- Ground Ambulance transportation is not available; and
- In a medical Emergency, transportation from one Hospital to another Hospital; when the first Hospital does not have the required services or facilities to treat Your condition and You need to be transported to another Hospital; and the two conditions above are met; and
- Your condition is unstable, and requires medical supervision and rapid transport.

Clinical Trials (Approved) For Life Threatening Diseases Or Conditions

Covered Expenses includes Routine Patient Costs for items and services furnished in connection with participation in an Approved Clinical Trial by a Qualified Individual with a Life-threatening Condition.

The Plan may require that a Qualified Individual participate in an Approved Clinical Trial through a participating provider if such provider will accept the Qualified Individual as a participant in the trial. However, The Plan will not preclude a Qualified Individual from participating in an Approved Clinical Trial conducted outside the state in which the Qualified Individual resides.

Diagnostic and Preoperative Testing

Diagnostic Complex Imaging and Testing Expenses

The Plan covers charges made on an outpatient basis by a Physician, Hospital or a licensed imaging or radiological facility for complex imaging services to diagnose an Illness or Injury, including:

- Computerized Axial Tomography (CT Scans);
- Computerized Axial Tomography Angiogram (CTA Scans);
- Genetic Testing;
- Magnetic Resonance Angiography (MRA);
- Magnetic Resonance Imaging (MRI);
- Positron Emission Tomography (PET Scans); and
- Sleep Studies.

Outpatient Diagnostic Lab Work and Radiological Services

Covered Expenses include charges for radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests provided to diagnose an Illness or Injury. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a Physician. The charges must be made by a Physician, Hospital or licensed radiological facility or lab.

Outpatient Preoperative Testing

Prior to a scheduled covered surgery, Covered Expenses include charges made for tests performed by a Hospital, Surgery Center, Physician or licensed diagnostic laboratory provided the charges for the surgery are Covered Expenses and the tests are:

- Completed within 14 days before Your surgery;
- Covered if You were an inpatient in a Hospital;
- Not repeated in or by the Hospital or Surgery Center where the surgery will be performed;
- Performed on an outpatient basis;
- Related to Your surgery, and the surgery takes place in a Hospital or Surgery Center;
- Test results should appear in Your medical record kept by the Hospital or Surgery Center where the surgery is performed.

Durable Medical and Surgical Equipment (DME)

Covered Expenses include charges by a DME supplier for the rental of equipment or, in lieu of rental:

- The initial purchase of DME if:
  - Long term care is planned; and
  - The equipment cannot be rented or is likely to cost less to purchase than to rent.

- Repair of purchased equipment.

- Replacement of purchased equipment if:
  - The replacement is needed because of a change in Your physical condition; and
  - It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The Plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment You purchase or rent for personal convenience or mobility.

Covered Durable Medical Equipment includes those items covered by Medicare unless excluded in the *What Is Not Covered (Medical Benefit Exclusions and Limitations)* section of this SPD. OhioHealthy reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of OhioHealthy.

Experimental or Investigational Treatment

Covered Expenses include charges made for Experimental or Investigational drugs, devices, treatments or procedures, provided all of the following conditions are met:

- OhioHealthy determines, based on at least two documents of medical and scientific evidence, that You would likely benefit from the treatment;
- Standard therapies have not been effective or are inappropriate;
- There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
  - The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
  - The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center;

   - The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
   - The drug, device, treatment or procedure to be investigated has been granted Investigational New Drug (IND) or Group c/treatment IND status; and
   - You are treated in accordance with protocol.
- You have been diagnosed with cancer or a condition likely to cause death within one year or less;

Gender Dysphoria Treatment

Coverage includes the following services for the treatment of gender dysphoria:

- Cross-sex hormone therapy administered by a medical provider during an office visit or dispensed from a pharmacy. Puberty suppressing medication is not cross-sex hormone therapy.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses.
- Surgery for the treatment of Gender Dysphoria, including the surgeries listed below.

Female to Male*:*

- Bilateral mastectomy or breast reduction
- Hysterectomy (removal of uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Male to Female:

- Clitoroplasty (creation of clitoris)
- Labiaplasty (creation of labia)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Urethroplasty (reconstruction of female urethra)
- Vaginoplasty (creation of vagina)

Specific documentation and written psychological assessments from one or more qualified behavioral health providers experienced in treating Gender Dysphoria are required prior to approval for a bilateral mastectomy, breast reduction surgery, or genital surgery.

Infertility

Infertility Services (includes Assisted Reproductive Technologies (in vitro fertilization, artificial insemination, etc.)). Covered Expenses are limited to a combined in-network and out-of-network maximum benefit of $10,000 per lifetime, subject to Deductible and Coinsurance requirements for each covered employee and/or dependent. Note: if the Lifetime Infertility maximum was met under any plan offered by OhioHealth, it will be met for this plan as well.

Covered Expenses include services listed below. The person receiving treatment must be a covered member under the Plan. Verification of infertility is not required.

Contraception and Reproductive Procedures

- Artificial Insemination: intra-cervical;
- Artificial Insemination: intra-uterine;
- Sperm washing for artificial insemination.

Fertility Diagnostic Services

A medically treatable condition may exist that results in the inability for person(s) to conceive. While this condition causes infertility, the condition is a medical condition and its diagnosis and treatment is considered to be a medical condition. Diagnostic services to determine or cure the underlying medical conditions are covered in the same manner as any other medically necessary services.

Infertility Treatment Services

- Assisted oocyte fertilization, microtechnique; greater than 10 oocytes;
- Assisted oocyte fertilization, microtechnique: less than or equal to 10 oocytes;
- Culture of oocytes(s)/embryo(s), less than 4 days
- Extended culture of oocyte(s)/embryo(s), 4-7 days;
- Insemination of oocytes;
- Sperm isolation: complex prep (e.g., Percoli gradient, albumin gradient) for insemination or diagnosis with semen analysis;
- Sperm isolation: simple prep (e.g., sperm wash and swim-up) for insemination or diagnosis with semen analysis.

Miscellaneous Prostate Procedures

- Electroejaculation

Procedural Components: In Vitro Fertilization

- Frozen Embryo transfer, Egg transfer, Embryo transfer, intrauterine;
- Thawing of Frozen Embryos;
- Follicle puncture for oocyte retrieval, any method;
- Gamete, zygote, or embryo intrafallopian transfer, any method.
- Cryopreservation or storage of cryopreserved eggs and embryos covered in limited circumstances such as cancer and other fertility-threatening medical conditions.

Fertility medications are covered with a member paid 40% Coinsurance up to an annual maximum benefit of $2000. (This is in addition to the $10,000 lifetime limit for all OhioHealth plans

Diabetic Education

Covered Expenses include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- Self-management training provided by a licensed health care provider certified in diabetes self-management training

Interruption of Pregnancy Services

Abortion is covered in the first twelve (12) weeks of pregnancy. After twelve (12) weeks abortion is covered if the mother’s life is at risk, or if there are major fetal abnormalities, or in the case of rape or incest.

Jaw Joint Disorder Treatment

The Plan covers charges made by a Physician, Hospital or Surgery Center for the diagnosis and surgical treatment of Jaw Joint Disorder.

Obesity Treatment

Non-Surgical Services

Covered Expenses include charges made by a Physician, licensed or certified dietician, nutritionist or Hospital for the non-surgical treatment of obesity for the following outpatient weight management services:

- An initial medical history and physical exam;
- Diagnostic tests given or ordered during the first exam; and

Morbid Obesity Surgical Expenses

Covered Expenses include charges made by a Hospital or a Physician for the surgical treatment of Morbid Obesity of a Covered Person.

Covered Expenses includes the following as long as they are incurred within a two-year period:

- One follow-up visit;
- One Morbid Obesity surgical procedure including complications directly related to the surgery;
- Pre-surgical visits; and
- Related outpatient services.

This two-year period begins with the date of the first Morbid Obesity surgical procedure, unless a multi-stage procedure is planned.

Complications, other than those directly related to the surgery, will be covered under the related medical plan's covered medical expenses, subject to plan limitations and maximums.

NOTE: The Plan provides coverage for the Medical Weight Treatment Program at the McConnell Heart Health Center.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered Expenses include charges made by a Physician, a Dentist and Hospital for:

- Hospital services and supplies received for a Stay required because of Your condition.

- Dental work, surgery and Orthodontic Treatment needed to remove, repair, restore or reposition:
  - Natural teeth damaged, lost, or removed; or
  - Other body tissues of the mouth fractured or cut due to Injury**;**
  - Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the Injury.
- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.
- Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, and jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:
  - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement;
  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement, or repair of teeth;
  - Cut out cysts, tumors, or other diseased tissues;

- Treat a fracture, dislocation, or wound.

If crowns, dentures, bridges, or in-mouth appliances are installed due to Injury, Covered Expenses only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of Orthodontic Treatment after the Injury.

Penile Implants

Covered Expenses include charges made by a Physician, Hospital, or Surgery Center for:

Penile Prosthesis is considered medically necessary for **1 or more** of the following:

- Implantation of semi-rigid penile prosthesis or inflatable penile prosthesis (implantable penile pumps) for individuals who have documented physiologic erectile dysfunction with **all of the** following:
  - Absence of **all** of the following:
    - Untreated depression or psychiatric illness
    - Drug-induced impotence related to **1 or more** of the following:
      - Alcohol
      - Anabolic steroids
      - Anticholinergics
      - Antidepressants
      - Antipsychotics
      - Central nervous system depressants
      - Illicit drug abuse
  - Normal levels of all of the following:
    - Prolactin
    - Testosterone
    - Thyroid hormone levels
  - History of **1 or more** of the following:
    - Injury to the bladder, perineum/genitalia, and/or erection control
    - Prior history of **1 or more** of the following:
      - Prostate Surgery
      - Bladder Surgery
      - Bowel surgery
      - Spinal surgery
    - Prior vascular surgery involving **1 or more** of the following:
      - Aorta
      - Femoral blood vessels
    - Neurological disease (e.g. diabetic neuropathy, spinal cord injury)
    - Peyronie's disease
    - Renal failure
    - Vascular insufficiency documented by dynamic infusion cavernosometry and cavernosography (DICC)
    - Venous incompetence documented by dynamic infusion cavernosometry and cavernosography (DICC)
    - Venous leak of the penis
  - Nonsurgical methods have been ineffective
- Removal of a penile implant is considered medically necessary for **1 or mo**re of the following:
  - Intractable pain
  - Mechanical failure
  - Urinary obstruction
  - An infected prosthesis
- Reimplantation of a penile implant is considered medically necessary for individuals with **all of** the following:

    - Absence of **all** of the following:
        - Untreated depression or psychiatric illness
        - Drug-induced impotence related to **1 or more** of the following:
            - Alcohol
            - Anabolic steroids
            - Anticholinergics
            - Antidepressants
            - Antipsychotics
            - Central nervous system depressants
            - Illicit drug abuse
    - Normal levels of all of the following:
        - Prolactin
        - Testosterone
        - Thyroid hormone levels
    - History of **1 or more** of the following:
        - Injury to the bladder, perineum/genitalia, and/or erection control
        - Prior history of **1 or more** of the following:
            - Prostate Surgery
            - Bladder Surgery
            - Bowel surgery
            - Spinal surgery
        - Prior vascular surgery involving **1 or more** of the following:
            - Aorta
            - Femoral blood vessels
        - Neurological disease (e.g. diabetic neuropathy, spinal cord injury)
        - Peyronie's disease
        - Renal failure
        - Vascular insufficiency documented by dynamic infusion cavernosometry and cavernosography (DICC)
        - Venous incompetence documented by dynamic infusion cavernosometry and cavernosography (DICC)
        - Venous leak of the penis
    - Nonsurgical methods have been ineffective
- Prior prosthesis was removed for medically necessary indications of **1 or more** of the following:
    - Intractable pain
    - Mechanical failure
    - Urinary obstruction
    - An infected prosthesis

Pregnancy Related Expenses

Covered Expenses include charges made by a Physician for pregnancy and childbirth services and supplies at the same level as any Illness or Injury. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, Covered Expenses include charges made by a Hospital for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section; or
- A shorter Stay, if the attending Physician, with the consent of the mother, discharges the mother or newborn earlier.

Covered Expenses also include charges made by a Birthing Center as described under Alternatives to Hospital Care.

Prosthetic Devices

Covered Expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by Illness, Injury or congenital defect. Covered Expenses also include instruction and incidental supplies needed to use a covered prosthetic device.

The Plan covers the first prosthesis You need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or Injury or congenital defects as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

Covered Expenses also include replacement of a prosthetic device if:

- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable; or
- The replacement is needed because of a change in Your physical condition; or normal growth or wear and tear.

The list of covered devices includes but is not limited to:

- A breast implant after a mastectomy;
- A cardiac pacemaker and pacemaker defibrillators;
- A durable brace that is custom made for and fitted for You;
- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- Foot orthotics, orthopedic shoes or other devices to support the feet, including orthopedic shoe that is an integral part of a covered leg brace.
- Mastectomy Bras or camisole: either 2 prosthetic Bras or 2 prosthetic camisoles initially (not both), then 1 prosthetic garment every 3 months thereafter, and Mastectomy Prosthetic / Form: 1 per side per year (or with bilateral mastectomy--one form for each side per year);
- Ostomy supplies, urinary catheters and external urinary collection devices; and
- Speech generating device.

The Plan will not cover expenses and charges for, or expenses related to:

- Therapeutic shoes; or
- Trusses, corsets, and other support items; or
- Any item listed in the *What Is Not Covered (Medical Benefit Exclusions and Limitations)* section.

Short-Term Rehabilitation Therapy Services

Cardiac and Pulmonary Rehabilitation Benefits

- Cardiac rehabilitation benefits are available as part of an inpatient Hospital Stay. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The Plan will cover charges in accordance with a treatment plan as determined by Your risk level when recommended by a Physician.

- Pulmonary rehabilitation benefits are available as part of an inpatient Hospital Stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states.

Covered Expenses include charges for short-term therapy services when prescribed by a Physician as described below up to the benefit maximums listed on Your Summary of Benefits. The services have to be performed by:

- A Hospital, Skilled Nursing Facility, or Hospice Facility;

- A licensed or certified physical, occupational or speech therapist; or
- A Physician.

Charges for the following short term rehabilitation expenses are covered:

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits

Coverage is subject to limits, if any, shown on the *Summary of Benefits*. Inpatient rehabilitation benefits for the services listed below will be paid as part of Your Inpatient Hospital and Skilled Nursing Facility benefits provision in this SPD.

- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute Illnesses and Injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute Illness, Injury or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function, (except as provided for the treatment of Pervasive Developmental Disorders/Autism Spectrum Disorders). Additionally, coverage for occupational therapy is available for the treatment of Pervasive Developmental Disorders/Autism Spectrum Disorders (as an exception to the above non-chronic condition coverage criteria).

- Physical therapy is covered for non-chronic conditions and acute Illnesses and Injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute Illness, Injury, or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function, (except as provided for the treatment of Pervasive Developmental Disorders/Autism Spectrum Disorders). Additionally, coverage for physical therapy is available for the treatment of Pervasive Developmental Disorders/Autism Spectrum Disorders (as an exception to the above non-chronic condition coverage criteria).

- Speech therapy is covered for non-chronic conditions and acute Illnesses and Injuries and expected to restore the speech function or correct a speech impairment resulting from Illness or Injury; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words. Additionally, coverage for speech therapy is available for the treatment of Pervasive Developmental Disorders/Autism Spectrum Disorders (as an exception to the above non-chronic condition coverage criteria).

A visit consists of no more than one hour of therapy. Refer to the Summary of Benefits for the visit maximum that applies to the Plan. Covered Expenses include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

Reconstructive or Cosmetic Surgery and Supplies

Covered Expenses include charges made by a Physician, Hospital, or Surgery Center for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an Illness or Injury) when:
  - The defect results in severe facial disfigurement, or
  - The defect results in significant functional impairment and the surgery is needed to improve function.
- Surgery to correct the result of an Accidental Injury, including subsequent related or staged surgery, provided that the surgery

occurs no more than 24 months after the original Injury. For a covered child, the time period for coverage may be extended through age 18.

- Surgery to correct the result of an Injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original Injury.

Reconstructive Breast Surgery

Covered Expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

Specialized Care and Therapies

Chemotherapy

Covered Expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient Hospitalization for chemotherapy is limited to the initial dose while hospitalized for the diagnosis of cancer and when a Hospital Stay is otherwise Medically Necessary based on Your health status.

Radiation Therapy Benefits

Covered Expenses include charges for the treatment of Illness by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Outpatient Infusion Therapy Benefits
Covered Expenses include charges made on an outpatient basis for infusion therapy by:

- A free-standing facility;
- The outpatient department of a Hospital; or
- A Physician in his/her office or in Your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of Your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are Covered Expenses:

- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Hydration therapy (includes fluids, electrolytes and other additives)
- Pain management (narcotics); and
- Professional services;
- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy; and
- Total parenteral nutrition (TPN).

Coverage is subject to the maximums, if any, shown in the Summary of Benefits.

Coverage for inpatient infusion therapy is provided under the Inpatient Hospital and Skilled Nursing Facility Benefits.

Benefits payable for infusion therapy will not count toward any applicable home health care maximums.

Spinal Manipulation Treatment

Covered Expenses include charges made by a chiropractor, Medical Doctor, or Doctor of Osteopathy on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Transplant Services

Covered Expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that You or one of Your Dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- Bone Marrow/Stem Cell;
- Heart;
- Heart/Lung;
- Intestine;
- Kidney;
- Liver;
- Lung;
- Multiple organs replaced during one transplant surgery;
- Pancreas;
- Re-transplant of same organ type within 180 days of the first transplant;
- Sequential transplants;
- Simultaneous Pancreas Kidney (SPK);
- Tandem transplants (Stem Cell);
- Any other single organ transplant, unless otherwise excluded under the Plan.

The following will be considered to be more than one transplant occurrence:

- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant);
- Pancreas transplant following a kidney transplant;
- Re-transplant after 180 days of the first transplant.

The In-Network level of benefits is paid only for a treatment received at a facility designated by OhioHealthy as a contracted facility for the type of transplant being performed.

The Plan covers:

- Charges for activating the donor search process with national registries.
- Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Charges made by a Physician or transplant team.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an “immediate” family member is defined as a first-degree biological relative. These are Your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; **or** upon the date You are discharged from the Hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program;
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;
3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to You and a donor during the one or more surgical procedures or medical therapies for a transplant; Prescription Drugs provided during Your inpatient Stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during Your inpatient **Stay** or outpatient visit(s); cadaveric and live donor organ procurement; and
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

The Plan will coordinate all organ and bone marrow transplants and other care You need. Covered Expenses You incur from a contracted transplant facility will be considered network care expenses. The transplant facility must be approved and designated by OhioHealthy to perform the transplant procedure.

Travel and Lodging Benefits, as applicable

Benefit for Cleveland Clinic Foundation:

a) Limited to certain procedures that cannot otherwise be delivered in network*
b) Lodging (limited to days appropriate for procedure)
    i. Up to $150 per day
    ii. One (1) room, double occupancy
        i. one (1) companion traveling with an adult patient
        ii. two (2) companions traveling with a child patient
c) Travel (limited to travel that is appropriate for the treatment)
    i. Mileage reimbursement based on the IRS standard mileage rates or equivalent
    ii. Mileage reimbursement or equivalent for round-trip from home to Cleveland Clinic
d) Travel and lodging are covered when incurred within the following timeframes in relation to the transplant procedure
    i. five (5) days before
    ii. one hundred twenty (120) days after
e) Other expenses, such as meals
    i. up to $25/day per person
    ii. Parking allowance of $10/day

Maximum benefit travel and lodging benefit: $10,000 per treatment cycle.

* The travel benefit is a part of the OhioHealthy - Cleveland Clinic Specialty Service Program (SSP). The travel benefit is subject to prior authorization and applies to treatment of certain cancers and highly complex medical and surgical cases. The major categories diagnoses/conditions and services that would be included for the SSP are:
- Acute leukemia treatment;
-Head & Neck surgeries;
- Tumors (benign or malignant) of the bone surgeries & treatments; and highly complex members/patients with multiple diagnoses, and health status found to exceed the expertise in the Central Ohio OhioHealthy provider network can also receive an authorization for the Cleveland Clinic Specialty Service Program (SSP), which include a travel benefit. SSP also includes the clinical coordination between with the OhioHealthy Case/Care Manager, the referring physician in the OhioHealthy network, and the treating Cleveland Clinic provider(s), as well as coordination with the patient on the medical appointments schedule, travel, lodging (if needed) and meals (including travel, i.e. meals and shared room lodging, for an adult $\geq$ 18 years of age travel companion), and the process for reimbursement of the member/patient for the approved travel benefits.

Members inquiring about the benefit are encouraged to discuss with their treating physicians, who should contact the OhioHealthy prior authorization department.

Travel Benefit for transplant Center of Excellence:

Any medically necessary solid organ, bone marrow, or stem cell transplants. Coverage is only available at a transplant Center of Excellence. For information regarding Center of Excellence providers, call 1-800-229-5522. For transplants received prior to becoming a covered participant, follow-up care may be covered under this Plan when pre-certified. Follow-up care will be subject to the same requirements that apply when the transplant is received while covered under this Plan. Benefits are available for donors when the recipient of the transplant is a plan participant. A National Bone Marrow Donor search fee is covered up to $30,000. Travel and lodging are covered as follows when the recipient lives more than seventy-five (75) miles from the transplant facility:

a) Lodging (limited to days appropriate for procedure)
    i. Up to $150 per day
    ii. One (1) room, double occupancy
        a) one (1) companion traveling with an adult patient
        b) two (2) companions traveling with a child patient
b) Travel (limited to travel that is appropriate for the transplant)
    i. one (1) companion traveling with an adult patient
    ii. two (2) companions traveling with a child patient
    iii. round-trip coach airfare, up to $300 per trip
c) Travel and lodging are covered when incurred within the following timeframes in relation to the transplant procedure
    i. five (5) days before
    ii. one hundred twenty (120) days after
d) Other expenses, such as meals
    i. up to $25/day per person
    ii. Parking allowance of $10/day
e) Maximum benefit travel and lodging benefit: $10,000 per treatment cycle.

Pre-certification is required.

Treatment of Mental Disorders and Substance Abuse

Treatment of Mental Disorders

Covered Expenses include charges made for the treatment of Mental Disorders by Behavioral Health Providers.

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan supervised by a Physician or licensed provider; and
- The plan is for a condition that can favorably be changed.

Benefits are payable for charges incurred in a Hospital, Psychiatric Hospital, Residential Treatment Facility or Behavioral Health Provider's office for the treatment of Mental Disorders as follows:

Inpatient Treatment

Covered Expenses include charges for Room and Board at the Semi-Private Room Rate**,** and other services and supplies provided during Your Stay in a Hospital, Psychiatric Hospital or Residential Treatment Facility. Inpatient benefits are payable only if Your condition requires services that are only available in an inpatient setting.

Partial Confinement Treatment

Covered Expenses include charges made for Partial Confinement Treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a Mental Disorder. Such benefits are payable if Your condition requires services that are only available in a Partial Confinement Treatment setting.

Outpatient Treatment

Covered Expenses include charges for treatment received while not confined as a full-time inpatient in a Hospital, Psychiatric Hospital or Residential Treatment Facility.

The Plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if You would need inpatient care if You were not admitted to this type of facility.

Treatment of Substance Abuse

Covered Expenses include charges made for the treatment of Substance Abuse by Behavioral Health Providers.

Substance Abuse

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan supervised by a Physician or licensed provider; and
- The plan is for a condition that can be favorably changed.

Please refer to the Summary of Benefits for any Substance Abuse Deductibles, Maximum Coinsurance and Payment Limit that may apply to Your Substance Abuse benefits.

Inpatient Treatment

This Plan covers Room and Board at the Semi-Private Room Rate and other services and supplies provided during Your Stay in a Psychiatric Hospital or Residential Treatment Facility, appropriately licensed by the state Department of Health or its equivalent.

Coverage includes:

- Treatment in a Hospital for the medical complications of Substance Abuse.
- "Medical complications" include Detoxification, electrolyte imbalances, malnutrition, and cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a Hospital is covered only when the Hospital does not have a separate treatment facility section.

Outpatient Treatment

Outpatient treatment includes charges for treatment received for Substance Abuse while not confined as a full-time inpatient in a Hospital, Psychiatric Hospital or Residential Treatment Facility.

This Plan covers partial Hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcohol or drug abuse. The partial Hospitalization will only be covered if You would need inpatient treatment if You were not admitted to this type of facility.

Partial Confinement Treatment

Covered Expenses include charges made for Partial Confinement Treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of Substance Abuse.

Such benefits are payable if Your condition requires services that are only available in a Partial Confinement Treatment setting.

Wigs

Coverage includes Medically Necessary wigs for loss of hair due to Illness or disease limited to one wig per calendar year.

Section 5 What The Plan Covers Pharmacy Benefits

How the Pharmacy Plan Works

It is important that You have the information and useful resources to help You get the most out of Your Prescription Drug Plan. This SPD explains:

- How to access Network Pharmacy and procedures You need to follow;
- How You share the cost of Your covered Prescription Drug expenses; a
- Other important information such as eligibility, claims and appeals, termination, and general administration of the Plan.
- Pharmacy definitions You need to know;
- What Prescription Drug expenses are covered and what limits may apply; and
- What Prescription Drug expenses are not covered by the Plan.

Getting Started: Common Definitions and Terms

You can refer to the Definitions at the back of this document for help. Words capitalized throughout the document are defined in the *Definitions* section.

Accessing Pharmacies and Benefits

This Plan provides access to covered benefits through a network of pharmacies including Riverside Medical Building (RMB) Pharmacy, vendors or suppliers. OptumRx has contracted for these Network Pharmacies to provide Prescription Drugs and other supplies to You. You also have the choice to access state licensed pharmacies outside the network for Covered Expenses.

Obtaining Your benefits through a Network Pharmacy has many advantages. Your out-of-pocket costs may vary between network and Out-of-Network Benefits. Benefits and cost sharing may also vary by the type of Network Pharmacy where You obtain Your Prescription Drug and whether or not You purchase a Brand-Name Drug or Generic Prescription Drug. Network Pharmacy includes retail, Mail Order and specialty pharmacies.

Read Your Summary of Benefits carefully to understand the cost sharing charges applicable to You.

To better understand the choices that You have with Your Plan, please carefully review the following information.

Accessing Network Pharmacy and Benefits

You may select a Network Pharmacy from the OptumRx Network Pharmacy Directory or by logging on the OptumRx website at www.optumrx.com. You can search OptumRx's online Directory for names and locations of a Network Pharmacy. If You cannot locate a Network Pharmacy in Your area call Member Services.

You must present Your Member ID card to the Network Pharmacy every time You get a Prescription filled to be eligible for Network Benefits. The Network Pharmacy will calculate Your claim online. You will pay any Deductible or Coinsurance Payment Percentage directly to the Network Pharmacy.

You do not have to complete or submit claim forms. The Network Pharmacy will take care of claim submission.

Availability of Providers

OptumRx cannot guarantee the availability or continued network participation of a particular Pharmacy. Either OptumRx or any Network Pharmacy may terminate the provider contract.

Cost Sharing for Network Benefits

You share in the cost of Your benefits. Cost Sharing amounts and provisions are described in the Summary of Benefits.

- You will be responsible for the Copay or Coinsurance for each Prescription or refill as specified in the Summary of Benefits. The Copay or Coinsurance is payable directly to the Network Pharmacy at the time the Prescription is dispensed.
- Your Coinsurance Payment Percentage is determined by applying the applicable Payment Percentage to the Negotiated Charge of the Prescription. When You obtain Your Prescription Drugs through a Network Pharmacy You will not be subject to balance billing.

Cost Sharing for Out-of-Network Benefits

You share in the cost of Your benefits. Cost Sharing amounts and provisions are described in the Summary of Benefits.

- You will be responsible for any applicable Payment Percentage for Covered Expenses that You incur. Your Payment Percentage share is based on the Recognized Charge. If the Out-of-Network Pharmacy charges more than the Recognized Charge, You will be responsible for any expenses above the Recognized Charge.

Emergency Prescriptions

When You need a Prescription filled in an Emergency or urgent care situation, or when You are traveling, You can obtain Network Benefits by filling Your Prescription at any network retail Pharmacy. The Network Pharmacy will fill Your Prescription and only charge You Your Plan's cost sharing amount. If You access an out-of-Network Pharmacy You will pay the full cost of the Prescription and will need to file a claim for reimbursement. You will be reimbursed for Your Covered Expenses up to the cost of the Prescription less Your Plan's cost sharing for Network Benefits.

When You Use an Out-of-Network Pharmacy

You can directly access an Out-of-Network Pharmacy to obtain covered outpatient Prescription Drugs. You will pay the Pharmacy for Your Prescription Drugs at the time of purchase and submit a claim form to receive reimbursement from the Plan. You are responsible for completing and submitting claim forms to OhioHealthy for reimbursement of Covered Expenses You paid directly to an Out-of-Network Pharmacy. The Plan will reimburse You for a Covered Expense up to the Recognized Charge, less any cost sharing listed in the Pharmacy Summary of Benefits that is required by You.

What the Plan Covers

The Plan covers charges for outpatient Prescription Drugs for the treatment of an Illness or Injury, subject to the *What Is Not Covered (Pharmacy Benefit Exclusions and Limitations*) section of the SPD. Prescriptions must be written by a Prescriber licensed to prescribe federal legend Prescription Drugs.

This Plan has a closed formulary and covers a specific list of drugs and medications. Drugs not included on the Plan's formulary will not be covered. Please use the following link to see a list of drugs on the Plan's formulary: www.optumrx.com.

Generic Prescription Drugs may be substituted by Your pharmacist for Brand-Name Prescription Drugs. You will pay less out-of-pocket for Generic Drugs. If You or Your Physician insists on a Brand-Name drug when a Generic equivalent is available You must pay Your Brand- Name Coinsurance plus the difference in cost between the Generic Drug and the Brand- Name Drug. The additional charges which result from a request for a Brand-Name Prescription Drug when a Generic Drug is available do not count toward the Plan's maximum out-of-pocket limit and must continue to be paid after the maximum out-of-pocket limit has been reached.

Coverage of Prescription Drugs may be subject to Step Therapy or other OptumRx requirements or limitations. Prescription Drugs covered by this Plan are subject to drug utilization review by OptumRx and/or Your provider and/or Your Network Pharmacy.

Coverage for Prescription Drugs and supplies is limited to the supply limits as described below.

Retail Pharmacy Benefits

Outpatient Prescription Drugs are covered when dispensed by a network retail Pharmacy. Each Prescription is limited to a maximum 90 day supply for maintenance medication when filled at a network retail Pharmacy and 30 days for all other prescriptions.

Mail Order Pharmacy Benefits

Outpatient Prescription Drugs are covered when dispensed by OptumRx Home Delivery, RMB or Marion General Hospital Ambulatory Pharmacy. Each Prescription is limited to a maximum 90 day supply when filled at a Network Mail Order Pharmacy. Prescriptions for more than a 90 day supply are not eligible for coverage.

Other Covered Pharmacy Expenses

The following Prescription Drugs, medications and supplies are also Covered Expenses under this coverage.

Contraceptives

Covered Expenses include charges made by a Network Pharmacy for the following contraceptive methods when prescribed by a Prescriber and the Prescription is submitted to the pharmacist for processing:

- Female contraceptives that are Generic Prescription Drugs and Brand-Name Prescription Drugs.
- Female contraceptive devices.

Diabetic Supplies

The following diabetic supplies upon Prescription by a Physician:

- Alcohol swabs.
- Diabetic needles and syringes.
- Diabetic test agents.
- Lancets/lancing devices.
- Test strips for glucose monitoring and/or visual reading.

Medical Exceptions:

Your Prescriber may seek a medical exception to obtain coverage for drugs for which coverage is denied through Step Therapy. The Prescriber must submit such exception requests to OptumRx. Coverage granted as a result of a medical exception shall be based on an individual, case by case Medical Necessity determination and coverage will not apply or extend to other Covered Persons.

Non-formulary requests: You have the right to request a non-formulary prescription drug if You believe that You need a prescription drug that is not on the Plan's list of covered drugs (formulary), or You have been receiving a specific non-formulary prescription drug for at least six months previous to the development or revision of the formulary and Your prescribing physician has determined that the formulary drug is inappropriate for Your condition or that changing drug therapy presents a significant health risk to You. Your physician must complete a medical necessity form and deliver it to the OptumRx pharmacy authorization department. After reasonable investigation and consultation with the prescribing physician, OptumRx will make a determination. OptumRx will act on such requests within one business day of receipt of the request. You will be responsible for all applicable Copayments, Coinsurance, or Deductibles depending upon which Tier a drug is placed in by the Plan.

Off-Label Use

FDA approved Prescription Drugs may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least two studies published in nationally recognized peer review journals. Coverage of off label use of these drugs may, in OptumRx's sole discretion, be subject to Step Therapy or other OptumRx requirements or limitations.

Over-the-Counter Drugs

- Under USPSTF recommended preventive care guidelines when prescribed by a health care provider, aspirin may be covered for certain men and women when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm.
- Under USPSTF recommended preventive care guidelines for women's contraceptive methods that are generally available OTC may be covered only if the method is both FDA-approved and prescribed for a woman by her health care provider. This does not include contraception for men.

Oral and Self-Injectable Infertility Drugs

The following Prescription Drugs used for the purpose of treating Infertility including, but not limited to:

- Urofollitropin, menotropin, human chorionic gonadotropin and progesterone.

Weight Loss Drugs

Approved weight loss Drugs may be covered with Pre-Authorization.

Step-Therapy

Recommendations on drug coverage are made by the OptumRx Pharmacy and Therapeutics Committee, which meets monthly and is composed of Physicians and pharmacists. The committee looks at peer-reviewed medical literature and then evaluates the drug looking at efficacy, safety, cost, and overall disease cost. The Committee may apply utilization management such as Pre-Authorization, step-edit or Step Therapy requirements or quantity limits to selected drugs. Selected drugs may require Your Physician to obtain Pre-Authorization from the Plan in order to be covered. You may be required to try one or more prerequisite drugs before a Step Therapy drug will be covered. You may be limited to a specific quantity of drug per day or per month.

Step Therapy is another form of Pre-Authorization. With Step Therapy, certain medications will be excluded from coverage unless one or more "prerequisite therapy" medications are tried first or unless the Prescriber obtains a medical exception.

The Plan will not cover the Step Therapy drug if Your Prescriber does not prescribe a prerequisite drug first or fails to obtain a medical exception.

Lists of the Step Therapy drugs and prerequisite drugs can be found on optumrx.com or the ohiohealthyhub.com. The list of Step Therapy drugs are subject to change by OptumRx.

Section 6 What Is Not Covered Medical Benefit Exclusions And Limitations

Not every medical service or supply is covered by the Plan, even if prescribed, recommended, or approved by Your Physician or Dentist. The Plan covers only those services and supplies that are Medically Necessary and included in the *What The Plan Covers: Medical Benefits* section. Charges made for the following are not covered unless it is listed under the *What The Plan Covers: Medical Benefits* section.

- Acupuncture
  - Acupuncture point injection for any other indication, including infertility and recurrent pregnancy loss;
  - Acupuncture treatments other than for the relief of migraines or back/neck pain;
  - Maintenance acupuncture services, when significant therapeutic improvement is not expected;
  - Treatment intended to improve or maintain general physical condition.
- Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine auto injections.
- Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this SPD.
- Any non-Emergency charges incurred outside of the United States if You traveled to such location to obtain medical services, Prescription Drugs, or supplies, even if otherwise covered under this SPD. This also includes Prescription Drugs or supplies if:
  - Such Prescription Drugs or supplies are unavailable or illegal in the United States; or
  - The purchase of such Prescription Drugs or supplies outside the United States is considered illegal.
- Applied Behavioral Analysis.
- Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.
- Charges for a service or supply furnished by a Network Provider in excess of the Negotiated Charge.
- Charges for a service or supply furnished by an Out-of-Network Provider in excess of the Recognized Charge.
- Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the Plan.
- Charges submitted for services by an unlicensed Hospital, Physician or other provider or not within the scope of the provider's license.
- Contraception, except as specifically described in the *What The Plan Covers: Medical Benefits* and *What The Plan Covers: Pharmacy Benefits* section.
  - Over-the-counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments except as specifically described in the *What The Plan Covers: Medical Benefits* section for women.
- Cosmetic services including surgeries and/or related services that are considered cosmetic, unproven, and not Medically Necessary; and plastic surgery or any treatment, surgery, service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:
  - Abdominoplasty;
  - Body contouring, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, Cosmetic eyelid surgery and other surgical procedures;

- Breast augmentation;
- Brow lifts;
- Calf implants;
- Check, chin and nose implants
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Face lifts, forehead lift, or neck tightening;
- Facial bone remodeling;
- Hair removal or hair transplantation;
- Injection of fillers or neurotoxins;
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants);except removal of an implant will be covered when Medically Necessary;
- Lip augmentation or lip reduction;
- Otoplasty;
- Pectoral implants;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy);
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Rhinoplasty;
- Skin resurfacing;
- Surgery to correct Gynecomastia;
- Thyroid cartilage reduction, reduction thyroid chondroplasty; trachea shave;
- Voice modification surgery, voice lessons or voice therapy.

➢ Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor except as specifically provided in the *What The Plan Covers: Medical Benefits* section.

➢ Court ordered services, including those required as a condition of parole or release.

➢ Custodial Care

➢ Dental Services: Any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of Injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- Services of Dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth.

➢ Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

➢ Drugs, medications and supplies:

- Any expenses for Prescription Drugs, and supplies covered under an OptumRx Prescription Drug Program will not be covered under this medical expense Plan.
- Any Prescription Drug purchased illegally outside the United States, even if otherwise covered under this Plan within the United States;
- Any Prescription Drugs, injectables, or medications or supplies provided by the Member or through a third party

vendor contract with the customer;
- Any services related to the dispensing, injection or application of a drug;
- Charges for any Prescription Drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy;
- Drugs related to the treatment of non-Covered Expenses;
- Except as specifically described in the *What The Plan Covers: Medical Benefits* section over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a Prescription including vitamins;
- Immunizations related to work and travel;
- Injectable drugs if an alternative oral drug is available;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;
- Outpatient prescription drugs;
- Performance enhancing steroids;
- Self-injectable Prescription Drugs and medications.

➢ Educational services (except as provided for the treatment of Pervasive Developmental Disorders/Autism Spectrum Disorders):

- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

➢ The following Examinations:

- Health examinations required by a third party, including examinations and treatments required to obtain or maintain employment;
- Health examinations an employer is required to provide under a labor agreement;
- Health examinations for securing insurance, school admissions or professional or other licenses;
- Health examinations for travel;
- Health examinations required to attend a school or camp;
- Health examinations required to participate in a sporting event or participate in a sport or other recreational activity; and
- Any special medical reports not directly related to treatment or examinations except when provided as part of a Covered Service.

➢ Experimental or Investigational drugs, devices, treatments or procedures, except as described in the *What The Plan Covers: Medical Benefits* section.

➢ Facility charges for care services or supplies provided in:

- Assisted living facilities;
- Health resorts;
- Infirmaries at schools, colleges, or camps;
- Rest homes;
- Similar institutions serving as an individual's primary residence or providing primarily custodial or rest care; or
- Spas, sanitariums.

➢ Food items: Any food item, including infant formulas, nutritional supplements, vitamins, including Prescription vitamins, medical foods and other nutritional items. This does not apply to enteral feedings to meet nutritional requirements as order by the Covered Person’s Physician.

➢ Foot care: Any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

- Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
- Shoes, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an Illness or Injury, except as described in the *What The Plan Covers: Medical Benefits* section.

➢ Growth/Height: Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

➢ Hearing:

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a Stay in a Hospital or other facility; and
- Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.

➢ Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:

- Equipment installed in Your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- Equipment or supplies to aid sleeping or sitting, including non-Hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
- Other additions or alterations to Your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools;
- Removal from Your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or Illness;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen Your Illness or Injury; and
- Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

➢ Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

➢ Infertility: Except as specifically described in the *What The Plan Covers: Medical Benefits* section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

- Any charges associated with care required to obtain ART services (e.g., office, Hospital, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures;
- Assisted Reproductive Technologies (ART) once the Plan's lifetime limit has been reached;
- Drugs related to the treatment of non-covered benefits;
- Home ovulation prediction kits or home pregnancy tests;
- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- Injectable Infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Ovulation induction and intrauterine insemination services if You are not Infertile;
- Procedures, services and supplies to reverse voluntary sterilization;

The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests.

- Maintenance Care.
- Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer.
- Miscellaneous charges for services or supplies including:
  - Annual or other charges to be in a Physician's practice;
  - Charges to have preferred access to a Physician's services such as boutique or concierge Physician practices;
  - Cancelled or missed appointment charges or charges to complete claim forms;
  - Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
    - Any care a public Hospital or other facility is required to provide;
    - Any care in a Hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws;
    - Care for conditions related to current or previous military service;
    - Care in charitable institutions; and
    - Care while in the custody of a governmental authority.
- Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).
- Non-Medically Necessary services, including but not limited to, those treatments, services, Prescription Drugs and supplies which are not Medically Necessary, as determined by OhioHealthy, for the diagnosis and treatment of Illness, Injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by Your Physician or Dentist.
- Personal comfort and convenience items: Any service or supply primarily for Your convenience and personal comfort or that of a third party, including: telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.
- Private duty nursing during Your Stay in a Hospital, or outpatient private duty nursing services.
- Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member.
- Services of a resident Physician or intern rendered in that capacity.
- Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.
- Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
  - Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.
- Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this SPD.
- Services that are not specifically listed as covered in this SPD.
- Services and supplies provided in connection with treatment or care that is not covered under the Plan.
- Speech therapy for treatment of delays in speech development, except as specifically provided in the *What The Plan Covers:*

Medical Benefits section. For example, the Plan does not cover therapy when it is used to improve speech skills that have not fully developed.

- Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the *What The Plan Covers: Medical Benefits* section.

- Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

    - Drugs or preparations to enhance strength, performance, or endurance;
    - Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching; and
    - Treatments, services and supplies to treat Illnesses, Injuries or disabilities related to the use of performance-enhancing drugs or preparations.

- Therapies for the treatment of delays in development, unless resulting from acute Illness or Injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered (except as provided for the treatment of Pervasive Developmental Delays/Autism Spectrum Disorders). Examples of non-covered diagnoses include Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

- Therapies and tests: Any of the following treatments or procedures:

    - Aromatherapy;
    - Bio-feedback and bioenergetic therapy;
    - Carbon dioxide therapy;
    - Chelation therapy (except for heavy metal poisoning);
    - Computer-aided tomography (CAT) scanning of the entire body;
    - Educational therapy (except as provided for the treatment of Pervasive Developmental Delays/Autism Spectrum Disorders);
    - Gastric irrigation;
    - Hair analysis;
    - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
    - Hypnosis, and hypnotherapy, except when performed by a Physician as a form of anesthesia in connection with covered surgery;
    - Lovaas therapy;
    - Massage therapy;
    - Megavitamin therapy;
    - Primal therapy;
    - Psychodrama;
    - Purging;
    - Recreational therapy;
    - Rolfing;
    - Sensory or auditory integration therapy;
    - Sleep therapy;
    - Thermograms and thermography.

- Tobacco Use: Treatments, services or supplies to stop or reduce smoking or the use of other tobacco products, or to treat or reduce nicotine addiction, dependence or cravings, except as specifically provided in the *What The Plan Covers: Medical Benefits* section. The Plan does not cover any of the following:

    - E-cigarettes
    - Gum
    - Hypnosis

- Transplant-The transplant coverage does not include charges for:

  - Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise Pre-Authorized by OhioHealthy;
  - Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing Illness;
  - Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing Illness;
  - Home infusion therapy after the transplant occurrence;
  - Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
  - Services and supplies furnished to a donor when recipient is not a Covered Person.

- Transportation costs, including Ambulance services for routine transportation to receive outpatient or inpatient services except as described in the *What The Plan Covers: Medical* section.

- Unauthorized services, including any service obtained by or on behalf of a Covered Person without Pre-Authorization by OhioHealthy when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.

- Vision-related services and supplies, except as described in the *What The Plan Covers: Medical Benefits* section. The Plan does not cover:

  - Acuity tests;
  - Eye exams during Your Stay in a Hospital or other facility for health care;
  - Eye exams for contact lenses or their fitting;
  - Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
  - Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
  - Replacement of lenses or frames that are lost or stolen or broken;
  - Services to treat errors of refraction;
  - Special supplies such as non-Prescription sunglasses and subnormal vision aids;
  - Vision service or supply which does not meet professionally accepted standards.

- Vitamin D screening if not Medically Necessary, as determined by OhioHealthy, for the diagnosis and treatment of Illness, Injury, restoration of physiological functions, or covered preventive services.

- Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including Morbid Obesity, regardless of the existence of comorbid conditions; except as specifically provided in the *What The Plan Covers: Medical Benefits* and *What The Plan Covers: Pharmacy Benefits* sections, including but not limited to:

  - Counseling, coaching, training, hypnosis or other forms of therapy;
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement;
  - Liposuction; and
  - Weight control services including, surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided in the SPD.

- Work related: Any Illness or Injury related to employment or self-employment including any Illness or Injury that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to You for the services or supplies. Sources of coverage or reimbursement may include Your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to You even if You waived Your right to payment from that source. If You are also covered under a workers' compensation law or similar law, and submit proof that You are not covered for a particular Illness or Injury under such law, that Illness or Injury will be considered non-occupational regardless of cause.

Section 7 What Is Not Covered Pharmacy Benefit Exclusions and Limitations

Not every health care service or supply is covered by the Plan, even if prescribed, recommended, or approved by Your Physician or Dentist. The Plan covers only those services and supplies that are Medically Necessary and included in the *What The Plan Covers: Medical Benefits* and *What The Plan Covers: Pharmacy Benefits* sections. Charges made for the following are not covered except to the extent listed under the *What The Plan Covers: Medical Benefits* and *What The Plan Covers: Pharmacy Benefits* sections or by amendment attached to this SPD. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

Pharmacy Benefit Limitations

- A Network Pharmacy may refuse to fill a Prescription order or refill when in the professional judgment of the pharmacist the Prescription should not be filled.

- OptumRx retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Plan's claim and appeal procedures.

- The number of Coinsurance amounts/Deductibles You are responsible for per vial of Depo-Provera, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per calendar year.

- The Plan will not cover expenses for any Prescription Drug for which the actual charge to You is less than the required Coinsurance or Deductible not yet met for the year, or for any Prescription Drug for which no charge is made to You.

- The Plan will not pay charges for any Prescription Drug dispensed for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.

- You will be charged the out-of-network Prescription Drug cost sharing for Prescription Drugs recently approved by the FDA, but which have not yet been reviewed by the OptumRx Pharmacy Committee.

Pharmacy Benefit Exclusions

These Prescription Drug exclusions are in addition to the exclusions listed under Your medical coverage. The Plan does not cover the following expenses:

- Any drugs or medications that are not included on the Plan's prescription drug formulary;

- Administration or injection of any drug;

- Any charges in excess of the benefit, dollar, day, or supply limits stated in this SPD;

- Allergy sera and extracts;

- Any non-Emergency charges incurred outside of the United States 1) if You traveled to such location to obtain Prescription Drugs, or supplies, even if otherwise covered under this SPD, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such Prescription Drugs or supplies outside the United States is considered illegal;

- Any drugs or medications, services and supplies that are not Medically Necessary, as determined by OhioHealthy, for the diagnosis, care or treatment of the Illness or Injury involved. This applies even if they are prescribed, recommended or approved by Your Physician or Dentist;

- Biological sera, blood, blood plasma, blood products or substitutes or any other blood products;
- Cosmetic drugs, medications or preparations used for Cosmetic purposes or to promote hair growth, including but not limited to:
  - Bleaching;
  - Chemical peels;
  - Creams;
  - Dermabrasion;
  - Health and beauty aids;
  - Ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin;
  - Treatments;
- Drugs given or entirely consumed at the time and place it is prescribed or dispensed;
- Drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy in oral, injectable and topical forms or any other form used internally or externally (including but not limited to gels, creams, ointments and patches). Any Prescription Drug in oral, topical or any other form that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes including but not limited to:
  - Alprostadil; or
  - Apomorphine;
  - Phentolamine;
  - Sildenafil citrate;
  - Any other Prescription Drug that is in a similar or identical class; or has a similar or identical mode of action or exhibits similar or identical outcomes;
- Drugs which do not, by federal or state law, need a Prescription order (i.e. over-the-counter (OTC) drugs), even if a Prescription is written, except as described in the *What The Plan Covers: Medical Benefits* and *What The Plan Covers: Pharmacy Benefits* sections;
- Drugs given by, or while the person is an inpatient in, any healthcare facility; or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it;
- Drugs, services and supplies provided in connection with treatment of an occupational Injury or occupational Illness;
- Drugs used primarily for the treatment of Infertility, or for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except as described in the *What The Plan Covers: Medical Benefits* and *What The Plan Covers: Pharmacy Benefits* sections;
- Drugs used for the purpose of weight gain or reduction, including but not limited to:
  - Appetite suppressants; and
  - Dietary regimens and supplements;
  - Food or food supplements;
  - Foods or diet supplements;
  - Preparations;
  - Stimulants;
  - Other medications;
- Drugs used for the treatment of obesity, except as described in the *What The Plan Covers: Medical Benefits* and *What The Plan Covers: Pharmacy Benefits* sections;
- All drugs or medications in a Therapeutic Drug Class if one of the drugs in that Therapeutic Drug Class is not a Prescription Drug;
- Durable Medical Equipment, monitors and other equipment;
- Experimental or Investigational drugs or devices, except as described in the *What The Plan Covers: Medical Benefits* and *What The Plan Covers: Pharmacy Benefits* sections. This exclusion will not apply with respect to drugs that:

- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
- Have been granted treatment Investigational New Drug (IND); or Group c/treatment IND status; and
- OhioHealthy determines, based on available scientific evidence, are effective or show promise of being effective for the Illness;

- Food items: Any food item, including infant formulas, nutritional supplements, vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition;
- Genetics: Any treatment, device, drug, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defect;
- Immunization or immunological agents;
- Implantable drugs and associated devices;
- Injectables:
  - Any charges for the administration or injection of Prescription Drugs or injectable insulin and other injectable drugs covered by the Plan;
  - Injectable drugs if an alternative oral drug is available;
  - Needles and syringes, except for diabetic needles and syringes;
- Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps;
- Over-the-counter contraceptive supplies except as listed in *What The Plan Covers: Medical Benefits* and *What The Plan Covers: Pharmacy Benefits* sections;
- Prescription Drugs for which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a Prescription is written, except for over-the-counter (OTC) drugs described in the *What The Plan Covers: Medical Benefits* and *What The Plan Covers: Pharmacy Benefits* sections;
- Prescription Drugs, medications, injectables or supplies provided through a third party vendor contract with the contract holder.
- Prescription orders filled prior to the effective date or after the termination date of coverage under this SPD;
- Prophylactic drugs for travel;
- Proton Pump Inhibitors;
- Refills in excess of the amount specified by the Prescription order. Before recognizing charges, OptumRx may require a new Prescription or evidence as to need, if a Prescription or refill appears excessive under accepted medical practice standard;
- Refills dispensed more than one year from the date the latest Prescription order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed;
- Sexual dysfunction/enhancement: Any drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or change the shape or appearance of a sex organ;
- Step Therapy drugs if Your Prescriber does not prescribe a prerequisite drug first or fails to obtain a medical exception;
- Strength and performance: Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids;
- Supplies, devices or equipment of any type, except as specifically provided in the *What The Plan Covers: Medical Benefits* and *What The Plan Covers: Pharmacy Benefits* sections;
- Test agents except diabetic test agents.

Section 8 How To File A Complaint

Your Right To File A Complaint

We want You to be satisfied with Your health plan services. If You are not satisfied We have a complaint process to handle Your concerns. **Please note that if You have been denied a Covered Benefit and want us to reconsider a coverage decision You should follow our internal and external appeal process described in *How to Appeal An Adverse Benefit Determination* section of this SPD.**

Some examples of typical complaints are:

- You are unhappy with a doctor or Hospital;
- You feel You received poor care at a Hospital;
- You are unhappy with our services.

We suggest You call Member Services first and one of our customer service representatives will assist You with the problem. Most problems can be handled in this manner. If You are still not satisfied You can file a written complaint by following the process below. We will not penalize You or cancel Your coverage because You exercise Your rights.

How To File A Complaint

You can file a complaint anytime within 180 days from the date of Your concern with Your care or services. Remember to include any additional documentation that will help Us resolve Your concern. You may have someone else, such as a doctor or family member, file a complaint for You. We may ask that You sign a form authorizing the other person to act for You.

Call Member Services and ask for a complaint form, or download the forms from our Web site www.ohiohealthyplans.com/ohiohealth. Mail or fax the completed forms and any additional documentation to:

OhioHealthy
Appeals Department
P.O. Box 62876
Virginia Beach, VA 23466-2876
Fax: 757-687-6232
Toll Free: 866-472-3920.

We will write to You and let You know We have received Your complaint. We will also tell You how long We think it will take Us to investigate Your complaint. When We have finished our investigation We will write to You and let You know how We have resolved Your complaint.

Section 9 How To Appeal An Adverse Benefit Determination

Appeals of Adverse Benefit Determinations

Some examples of when You are entitled to an appeal are:

- We did not approve a request for Pre-Authorization;
- We did not cover a treatment because it is Experimental;
- We did not cover a service because it is not Medically Necessary;
- We did not pay for a treatment or service according to Your benefits.
- We have notified You that Your coverage is being rescinded for fraud or material misrepresentation.

You have the right to a full and fair appeal of an Adverse Benefit Determination. You have 180 days from our notice to You of an Adverse Benefit Determination to ask for an appeal.

You can have someone else, such as a doctor or family member file an appeal for You. We may ask You to sign a form to authorize this person to act for You.

When We review Your appeal We will look at all comments, documents, records, and other information submitted to Us. We will do a new review without regard to the first review of Your case. Make sure You send Us any new information You want Us to review. You can submit new information to Us in writing or in person.

The person reviewing Your appeal will not have participated in the original coverage decision.

Appeals involving a medical judgment, including whether a particular treatment, drug, or other service is Experimental, Investigational, or not Medically Necessary will be reviewed by a clinical peer reviewer who did not participate in the first coverage decision.

Before We make our final decision on Your appeal We will provide You free of charge any new information We relied on, or rationale We used; and We will give You time to provide comments.

Appeals of Pre-Service Claims

For Pre-Service Claims, We will make a decision and notify You within 30 calendar days of receipt of Your written request for the appeal.

Appeals of Post-Service Claims

If Your appeal involves a Post-Service Claim, We will make a decision and notify You within 60 calendar days of receipt of Your written request for the appeal.

Appeals of Concurrent Claims or Review Decisions

For Concurrent Care Claims, We will make a decision and notify You as soon as possible; and prior to the benefit being reduced or terminated.

We will continue to provide coverage during Your appeal of a Concurrent Review.

Expedited Appeals for Urgent Claims

You can request an expedited appeal if Your claim for medical care or treatment is urgent and using our normal appeal process would:

- seriously jeopardize Your life or health; or
- seriously jeopardize Your ability to regain maximum function; or
- in the opinion of a Physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without the care or treatment.

You or Your treating Physician can request an expedited appeal by telephone, fax, or letter. Please make sure to explicitly state "expedited appeal" in the request to initiate this process.

We will make a decision on an expedited appeal and notify You as soon as possible, but no later than 72 hours from receipt of the request.

Expedited appeals relating to a Prescription to alleviate cancer pain will be decided not more than 24 hours from receipt of the request.

You also have the right to request an external review at the same time as You request for an expedited internal appeal. Please refer to the section below for information on how to request an External Review.

How To Begin Your Appeal

- You can ask for forms to start a written appeal by:

  1. Calling Member Services at the number on Your ID card; or
  2. Downloading the forms at www.ohiohealthyplans.com/ohiohealth ; or
  3. Sending Us a fax at 757-687-6232 or 1-866-472-3920; or
  4. Sending Us a letter by mail at:

  OhioHealthy
  APPEALS DEPARTMENT
  P.O. Box 62876
  Virginia Beach, VA 23466-2876]

- For an Urgent care appeal You or Your treating Physician can request an expedited appeal by telephone, fax, or letter. Please make sure to explicitly state "expedited appeal" in the request to initiate this process.

- When You have completed the forms return them to Us. Remember to include all of the following with Your appeal forms:

  1. Your name, address, and telephone number;
  2. Your Member number and group number;
  3. The date of service, and place of service;
  4. The name of the doctor or other service provider;
  5. The charge related to the service; and
  6. Any new additional written comments, documents, records, or other information You want Us to consider.

- When We complete Your appeal We will send written notification of our decision. If We don't change our initial decision our notice will include:

  1. Information to confirm the identity of the claim at issue, including the date of service, provider's name and claim amount; and
  2. The specific reason for our decision, including any applicable denial code and its corresponding meaning; and
  3. The specific Plan provisions We based our decision on; and
  4. Information about Your right to bring a lawsuit under Section 502(a) of ERISA and any external appeal rights available to You.

- You can also request the following free of charge:

  1. Reasonable access to, and copies of, all documents, records, and other information relevant to Your appeal; and
  2. Copies of any internal rule, guideline, protocol, or other criteria We relied on for our decision; and
  3. The diagnosis and treatment codes (and their corresponding meanings) applicable to the claim; and
  4. For denials due to Medical Necessity, Experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to Your medical circumstances.

Your Right To External Review Of An Adverse Benefit Determination Or A Final Adverse Benefit Determination.

If We have denied Your request for the provision of or payment for a health care service or course of treatment You may have the right to have our decision reviewed by health care professionals who have no association with Us. This is called an external review. The circumstances under which You can request this type of review are listed below.

We will send You copies of the forms and instructions that You need to file an external review or an expedited external review with our notice of an Adverse Benefit Determination or final adverse determination. You can also get copies of the forms and instructions that You need by calling Member Services at the number on Your Optima ID Card.

You or Your authorized representative may file a request for an external review of an adverse determination in the following situations where You have exhausted (or are treated as having exhausted) our internal appeal process as described below:

- If We have denied Your request for a Covered Service, or We have denied payment for a Covered Service or course of treatment, and our decision involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment You requested;
- If the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is Experimental or Investigational; or
- If We provide You notice that Your coverage is being rescinded.

You or Your authorized representative can request an expedited external review in the following situations:

- You have a medical condition where the time frame for completion of a standard internal or external review would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function; or
- You have appealed the denial of a claim involving an admission, availability of care, continued Stay, or health care item or service for which You received Emergency Services, but have not been discharged from a facility and We provided You with a final adverse determination denying that claim.

You have 4 months from the date You receive notice of a final adverse benefit determination to request an External appeal.

You must have exhausted our internal appeal process. Depending on Your situation exhausted means:

1. You have filed an internal appeal and We have notified You of our final adverse benefit decision; or
2. You filed an internal appeal, and We have not given You a response on our determination by either 30 days from the date of filing for a Pre-Service Claim or by 60 days from the date of filing for a Post-Service Claim. This does not apply if You agreed to give Us more time to work on Your appeal or as described below; or
3. You filed an expedited or urgent appeal with Us; or
4. We have agreed to waive the exhaustion requirement for Your appeal.

The internal appeal process is generally treated as having been exhausted if We do not comply with the claims and appeals procedures described in this SPD. However, if the violation of these procedures is "de minimus," You will not be treated as though You had exhausted the internal appeals process. The violation will be considered de minimus if it is not likely to cause prejudice or harm to Your claim, it was for good cause or due to matters beyond the Plan's control and was in the context of an ongoing, good faith exchange of information between You and the Plan.

How Your External Appeal will be handled.

We will verify that Your case is eligible for external appeal, and that Your appeal request is complete.

You will have to authorize the release of any medical records needed to reach a decision on the external review.

If any additional information is needed to complete Your request or verify eligibility, We will ask You to provide the specific information needed. We will give You a timeframe to submit this information. If You do not submit this information to Us a timely manner, Your request for an external review may be concluded.

You will be notified that Your request is complete and eligible for external review. The Independent Review Organization (IRO) performing Your appeal will not be affiliated with OhioHealthy or OhioHealth so that there is no conflict of interest with Your case. You will have 5 business days from notification to submit any additional information You would like the IRO to review about Your case. We will also submit all of our documents and information We used to make our decision on Your internal appeal to the IRO for review.

The IRO will notify You and Optima of its decision on Your external appeal. The decision is binding on Us. The decision is also binding on You except to the extent the Covered Person has other remedies available under applicable federal or state law.

If a request for an expedited External Review is submitted at the same time as a request for an expedited internal appeal request has been made, the IRO will make a determination as to whether the internal expedited appeal process must be completed prior to the expedited External Review process beginning.

We may reconsider any final Adverse Benefit Determination that is the subject of an external review at any time. Reconsideration by Us will not delay or end the external review.

Sources For Additional Help

You may have the right to bring civil action under Section 502 (a) of ERISA if all required reviews of Your appeal have been completed and Your appeal has not been approved. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency. Contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration Toll-free at 1-866-275-7922 or visit their website at www.dol.gov.

Section 10 When Your Coverage Will End

Coverage under Your Plan can end for a variety of reasons. In this section, You will find details on how and why coverage ends, and how You may still be able to continue coverage.

When Coverage Ends for Associates

Your Plan coverage will end at the end of the month if:

- The Plan is discontinued;
- You are no longer eligible for coverage;
- You become covered under another plan offered by Your Employer;
- You do not make any required contributions;
- You voluntarily stop Your coverage during the designated annual enrollment timeframe; or
- Your Employer notifies OhioHealthy that Your employment is ended.

It is Your Employer's responsibility to let OhioHealthy know when Your employment ends.

When Coverage Ends for Dependents

Coverage for Your Dependents will end if:

- The Plan is discontinued;
- You are no longer eligible for coverage or You do not submit dependent eligibility documentation;
- You do not make Your contribution for the cost of Dependents' coverage;
- You drop coverage of Your eligible Dependent during the designated annual enrollment timeframe; or
- Your Dependent is no longer eligible for coverage. Coverage ends at the end of the calendar month when Your Dependent does not meet the Plan's definition of a Dependent.

Coverage for Dependents may continue for a period after Your death. Coverage for handicapped Dependents may continue after they reach any limiting age. See Continuation of Coverage for more information.

Continuation of Coverage Handicapped Children

Coverage under the Plan for Your fully handicapped child may be continued past the maximum age for a child.

Your child is fully handicapped if:

- He or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for eligible children under Your Plan; and
- He or she depends chiefly on You for support and maintenance.

Proof that Your child is fully handicapped must be submitted to OhioHealthy no later than 31 days after the date Your child reaches the maximum age under Your Plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of dependent coverage as to Your child for any reason other than reaching the maximum age under Your Plan.

OhioHealthy will have the right to require proof of the continuation of the handicap. OhioHealthy also has the right to examine Your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date Your child reached the maximum age under Your Plan.

Section 11 COBRA Continuation of Coverage General Information

COBRA Continuation of Coverage

Health Plan continuation is provided under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA You and Your Dependents can continue health coverage, subject to certain conditions and Your payment of contributions. Continuation rights are available following a "qualifying event" that causes You or family members to otherwise lose coverage. Qualifying events are listed in this section.

Continuing Coverage through COBRA

When You or Your Dependents become eligible, Your Employer will provide You with detailed information on continuing Your health coverage through COBRA.

You or Your Dependents will need to:

- Agree to pay the required contributions.
- Complete and submit an application for continued health coverage, which is an election notice of Your intent to continue coverage.
- Submit Your application within 60 days of the qualifying event, or within 60 days of Your Employer's notice of this COBRA continuation right, if later.

Who Qualifies for COBRA

You have 60 days from the qualifying event to elect COBRA. If You do not submit an application within 60 days, You will forfeit Your COBRA continuation rights.

Below You will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

Qualifying Event Causing Loss of Health Coverage	Covered Persons Eligible to Elect Continuation	Maximum Continuation Periods
Your active employment ends for reasons other than gross misconduct	You and Your Dependents	18 months
Your working hours are reduced	You and Your Dependents	18 months
You divorce or legally separate and are no longer responsible for Dependent coverage	Your Dependents	36 months
Your Dependent children no longer qualify as Dependents under the Plan	Your Dependent children	36 months
You die	Your Dependents	36 months

Disability May Increase Maximum Continuation to 29 Months If You or Your Dependents Are Disabled

If You or Your Dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18 month continuation period, You or Your Dependent:

- Are responsible to pay the contributions after the 18th month, through the 29th month of COBRA coverage.
- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Must notify the Employer within 30 days after the date of any final determination that You or a Dependent is no longer disabled.
- Must notify Your Employer within 60 days of the disability determination status and before the 18 month continuation period ends.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.

If There Are Multiple Qualifying Events

A Dependent could qualify for an extension of the 18 or 29 month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

Determining Your Contributions For Continuation Coverage

Your contributions are regulated by law, based on the following:

- For the 18 or 36 month periods, contributions may never exceed 102 percent of the Plan costs.
- During the 18 through 29 month period, contributions for coverage during an extended disability period may never exceed 150 percent of the Plan costs.

When You Acquire a Dependent During a Continuation Period

If through birth, adoption or marriage, You acquire a new dependent during the continuation period, Your dependent can be added to the health Plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent,
- Your Employer is notified about Your dependent within 31 days of eligibility, and
- Additional contributions for continuation are paid on a timely basis, if applicable.

When Your COBRA Continuation Coverage Ends

Your COBRA coverage will end when the first of the following events occurs:

- The date You or a Dependent become enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- The date Your Employer no longer offers a group health plan.
- You or Your Dependent dies.
- You or Your Dependents do not pay required contributions.
- You or Your Dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time Your continuation period ends, if he or she is not disabled nor eligible for an extended maximum).

Section 12 When You Are Covered Under More Than One Health Plan

If You are covered by more than one health Plan Your benefits under the Plans will be coordinated so that the same services don't get paid for twice. This section explains those coordination of benefits (COB) rules.

You must tell OhioHealthy if You or a covered family member has coverage under any other health Plan. When You have double coverage, one Plan normally pays its benefits in full as the primary payor. The other Plan pays a reduced benefit as the secondary payor. When We are the primary payor, We will pay the benefits described in this SPD. When We are the secondary payor, We will determine our allowance. After the Primary Plan pays, We will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

Determining Which Plan Is Primary And Which Plan Is Secondary (Order Of Benefit Determination Rules)

When an Associate is covered under more than one insurance Plan, the Plan that covers the Associate as an employee (not a spouse or dependent) is normally the Primary Plan.

Depending on the circumstance We use the following rules to determine which plan is primary and which plan is secondary.

- **If a person is covered as an employee under one Plan and as a dependent under another Plan:**

  1. The Plan that covers the person as the employee pays its covered benefits first.
  2. The Plan that covers the person as a dependent then pays any of its covered benefits that the first Plan did not pay.

- **If children are covered as dependents under both the mother's and the father's Plan and the parents are not separated or divorced:**

  1. The Plan that covers the parent whose birthday falls earlier in a year pays its benefits first. The Plan that covers the other parent then pays any of its covered benefits that the first Plan did not pay. (If the other Plan has a rule based on the parent's sex instead of this rule, the other Plan's rule applies.)
  2. If both parents have the same birthday, the Plan that has covered one of the parents the longest pays its benefits first. The other Plan then pays any of its covered benefits that the first Plan did not pay.

- **If children are covered as dependents under both the mother's and the father's Plan and the parents are separated or divorced: the Plans pay in the following order**:

  1. The Plan of the parent with custody of the child pays its benefits;
  2. The Plan of the spouse of the parent with custody of the child, if any, pays its covered benefits not paid by the spouse's Plan;
  3. The Plan of the parent not having custody of the child pays any of its covered benefits left over:
  4. Finally, the Plan of the spouse of the non-custodial parent pays any of its covered benefits left over.

  If a court decree specifically states that one of the parents is responsible for the health care expense of the child, and that parent's health benefits Plan actually knows that parent is responsible, then the responsible parent's Plan pays its benefits first. The other parent's Plan is the Secondary Plan. If the responsible parent's health benefits Plan does not have actual knowledge of the court decree terms, this paragraph does not apply.

- **For active and inactive employees the Plans pay in the following order:**

1. The health benefits Plan of an active employee (one not laid off or retired) and his or her dependents pays its benefits first.
2. The Plan which covers a laid off or retired employee and his or her dependents is the Secondary Plan. Both Plans must have this rule for it to apply.

- **If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee longer are determined first.**

1. Two consecutive Plans are treated as one Plan if the person starts the second Plan within 24 hours of the termination of the first Plan.
2. The start of a new Plan does not include:

a) A change in the amount or scope of a Plan's benefits; or
b) A change in the entity paying, providing or administering Plan benefits; or
c) A change from one type of Plan to another (e.g., single employer to multiple employer Plan).

Effect On The Benefits Of This Plan When We Are A Secondary Plan

If this Plan is not the Primary Plan, We will coordinate benefits with the Primary Plan. We will pay the difference between what the Primary Plan(s) pay the provider and what We would pay if We were the Primary Plan.

When the benefits of this Plan are coordinated as described in the rules above, each benefit is coordinated in proportion. It is then charged against any applicable benefit limit of this Plan.

Facility Of Payment

If You are entitled to a benefit under the Plan and You are under a legal disability, or in the opinion of the Plan Administrator, incapacitated and unable to manage Your financial affairs, the Plan may pay Your benefits to a legal representative or an immediate family member on Your behalf, in the Plan Administrator's discretion. Any payment to Your legal representative or an immediate family member will satisfy the Plan's obligation to pay the benefits owed to You.

Right To Receive And Release Needed Information

We require certain information to apply these COB rules. Each Member must submit to Us any completed consents, releases, assignments and/or other documents that are necessary for Us to coordinate benefits. We may get information from other organizations or persons. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Plan all facts it needs to pay the claim. If You have questions about how We can get and use information please refer to the information on privacy practices notice in this document.

Right Of Recovery

If We pay more than We should have paid under COB, We may recover the excess from one or more of:

- the person(s) We paid; or
- insurance companies; or
- other organizations.

We are not required to reimburse a Member in cash for the value of services provided.

The Following Definitions Apply To This Section 12

"**Plan**" is any of the following which provide health benefits or services:

1. Group insurance or group-type coverage, whether insured or self-insured. This does not include Workers' Compensation.
2. A government health plan, or coverage required or provided by law. This does not include a state plan under Medicaid.

Each contract or other arrangement for coverage is a separate Plan. If a Plan has more than one part and COB rules apply to less than all of the parts, each of the parts is a separate Plan.

"**This Plan**" or "**We**" is the part of this SPD that provides benefits for health care expenses.

"**Primary Plan/Secondary Plan**". When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When this Plan is a Secondary Plan, its benefits may be coordinated with any other health insurance or health care benefits or services that are provided by any other group policy, group contract, or group health care Plan so that no more than 100% of the eligible incurred expenses are paid. This Plan may recover from the Primary Plan the reasonable cash value of services provided by this Plan.

We Do Not Cover Any Of The Following:

- Benefits available under Workers' Compensation. If We provide services covered under Workers' Compensation, Workers' Compensation will pay the provider of the services directly for those services. The Plan will coordinate benefits with the provider of the service. Any money received by Us belongs to Us.
- Benefits available under Medicare Parts A, B, or C unless required to do so by federal law. If We provide services covered under Medicare, Medicare will pay the provider of the services directly for those services. We will coordinate benefits with the provider of the services. Any money received by Us belongs to Us.
- Benefits available under any other government program, unless required to do so by law. If We provide services under a government program, the government program will pay the provider of the services directly for those services. We will coordinate benefits with the provider of the services. Any money received by Us belongs to Us.

Section 13 General Provisions

Additional Provisions

The following additional provisions apply to Your coverage:

- In the event of a misstatement of any fact affecting Your coverage under the Plan, the true facts will be used to determine the coverage in force.
- The Plan may be changed or discontinued with respect to Your coverage.
- This document describes the main features of the Plan. If You have any questions about the terms of the Plan or about the proper payment of benefits, contact Your Employer or OhioHealthy.
- This SPD applies to coverage only, and does not restrict Your ability to receive health care services that are not, or might not be, Covered Expenses.
- You cannot receive multiple coverage under the Plan because You are connected with more than one Employer.

Assignments

Coverage and Your rights under this Plan may not be assigned. A direction to pay a provider on your behalf is not an assignment of any right under this Plan or of any legal or equitable right to institute any court proceeding.

Contacting OhioHealthy

If You have questions, comments or concerns about Your benefits or coverage, or if You are required to submit information to OhioHealthy, You may contact OhioHealthy's Home Office at:

OhioHealthy Plan
4417 Corporation Lane
Virginia Beach, VA 23462

You may also use OhioHealthy's toll free Member Services phone number on Your Member ID card or visit OhioHealthy's web site at www.ohiohealthyplans.com/ohiohealth.

Discount Arrangements

From time to time, We may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, Dentists, alternative medicine, wellness and healthy living providers to You under this Plan. Some of these arrangements may be made available through third parties who may make payments to OhioHealthy in exchange for making these services available.

The third party service providers are independent contractors and are solely responsible to You for the provision of any such goods and/or services. We reserve the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance or benefits under the Plan. There are no benefits payable to You nor do We compensate providers for services they may render through discount arrangements.

Incentives

In order to encourage You to access certain medical services when deemed appropriate by You in consultation with Your Physician or other service providers, We may, from time to time, offer to waive or reduce a Member's Coinsurance, Payment Percentage, and/or a Deductible otherwise required under the Plan or offer coupons or other financial incentives. We have the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the Covered Persons to whom these arrangements are available.

Legal Action

No legal action can be brought to recover payment under any benefit after 1 year from the deadline for filing claims.

Misstatements

The Employer's or OhioHealthy's failure to implement or insist upon compliance with any provision of this Plan at any given time or times shall not constitute a waiver of the Employer's or OhioHealthy's right to implement or insist upon compliance with that provision at any other time or times.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

All covered health benefits are payable to You. However, OhioHealthy has the right to pay any health benefits to the service provider. This will be done unless You have told OhioHealthy otherwise by the time You file the claim.

The Plan may pay up to $1,000 of any benefit to any of Your relatives to whom it believes is fairly entitled to it. This can be done if the benefit is payable to You and You are a minor or not able to give a valid release.

When a PCP provides care for You or a Dependent, or care is provided by a Network Provider (Network Services or supplies), the Network Provider will take care of filing claims. However, when You seek care on Your own (Out-of-Network Services and supplies), You are responsible for filing Your own claims.

Physical Examinations

OhioHealthy will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to You.

Type of Coverage

Coverage under the Plan is non-occupational. Only Non-Occupational Injuries and Non-Occupational Illnesses are Covered Expenses. The Plan covers charges made for services and supplies only while the person is covered under the Plan.

Fraudulent misstatements in connection with any claim or application for coverage or a claim for benefits may result in termination of all coverage under this Plan.

Section 13 General Provisions

Recovery of Overpayments

If a benefit payment is made by the Plan, to or on Your behalf, which exceeds the benefit amount that You are entitled to receive, the Plan has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery the Plan may have with respect to such overpayment.

Reporting of Claims

A claim must be submitted to OhioHealthy Plans in writing. It must give proof of the nature and extent of the loss.

All claims should be reported promptly. The deadline for filing a claim is 365 days after the date of the loss.

Subrogation and Right of Recovery Provision

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, noneconomic damages, and/or general damages only.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that if he/she receives any payment from any Responsible Party as a result of an Injury, Illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

Cooperation

The Covered Person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to Injury, Illness or condition sustained by the Covered Person. The Covered Person and his/her agents shall provide all information requested by the Plan, the claims administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights, or failure to reimburse the Plan from any settlement or recovery obtained by the Covered Person, may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of the Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

The Covered Person acknowledges that the Plan has the right to conduct an investigation regarding the Injury, Illness or condition to identify any Responsible Party. The Plan reserves the right to notify Responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Section 13 General Provisions

Definitions

As used throughout this subrogation and right of recovery provision, the term **Responsible Party** means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's Injury, Illness or condition. The term Responsible Party includes the liability insurer of such party or any Insurance Coverage.

For purposes of this subrogation and right of recovery provision, the term **Insurance Coverage** refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile Insurance Coverage, or any first party Insurance Coverage.

For purposes of this subrogation and right of recovery provision, a **Covered Person** includes anyone on whose behalf the Plan pays or provides any benefit including, but not limited to, the minor child or Dependent of any Plan Member or person entitled to receive any benefits from the Plan.

First-Priority Claim

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that the Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The Plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the claims administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the Illness, Injury or condition for which Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any Insurance Coverage, related to treatment for any Illness, Injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person, the Covered Person's representative or agent, Responsible Party, Responsible Party's insurer, representative, or agent, and/or any other source possessing funds representing the amount of benefits paid by the Plan.

Reimbursement

In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an Injury, Illness or condition, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts the Plan has paid and will pay as a result of that Injury, Illness or condition, from such payment, up to and including the full amount the Covered Person receives from any Responsible Party.

Section 13 General Provisions

Subrogation

Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's Injury, Illness or condition to the full extent of benefits provided or to be provided by the Plan.

Workers' Compensation

If benefits are paid under the Plan and OhioHealthy determines You received Workers' Compensation benefits for the same incident, OhioHealthy has the right to recover as described under thus subrogation and right of recovery provision. OhioHealthy, on behalf of the Plan, will exercise its right to recover against You.

The recovery rights will be applied even though:

- The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that bodily Injury or Illness was sustained in the course of or resulted from Your employment;
- The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by You or the Workers' Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this Plan, You will notify OhioHealthy of any Workers' Compensation claim You make, and that You agree to reimburse OhioHealthy, on behalf of the Plan, as described above.

If benefits are paid under this Plan, and You or Your Dependent recover from a responsible party by settlement, judgment or otherwise, OhioHealthy, on behalf of the Plan, has a right to recover from You or Your Dependent an amount equal to the amount the Plan paid.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:

- Copies of all bills and receipts.
- Dates expenses are incurred.
- Names of Physicians, Dentists and others who furnish services.

Section 14 Definitions

In this section, You will find definitions for the words and phrases that are capitalized throughout the text of this SPD.

A

Accident or Accidental

This means a sudden; unexpected; and unforeseen; identifiable Occurrence or event producing, at the time, objective symptoms of a bodily Injury. The Accident must occur while the person is covered under this Plan. The Occurrence or event must be definite as to time and place. It must not be due to, or contributed by, an Illness or disease of any kind.

Adverse Benefit Determination

An Adverse Benefit Determination means that We have made a decision not to Pre-Authorize, cover, or pay (in whole or in part) for a service because:

- Optima has notified You that Your coverage is being rescinded.
- The service does not meet our requirements for:
  - Appropriateness;
  - effectiveness;
  - health care setting;
  - level of care;
  - Medical Necessity; or
- Tthe service is excluded from coverage under the Plan; or
- Tthe service is Experimental or Investigational; or
- You are not eligible for benefits under the Plan; or

Ambulance

A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

Associate or Covered Associate

Employees who are covered under the Plan.

B

Behavioral Health Provider

A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Birthing Center

A freestanding facility that meets all of the following requirements:

- Accepts only patients with low-risk pregnancies.
- Charges for its services.
- Extends staff privileges to Physicians who practice obstetrics and gynecology in an area Hospital.
- Has a Physician or certified nurse midwife present at all births and during the immediate postpartum period.
- Has a written agreement with a Hospital in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.

- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is directed by at least one Physician who is a Specialist in obstetrics and gynecology.
- Is equipped and has trained staff to handle Emergency Medical Conditions and provide immediate support measures to sustain life if:
  - A child is born with an abnormality which impairs function or threatens life.
  - Complications arise during labor.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care; or
- Keeps a medical record on each patient and child.
- Meets licensing standards.
- Provides an ongoing quality assurance program. This includes reviews by Physicians who do not own or direct the facility.
- Provides, during labor, delivery and the immediate postpartum period, full-time Skilled Nursing Services directed by an R.N. or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.

Body Mass Index

This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Brand-Name Prescription Drug

A Prescription Drug with a proprietary name assigned to it by the manufacturer or distributor and so indicated by OptumRx or any other similar publication designated by OptumRx or an affiliate.

C

Clinical Trials For Life Threatening Diseases or Conditions

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and the study or investigation is (i) a federally funded or approved trial, (ii) conducted under an Investigational new drug application reviewed by the U.S. Food and Drug Administration, or (iii) a drug trial that is exempt from having an Investigational new drug application.

Life Threatening Condition means any disease or condition from which the likelihood of death is probable unless the course of disease or condition is interrupted.

Qualified Individual means a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol, with respect to treatment of cancer or other life-threatening disease or condition, and the referring health care professional has concluded that the individual's participation in such trial is appropriate to treat the disease or condition, or the individual's participation is based on medical and scientific information.

Routine Patient Costs means all items and services consistent with the coverage provided under the health benefit Plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include the Investigational item, device, or service itself; items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Coinsurance

Your share of the cost of a Covered Service calculated as a percent (for example, 20%) of the Plan's Negotiated Charge for that service. Your Coinsurance amounts are listed on the Summary of Benefits. You pay Coinsurance directly to an In-Network or Out-of-Network Provider after You have met any Deductible You owe. For example, if the Plan's Negotiated Charge for a PCP office visit is $100 and You've met Your Deductible, Your Coinsurance payment of 20% would be $20.

Concurrent Care Claim

A claim for a benefit where We are reducing or ending a service previously approved. It can also be a request to extend a course of treatment. An example would be a review of an inpatient Hospital Stay approved for five days on the third day to determine if the

full five days is appropriate. Another example would be a request for additional outpatient therapy visits.

Concurrent Review

Concurrent Review means review of an ongoing course of treatment that has been approved to be provided over a period of time or for a specified number of treatments.

Copay

Your share of the cost of a Covered Service is a flat dollar amount for that service. Your Copay amounts are listed on the Summary of Benefits. You pay Copays directly to an In-Network Provider.

Cosmetic

Services or supplies that alter improve or enhance appearance.

Covered Expenses or Covered Services

Medical and Pharmacy services and supplies shown as covered under this SPD.

Covered Person

An Associate and their eligible Dependent(s) enrolled in and covered under the Plan.

Custodial Care

Services and supplies that are primarily intended to help You meet personal needs. Custodial Care can be prescribed by a Physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of Custodial Care include:

- Any service that can be performed by a person without any medical or paramedical training
- Care of a stable colostomy/ileostomy;
- Care of a stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Care of a stable tracheostomy (including intermittent suctioning);
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Institutional care, including Room and Board for rest cures, adult day care and convalescent care;
- Respite care, adult (or child) day care, or convalescent care;
- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications; and
- Watching or protecting You.

D

Day Care Treatment

A Partial Confinement Treatment program to provide treatment for You during the day. The Hospital, Psychiatric Hospital or Residential Treatment Facility does not make a room charge for day care treatment. Such treatment must be available for at least 4 hours, but not more than 12 hours in any 24-hour period.

Deductible

Deductible means the dollar amount You must pay out-of-pocket each calendar year for Covered Services before the Plan begins to pay for Your benefits. Additional information regarding Deductibles and Deductible amounts can be found in the Summary of Benefits.

Dentist

A legally qualified Dentist, or a Physician licensed to do the dental work he or she performs.

Dependent

A member of an Associate's family who meets all of the Plan's eligibility requirements and who is enrolled in the Plan.

Detoxification

The process, by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Alcohol in combination with drugs;
- Alcohol or drug-dependent factors; or
- Intoxicating alcohol or drug;

as determined by a Physician. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

Directory

A listing of all Network Providers serving the class of Associates to which You belong. Network Provider information is available through OhioHealthy's online provider directory.

Durable Medical and Surgical Equipment (DME)

Equipment and the accessories needed to operate it, that is:

- Made for and mainly used in the treatment of an Illness or Injury;
- Made to withstand prolonged use;
- Not for exercise or training;
- Not for use in altering air quality or temperature;
- Not normally of use to people who do not have an Illness or Injury; and
- Suited for use in the home.

Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

E

Emergency

Emergency means the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (a) serious jeopardy to the mental or physical health of the individual, or (b) danger of serious impairment of the individual's bodily functions, or (c) serious dysfunction of any of the individual's bodily organs, or (d) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Medical Condition(s)

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e) (1) (A) of the

Social Security Act (42 U.S.C. 1395dd (e) (1) (A)).   That provision of the Social Security Act, refers to the following conditions: clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

Emergency Services

Emergency Services means, with respect to an Emergency Medical Condition, a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is A) within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and B) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Employer

OhioHealth Corporation, including its related entities, as applicable.

Experimental or Investigational

An Experimental or Investigational drug, device, medical treatment or procedure may be considered Experimental/Investigational if:

- The drug or device is not approved for marketing by the Food and Drug Administration (FDA); or
- The drug, device, medical treatment or procedure is:
  - An Experimental study/Investigational arm of a Phase III clinical study or
  - Currently under study in a Phase I or II clinical trial or
  - Otherwise under study to determine safety and efficacy/compare its safety and efficacy to current standards of care
- The drug, device, or medical treatment is approved as Category B Non-Experimental/Investigational by the FDA; or
- The majority of the medical community does not support the use of this drug, device, medical treatment or procedure; or
- The research regarding this drug, device, medical treatment or procedure may be so limited than an evaluation of safety and efficacy cannot be made; or
- The use of this drug, device, medical treatment or procedure may have been shown to be unsafe and/or of no or questionable use as reported by current scientific literature and/or regulatory agencies.

G

Gender Dysphoria

Gender Dysphoria is defined as a condition characterized by the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender also known as "natal gender", which is the individuals' sex determined at birth.

Generic Prescription Drug or Generic Drug or Generic

- A Prescription Drug, whether identified by its chemical, proprietary, or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient and so indicated by OptumRx or any other publication designated by OptumRx

H

Homebound
This means that You are confined to Your place of residence:

- Because the act of transport would be a serious risk to Your life or health; or
- Due to an Illness or Injury which makes leaving the home medically contraindicated.

Section 14 Definitions

Home Health Care Agency

An agency that meets all of the following requirements.

- Has an administrator.
- Has full-time supervision by a Physician or an R.N.
- Is associated with a professional group (of at least one Physician and one R.N.) which makes policy.
- Keeps complete medical records on each person.
- Mainly provides Skilled Nursing Services and other therapeutic services.
- Meets licensing standards.

Home Health Care Plan

This is a plan that provides for continued care and treatment of an Illness or Injury. The care and treatment must be:

- An alternative to a Hospital or Skilled Nursing Facility Stay; and
- Prescribed in writing by the attending Physician.

Hospice Care

This is care given to a Terminally Ill person by or under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care Program.

Hospice Care Agency

An agency or organization that meets all of the following requirements:

- Assesses the patient's medical and social needs.
- Develops a Hospice Care Program to meet those needs.
- Establishes policies about how Hospice Care is provided.
- Has a full-time administrator.
- Has at least the following personnel one Physician, one R.N. and one licensed or certified social worker employed by the agency.
- Has Hospice Care available 24 hours a day.
- Keeps a medical record on each patient.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Permits all area medical personnel to utilize its services for their patients.
- Provides an ongoing quality assurance program. This includes reviews by Physicians, other than those who own or direct the agency.
- Provides Skilled Nursing Services, medical social services; and psychological and dietary counseling.
- Provides, or arranges for, other services which include:
    - Physician services;
    - Physical and occupational therapy;
    - Part-time home health aide services which mainly consist of caring for Terminally Ill people; and
    - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Uses volunteers trained in providing services for non-medical needs.

Hospice Care Program

This is a written plan of Hospice Care, which:

- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs;
- Is designed to provide palliative and supportive care to Terminally Ill persons, and supportive care to their families; and
- Is established by and reviewed from time to time by a Physician attending the person, and appropriate personnel of a Hospice Care Agency.

Hospice Facility

A facility or distinct part of one that meets all of the following requirements:

- Charges patients for its services.
- Has a full-time administrator.
- Is run by a staff of Physicians. At least one staff Physician must be on call at all times.
- Keeps a medical record on each patient.
- Mainly provides inpatient Hospice Care to Terminally Ill persons.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides 24-hour-a-day nursing services under the direction of an R.N.
- Provides an ongoing quality assurance program including reviews by Physicians other than those who own or direct the facility.

Hospital

An institution that:

- Charges patients for its services;
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a Hospital and is accredited as a Hospital by the Joint Commission on the Accreditation of Healthcare Organizations;
- Is operating in accordance with the laws of the jurisdiction in which it is located;
- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of Physicians; and
- Provides twenty-four (24) hour-a-day R.N. service,

Hospitalization

A continuous confinement as an inpatient in a Hospital for which a Room and Board charge is made.

I

Illness or Illnesses

Illness means a pregnancy or a medical condition, bodily disorder or infirmity that is not work-related.

Infertile or Infertility

The condition of a presumably healthy Covered Person who is unable to conceive or produce conception after:

- For a woman who is under 35 years of age: 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- For a woman who is 35 years of age or older: 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

Injury or Injuries

An Accidental bodily Injury that is the sole and direct result of:

- An act or event must be definite as to time and place.
- An unexpected or reasonably unforeseen Occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.

In- Network Provider

A health care provider that has contracted to furnish services or supplies for this Plan; but only if the provider is, with OhioHealthy's consent, included in the Directory as a Network Provider for:

- The service or supply involved; and
- The class of Associates to which You belong.

In-Network Benefit(s)

Health care service or supply that is:

- Furnished by a Network Provider; or
- Furnished or arranged by Your PCP.

J

Jaw Joint Disorder

This is:

- A Temporomandibular Joint (TMJ) dysfunction or any alike disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

L

L.P.N.

A licensed practical or vocational nurse.

M

Mail Order Pharmacy

An establishment where Prescription Drugs are legally given out by mail or other carrier.

Maintenance Care

Care made up of services and supplies that:

- Are given mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Give a surrounding free from exposures that can worsen the person's physical or mental condition.

Maximum Coinsurance

The total dollar amount listed on the Summary of Benefits that You pay out-of-pocket for most In-Network Covered Services during a calendar year after You have met Your Deductible. Additional information regarding Maximum Coinsurance and Deductible amounts can be found in the Summary of Benefits in this SPD.

Medically Necessary or Medical Necessity

This means services or supplies as provided by a Hospital, Skilled Nursing Facility, Physician or other provider required to identify or treat a Covered Person's Illness or Injury and which, as determined by the Covered Person's Physician and the Plan, are: (1) consistent with the symptoms, diagnosis and treatment of the Covered Person's condition, disease, ailment or Injury; (2) in accordance with recognized standards of care for the Covered Person's disease, ailment or Injury; (3) appropriate with regard to standards of good medical practice; (4) not solely for the convenience of the Covered Person, his or her Physician, Hospital, or other health care

provider; and (5) the most appropriate supply or level of service which can be safely provided to the Covered Person. When specifically applied to an inpatient, it further means that the Covered Person's medical symptoms or condition requires that the diagnosis, treatment or service cannot be safely provided to the Covered Person as an outpatient.

Member or Covered Person

An Associate and their eligible Dependent(s) enrolled in and covered under the Plan.

Mental Disorder

An Illness commonly understood to be a Mental Disorder, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a Behavioral Health Provider such as a Psychiatric Physician, a psychologist or a psychiatric social worker.

Any one of the following conditions is a Mental Disorder under this Plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive Developmental Disorder (including Autism).
- Psychotic disorders/Delusional disorder.
- Schizo-affective disorder.
- Schizophrenia.

Morbid Obesity

This means a Body Mass Index that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

N

Negotiated Charge

As to coverage other than Prescription Drug Expense Coverage:

The Negotiated Charge is the maximum charge a Network Provider has agreed to make as to any service or supply for the purpose of the benefits under this Plan. Negotiated Charge is the amount OhioHealthy determines should be paid to a provider for a Covered Service or Covered Expense. When You use In-Network Benefits from Plan Providers Negotiated Charge is the provider’s contracted rate with OhioHealthy or the provider’s actual charge for the service, whichever is less. Plan Providers accept this amount as payment in full.

The Negotiated Charge does not include or reflect any amount a provider may receive under a contracted rate or arrangement with OhioHealth for services provided in an identified “bundled” program (e.g., maternity benefits or similar programs). OhioHealth may receive or pay additional amounts related to such bundled program services under negotiated price guarantees. These amounts will not change the Negotiated Charge under this Plan.”

Night Care Treatment

A Partial Confinement Treatment program provided when You need to be confined during the night. A room charge is made by the Hospital, Psychiatric Hospital or Residential Treatment Facility. Such treatment must be available at least:

- 8 hours in a row a night; and
- 5 nights a week.

Non-Occupational Illness or Illnesses

A Non-Occupational Illness is an Illness that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an Illness that does.

An Illness will be deemed to be Non-Occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that Illness under such law.

Non-Occupational Injury or Injuries

A Non-Occupational Injury is an Accidental bodily Injury that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an Injury which does.

Non-Specialist

A Physician who is not a Specialist.

O

Occupational Injury or Occupational Illness

An Injury or Illness that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an Injury or Illness that does.

Occurrence

This means a period of disease or Injury. An occurrence ends when 60 consecutive days have passed during which the Covered Person:

- Receives no medical treatment; services; or supplies; for a disease or Injury; and
- Neither takes any medication, nor has any medication prescribed, for a disease or Injury.

Orthodontic Treatment

This is any medical or dental service or supply furnished to prevent, diagnose or to correct a misalignment of the teeth, the bite, the jaws or the jaw joint relationship whether or not for the purpose of relieving pain.

The following are not considered Orthodontic Treatment:

- The installation of a space maintainer; or

- A surgical procedure to correct malocclusion.

Out-of-Network Benefits

Health care benefits, services or supplies furnished by an Out-of-Network Provider.

Out-of-Network Provider

A health care provider who has not contracted with OhioHealthy, an affiliate, or a third party vendor, to furnish services or supplies for this Plan.

P

Partial Confinement Treatment

A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat Substance Abuse or Mental Disorders. The plan must meet these tests:

- Day Care Treatment and Night Care Treatment are considered Partial Confinement Treatment.
- It does not require full-time confinement.
- It is carried out in a Hospital; Psychiatric Hospital or Residential Treatment Facility; on less than a full-time inpatient basis.
- It is in accord with accepted medical practice for the condition of the person.
- It is supervised by a Psychiatric Physician who weekly reviews and evaluates its effect.

Payment Percentage

Payment Percentage is both the percentage of Covered Expenses that the Plan pays, and the percentage of Covered Expenses that You pay. The percentage that the Plan pays is referred to as the "Plan Payment Percentage," and varies by the type of expense. Please refer to the Summary of Benefits for specific information on Payment Percentage amounts.

Payment Limit

Payment Limit is the maximum out-of-pocket amount You are responsible to pay for Your Payment Percentage for Covered Expenses during the calendar year. Once You satisfy the Payment Limit, the Plan will pay 100% of the Covered Expenses that apply toward the limit for the rest of the calendar year. The Payment Limit applies to both Network and Out-of-Network Benefits.

Pharmacy

An establishment where Prescription Drugs are legally dispensed. Pharmacy includes a retail Pharmacy, Mail Order Pharmacy and Specialty Pharmacy. Network Pharmacy is a Pharmacy that has entered into a contractual agreement with OptumRx, an affiliate, or a third party vendor, for the provision of Covered Services to You and Your Dependents. Out-of-Network Pharmacy is a Pharmacy that has not contracted with OptumRx, an affiliate, or a third party vendor and does not participate in the Pharmacy network.

Physician

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- A Physician is not You or related to You;

- Has the medical training and clinical expertise suitable to treat Your condition;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Specializes in psychiatry, if Your Illness or Injury is caused, to any extent, by alcohol abuse, Substance Abuse or a Mental Disorder; and
- Under applicable insurance law is considered a Physician for purposes of this coverage.

Post-Service Claim

Any claim for a benefit that is not a Pre-Service Claim. An example would be a claim for payment for a diagnostic test or other services You have already had done.

Pre-Authorization or Pre-Authorize

A process where OhioHealthy is contacted before certain services are provided, such as Hospitalization or outpatient surgery, or Prescription Drugs are prescribed to determine whether the services being recommended or the drugs prescribed are considered Covered Expenses under the Plan. It is not a guarantee that benefits will be payable.

Prescriber

Any Physician or Dentist, acting within the scope of his or her license, who has the legal authority to write an order for a Prescription Drug.

Prescription

An order for the dispensing of a Prescription Drug by a Prescriber. If it is an oral order, it must be promptly put in writing by the Pharmacy.

Prescription Drug

A drug, biological, or compounded Prescription which, by State and Federal Law, may be dispensed only by Prescription and which is required to be labeled "Caution: Federal Law prohibits dispensing without Prescription." This includes an injectable drug prescribed to be self-administered, or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Prescription Drug Formulary Guide

A listing of Prescription Drugs established by OptumRx or an affiliate, which includes both Brand-Name Prescription Drugs and Generic Prescription Drugs. This list is subject to periodic review and modification by OptumRx or an affiliate. A copy of the Drug Formulary Guide will be available upon Your request or may be accessed on the OptumRx website at optumrx.com.

Pre-Service Claim

A claim for a benefit or service that requires Pre-Authorization before You receive care. An example would be obtaining Pre-Authorization for a diagnostic test or medical procedure.

Primary Care Physician (PCP)

This is the Network Provider who:

- Is selected by a person from the list of Primary Care Physicians in the Directory;
- Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician; and
- Is shown on OhioHealthy's records as the person's PCP.

Psychiatric Hospital

This is an institution that meets all of the following requirements.

- Has a Psychiatric Physician present during the whole treatment day;
- Is not mainly a school or a custodial, recreational or training institution;
- Is staffed by Psychiatric Physicians involved in care and treatment;
- Is supervised full-time by a Psychiatric Physician who is responsible for patient care and is there regularly;
- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, Substance Abuse or Mental Disorders;
- Makes charges; and
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a Psychiatric Physician;
- Provides infirmary-level medical services. Also, it provides, or arranges with a Hospital in the area for, any other medical service that may be required;
- Provides, at all times, psychiatric social work and nursing services;
- Provides, at all times, Skilled Nursing Services by licensed nurses who are supervised by a full-time R.N.;

Psychiatric Physician

This is a Physician who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, Substance Abuse or Mental Disorders.

Q

Qualified Medical Child Support Order (QMCSO)

A court order requiring a parent to provide health care coverage to one or more children.

R

Recognized Charge

The Covered Expense is only that part of a charge which is the Recognized Charge.

As to medical, vision and hearing expenses, the Recognized Charge for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For professional services and other services or supplies not mentioned below:
    - The 80th percentile of the Prevailing Charge Rate; for the Geographic Area where the service is furnished.

If OhioHealthy has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that OhioHealthy will pay for a service or supply, then the Recognized Charge is the rate established in such agreement.

OhioHealthy may also reduce the Recognized Charge by applying OhioHealthy Reimbursement Policies. OhioHealthy Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- If follow up care is included;
- The duration and complexity of a service;
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided;

- Whether an assistant surgeon is involved and necessary for the service;
- Whether multiple procedures are billed at the same time, but no additional overhead is required; and
- Whether there are any other characteristics that may modify or make a particular service unique.

OhioHealthy Reimbursement Policies are based on OhioHealthy's review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with Physician or dental

specialty society recommendations; and the views of Physicians and Dentists practicing in the relevant clinical areas. OhioHealthy uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.

- Prevailing Charge Rates: These are rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. OhioHealthy updates its systems with these changes within 180 days after receiving them from FAIR Health.

Rehabilitation Services

The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if You are disabled by Illness or Injury.

Retrospective Review

Retrospective Review means our review of the Member's medical records and other supporting documentation after services have been received to determine if the services were Medically Necessary and if the Plan will pay for them.

Residential Treatment Facility (Mental Disorders)

This is an institution that meets all of the following requirements:

- Has access to necessary medical services 24 hours per day/7 days a week;
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission;
- Has peer-oriented activities;
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults);
- Is admitted by a Physician;
- Is not a wilderness treatment program or any such related or similar program, school and/or education service;
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located;
- Offers group therapy sessions with at least an RN or Masters-level health professional;
- On-site licensed Behavioral Health Provider 24 hours per day/7 days a week;
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission);
- Provides a level of skilled intervention consistent with patient risk;
- Provides access to at least weekly sessions with a Psychiatrist or psychologist for individual psychotherapy;
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs; and
- Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the OhioHealthy credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).

Residential Treatment Facility (Substance Abuse)

This is an institution that meets all of the following requirements:

- 24-hours per day/7 days a week supervision by a Physician with evidence of close and frequent observation; and
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on-site or externally;
- Has access to necessary medical services 24 hours per day/7 days a week;
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission;
- Has peer-oriented activities;
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults);
- If the Member requires Detoxification services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending Physician;.
- Is admitted by a Physician;
- Is not a wilderness treatment program or any such related or similar program, school and/or education service;
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located;
- Offers group therapy sessions with at least an RN or Masters-level health professional;
- On-site, licensed Behavioral Health Provider, medical or Substance Abuse professionals 24 hours per day/7 days a week;
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission);
- Provides a level of skilled intervention consistent with patient risk;
- Provides access to at least weekly sessions with a Psychiatrist or psychologist for individual psychotherapy;
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs; and
- Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the OhioHealthy credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).

R.N.

A registered nurse.

Room and Board

Charges made by an institution for Room and Board and other Medically Necessary services and supplies. The charges must be regularly made at a daily or weekly rate.

S

Self-injectable Prescription Drug(s) or Self-injectable Infertility Drug(s)

Prescription Drugs that are intended to be self-administered by injection to a specific part of the body to treat medical conditions.

Semi-Private Room Rate

The Room and Board charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, OhioHealthy will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Service Area

This is the geographic area, as determined by OhioHealthy, in which Network Providers for this Plan are located.

Skilled Nursing Facility

An institution that meets all of the following requirements:

- An institution or a distinct part of an institution that meets all of the following requirements:
    - It is licensed or approved under state or local law;

  - Is primarily engaged in providing Skilled Nursing Services and related services for residents who require medical or nursing care, or Rehabilitation Services for the rehabilitation of injured, disabled, or sick persons;
- Charges patients for its services;
- Has a utilization review plan;
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of Mental Disorders;
- Is supervised full-time by a Physician or an R.N.;
- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from Illness or Injury:
  - Professional nursing care by an R.N., or by an L.P.N. directed by a full-time R.N.; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities;
- Keeps a complete medical record on each patient;
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.;
- Qualifies as a Skilled Nursing Facility under Medicare or as an institution accredited by:
  - The Bureau of Hospitals of the American Osteopathic Association;
  - The Commission on the Accreditation of Rehabilitative Facilities; or
  - The Joint Commission on Accreditation of Health Care Organizations

Skilled Nursing Facilities also include rehabilitation Hospitals (all levels of care, e.g. acute) and portions of a Hospital designated for skilled or Rehabilitation Services.

Skilled Nursing Facilities does not include:

- Institutions which provide only minimal care, Custodial Care services, ambulatory; or part-time care services; or
- Institutions which primarily provide for the care and treatment of alcoholism, Substance Abuse or Mental Disorders.

Skilled Nursing Services

Services that meet all of the following requirements:

- The services require medical or paramedical training;
- The services are rendered by an R.N. or L.P.N. within the scope of his or her license; and
- The services are not custodial.

Specialist

A Physician who practices in any generally accepted medical or surgical sub-specialty.

Specialty Care Drugs

Prescription Drugs include injectable, infusion and oral drugs prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis which are listed in the specialty care drug list.

Specialty Pharmacy Network

A network of pharmacies designated to fill Specialty Care Drugs.

Stay

A full-time inpatient confinement for which a Room and Board charge is made.

Step Therapy

A form of Pre-Authorization under which certain Prescription Drugs will be excluded from coverage, unless a first-line therapy drug(s) is used first by You. The list of Step Therapy drugs is subject to change by OptumRx or an affiliate. An updated copy of the list of drugs subject to Step Therapy shall be available upon request by You or may be accessed on the OptumRx website at optumrx.com.

Substance Abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to You or Your Dependents.) This term does not include conditions not attributable to a Mental Disorder that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

Summary of Benefits

The general list of Covered Services and cost sharing including Coinsurance, Deductibles and Maximum Coinsurance, found in this Summary Plan Description (SPD)

Summary Plan Description (SPD)

This document containing a description of Covered Expenses under the Plan.

Surgery Center

A freestanding ambulatory surgical facility that meets all of the following requirements:

- Charges for its services;
- Does not have a place for patients to Stay overnight;
- Extends surgical staff privileges to Physicians who practice surgery in an area Hospital; and Dentists who perform oral surgery;
- Has at least 2 operating rooms and one recovery room;
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period;
- Is directed by a staff of Physicians. At least one of them must be on the premises when surgery is performed and during the recovery period;
- Is equipped and has trained staff to handle Emergency Medical Conditions;
- Is set up, equipped and run to provide general surgery;
- Meets licensing standards;
- Provides, in the operating and recovery rooms, full-time Skilled Nursing Services directed by an R.N.; and
- Provides, or arranges with a medical facility in the area for, diagnostic X-ray and lab services needed in connection with surgery.

Must have all of the following:

- A blood volume expander;
- A defibrillator;
- A Physician trained in cardiopulmonary resuscitation;
- A tracheotomy set;
- Has a written agreement with a Hospital in the area for immediate emergency transfer of patients;
- Keeps a medical record on each patient;
  own or direct the facility;
- Provides an ongoing quality assurance program. The program must include reviews by Physicians who do not; and
- Written procedures for such a transfer must be displayed and the staff must be aware of them.

T

Terminally Ill (Hospice Care)

Terminally Ill means a medical prognosis of 12 months or less to live.

Therapeutic Drug Class

A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or Injury.

U

Urgent Care Provider

This is:

- A freestanding medical facility that meets all of the following requirements:
  - Has a full-time administrator who is a licensed Physician;
  - Is licensed and certified as required by any state or federal law or regulation;
  - Is run by a staff of Physicians with at least one Physician on call at all times;
  - Keeps a medical record on each patient;
  - Makes charges;
  - Provides an ongoing quality assurance program. This includes reviews by Physicians other than those who own or direct the facility;
  - Provides unscheduled medical services to treat an Urgent Condition if the person's Physician is not reasonably available; and
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.

- A Physician's office that has contracted with OhioHealthy to provide urgent care; and is, with OhioHealthy's consent, included in the directory as a Network Urgent Care Provider.

Urgent Claim

A request for medical care or treatment where using our normal Pre-Authorization standards would:

- Seriously jeopardize the Member's life or health; or
- Seriously jeopardize the ability of the Member to regain maximum function; or
- In the opinion of a Physician with knowledge of the Member's medical condition, subject the Member to severe pain that cannot be adequately managed without the care or treatment.

Urgent Condition

This means a sudden Illness; Injury; or condition; that:

- Does not require the level of care provided in the emergency room of a Hospital;
- Includes a condition which would subject You to severe pain that could not be adequately managed without
- Is severe enough to require prompt medical attention to avoid serious deterioration of Your health; and
- Requires immediate outpatient medical care that cannot be postponed until Your Physician becomes reasonably available.
  urgent care or treatment;

V

Virtual Consult

A medical consult using a secure platform (as determined by OhioHealthy in its sole discretion) with email, interactive video, and telephone to connect a provider and a patient.

W

Walk-in Clinic

Walk-in Clinics are freestanding health care facilities. They are an alternative to a Physician's office visit for:

- Injuries;
- Non-Emergency Illnesses;
- The administration of certain immunizations; and
- Treatment of unscheduled.

It is not an alternative for emergency room services or the ongoing care provided by a Physician. Neither an emergency room, nor the outpatient department of a Hospital, shall be considered a Walk-in Clinic.

We or Us means OhioHealthy.

Y

You or Your means an eligible Associate and any eligible Dependents covered under the Plan.

Section 15 Important Plan Information And Notices

The following information is provided to You in accordance with the Employee Retirement Income Security Act of 1974 (ERISA) by OhioHealth Corporation.

Name of Plan:

The Plan is a component of the OhioHealth Corporation Welfare Benefits Plan

Employer Identification Number:

31-4394942

Plan Number:

503

Type of Plan:

The Plan is the portion of the OhioHealth Corporation Welfare Benefits Plan that provides group medical and Prescription Drug benefits.

Type of Administration:

Administrative Services Contract with:

OhioHealthy Medical Plans, Inc.
OhioHealth David P. Blom Administrative Campus
3430 OhioHealth Parkway
Columbus, OH 43202
Funding

The benefits are self-funded by OhioHealth Corporation and are paid from the company's general assets and associate contributions.

Employer/Plan Administrator:

OhioHealth Corporation
OhioHealth David P. Blom Administrative Campus
3430 OhioHealth Parkway
Columbus, OH 43202
Telephone Number: (614) 533-8888

Agent For Service of Legal Process:

OhioHealth Corporation
OhioHealth David P. Blom Administrative Campus
3430 OhioHealth Parkway
Columbus, OH 43202

Service of legal process may also be made upon the Plan Administrator

End of Plan Year:

December 31

Source of Contributions:

Employer/Associate

Procedure for Amending the Plan:

The Employer may amend the Plan from time to time by a written instrument signed by the Plan's sponsor or as otherwise provided in the Plan's governing document. Plan amendments include amendments to terminate the Plan or to terminate coverage for some or all employees. If the Plan is terminated, Your rights are limited to the payment of eligible expenses incurred prior to the Plan's termination.

ERISA Notice

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Assistance with Your Questions

If you have any questions about Your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Newborns' And Mothers' Health Protection Act Of 1996

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

Women's Health And Cancer Rights Act Of 1998

The Women's Health and Cancer Rights Act of 1998 requires the Plan to notify You of Your rights related to benefits provided by the Plan in connection with a mastectomy. Please retain this notice with Your important health care records. If You have any questions regarding this Notice or the benefits You are entitled to under the Plan please call Member Services at the number listed on Your Plan insurance identification card.

As a Member of the Plan You have rights to coverage to be provided in a manner determined in consultation with Your attending Physician for:

- All stages of reconstruction of the breast on which the mastectomy was performed; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema; and
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.

These benefits are subject to the exclusions, limitations, and conditions including Coinsurance, and/or Deductibles set forth in this document.

HIPAA Privacy Practices Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of Your private health information. A complete description of Your rights under HIPAA can be found in the Privacy Notice which was distributed to You upon enrollment and is available from the HR Resource Center, phone 614-533-8888.

This Plan, and the Plan Sponsor, will not use or further disclose information ("protected health information or PHI") that is protected by HIPAA except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan Sponsor will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit Plan of the Plan Sponsor.

Under HIPAA You have certain rights to see and copy protected health information about You. You have the right to request an accounting of certain disclosures of the information and under certain circumstances, amend the information. You have the right to file a complaint with the Plan Sponsor or with the Secretary of the U.S. Department of Health and Human Services if You believe Your rights under HIPAA have been violated.

If You have any questions regarding Your rights under HIPAA's privacy rules please consult the Plan's Privacy Notice (provided below).

Plan HIPAA Notice of Privacy Practices

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of our Plan participants' medical Information and to provide notice of our legal duties and privacy practices with respect to said medical Information.

This notice, effective September 23, 2013, describes how OhioHealthy may use and disclose medical Information about you, and important information about your privacy rights. Please review it carefully. If you have any questions regarding this notice you may contact the OhioHealth Privacy Officer at 1-(866) 411-6181.

HIPAA imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information, includes virtually all individually identifiable health information held by the Plan – whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the following benefit programs: the medical, dental, vision, prescription drug, employee assistance, healthcare flexible spending account and health savings account components of the OhioHealth Corporation Welfare Benefits Plan, The Plan's component programs covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These component benefit programs are collectively referred to as the Plan in this notice, unless specified otherwise.

I. The Plan's duties with respect to health information about you
The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the insurer. It's important to note that these rules apply to the Plan, not OhioHealth as an employer – that's the way the HIPAA rules work. Different policies may apply to other OhioHealth benefit programs or to data unrelated to the health plan.

II. How the Plan may use or disclose your health information
Except as outlined below, the Plan will not use or disclose your protected health information unless you have signed a form authorizing the use or disclosure. You have the right to revoke the authorization in writing unless we have taken any action in reliance on the authorization. In other words, you cannot revoke your authorization with respect to disclosures the Plan has already made. There are certain uses and disclosures of your health information for which we will always obtain a prior authorization, and these include:

- Marketing communication unless the communication is made directly to you in person, is simply a promotional gift of nominal value, is a prescription refill reminder, general health or wellness information, or a communication about health related products or services that we offer or that are directly related to your treatment.
- Most sales of your protected health information unless for treatment or payment purposes or as required by law.
- Psychotherapy notes unless otherwise permitted or required by law.

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of ***health care treatment, payment activities, and health care operations***. Here are some examples of what that might entail:

- Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. *For example, the Plan may share health information about you with physicians who are treating you.*
- Payment includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" Plan functions such as risk adjustment, collection, or reinsurance. *For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.*

- Health care operations include activities by this Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution (i.e., claim appeals). Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. *For example, the Plan may use information about your claims to review the effectiveness of wellness programs.*

The amount of health information used or disclosed will be limited to the "minimum necessary" for these purposes, as defined under the HIPAA rules.

How the Plan may share your health information with OhioHealth
The Plan may disclose your health information without your written authorization to OhioHealth for plan administration purposes.

OhioHealth may need your health information to administer benefits under the Plan. The Human Resources Department and to a limited extent the Information Technology department are the only OhioHealth employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and OhioHealth, as allowed under the HIPAA rules:

- The Plan may disclose "summary health information" to OhioHealth if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, but from which names and other identifying information has been removed.
- The Plan may disclose to OhioHealth information on whether an individual is participating in the Plan, or has enrolled or disenrolled in the Plan.

In addition, you should know that OhioHealth will not use health information obtained from the Plan for any employment-related actions. However, health information collected by OhioHealth from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information
In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan is also allowed to use or disclose your health information without your written authorization for the following activities:

Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Plan's compliance with the HIPAA privacy rule
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that prevent releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Public Health Activities	Disclosures authorized by law to persons who may be at risk of contracting or

	spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies or authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Workers' Compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws

The Plan is prohibited from using or disclosing your genetic information for underwriting purposes.

III. Your individual rights
You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death – or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

- the access or copies you requested;
- a written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan may also charge reasonable fees for copies or postage.

If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

- make the amendment as requested;
- provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures the Plan has made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You do not have a right to receive an accounting of any disclosures made:

- as part of a "limited data set" (health information that excludes certain identifying information);
- for national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances;
- for treatment, payment, or health care operations, unless made through an electronic health record and the Plan is required to include such disclosures;
- incidental to other permitted or required disclosures;
- to family members or friends involved in your care (where disclosure is permitted without authorization); or
- to you about your own health information;
- where authorization was provided.

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.
If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

You may make one request in any 12 month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request. Accountings that do not include disclosures made through an electronic health record will be limited to six years prior to the date of your request. Electronic health record accountings will be limited to the three years prior to your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

IV. Notification of Unauthorized Releases

In the unlikely event that there is a breach, or unauthorized release of your protected health information, you will receive notice and information on steps you may take to protect yourself from potential harm.

V. Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. The ***Plan reserves the right*** to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice that will be mailed to your home.

VI. How to Complain About Our Privacy Practices

If you believe your privacy rights have been violated, or you disagree with a decision we made about access to your health information, you may file a complaint in writing or by calling the:

- OhioHealth Privacy Officer, in Corporate Ethics and Compliance (see contact information below.)
- You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. within 180 days of a violation of your rights.

We will take no retaliation if you file a complaint.

For More Information About This Notice. If you have questions or need further help with this Notice, you may contact or write to the OhioHealth Privacy Officer, in Corporate Ethics and Compliance, OhioHealth David P. Blom Administrative Campus 3430 OhioHealth Parkway Columbus, OH 43202 (614-544-4200).

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If Your Employer grants You an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by Your Employer on a nondiscriminatory basis.

If Your Employer grants You an approved FMLA leave in accordance with FMLA, You may, during the continuance of such approved FMLA leave, continue your medical coverage for You and Your eligible Dependents.

At the time You request the leave, You must agree to make any contributions required by Your Employer to continue coverage.

If any coverage Your Employer allows You to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while You are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date You are required to make any contribution and You fail to do so.
- The date Your Employer determines Your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to Your eligible class. However, coverage for health expenses may be available to You under another plan sponsored by Your Employer.

Any coverage being continued for a Dependent will not be continued beyond the date it would otherwise terminate.

If your group health coverage terminates because Your approved FMLA leave is deemed terminated by Your Employer, You may, on the date of such termination, be eligible for continuation under federal law on the same terms as though Your employment terminated, other than for gross misconduct, on such date. If this Plan provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined Dependent), You (or Your eligible Dependents) may be eligible for such continuation on the date Your Employer determines Your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If You acquire a new dependent while Your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if You were actively at work, not on an approved FMLA leave.

If You return to work for Your Employer following the date Your Employer determines the approved FMLA leave is terminated, Your coverage under this Plan will be in force as though You had continued in active employment rather than going on an approved FMLA leave provided You make a request for such coverage within 31 days of the date Your Employer determines the approved FMLA leave to be terminated. If You do not make such request within 31 days, coverage will again be effective under this Plan only if and when this Plan gives its written consent or you otherwise qualify for coverage under the Plan's eligibility rules.

Important Notice from OhioHealth Corporation About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where You can find it. This notice has information about Your current Prescription Drug coverage with OhioHealth Corporation and about Your options under Medicare's Prescription Drug coverage. This information can help You decide whether or not You want to join a Medicare drug plan. If You are considering joining, You should compare Your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare Prescription Drug coverage in Your area. Information about where You can get help to make decisions about Your Prescription Drug coverage is at the end of this notice.

There Are Two Important Things You Need to Know About Your Current Coverage and Medicare's Prescription Drug Coverage:

1. Medicare Prescription Drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if You join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers Prescription Drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. OhioHealth Corporation has determined that the Prescription Drug coverage offered by the Plan is, on average for all Plan participants, expected to pay out as much as standard Medicare Prescription Drug coverage pays and is therefore considered Creditable Coverage. You can keep this coverage and not pay a higher premium (a penalty) if You later decide to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If You decide to join a Medicare drug plan, You can keep Your current OhioHealth coverage and the Plan will coordinate with the Medicare drug plan.

If You do decide to join a Medicare drug plan and drop Your current Plan coverage, be aware that You and Your Dependents will be able to get coverage back into the Plan during an open enrollment period under the OhioHealth benefit plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when You first become eligible for Medicare and each year from October 15th to December 7th.

However, if You lose Your current creditable Prescription Drug coverage, through no fault of Your own, You will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if You drop or lose Your current coverage with OhioHealth Corporation and don't join a Medicare drug plan within 63 continuous days after Your current coverage ends, You may pay a higher premium (a penalty) to join a Medicare drug plan later.

If You go 63 continuous days or longer without creditable Prescription Drug coverage, Your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that You did not have that coverage. For example, if You go nineteen months without creditable coverage, Your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as You have Medicare Prescription Drug coverage. In addition, You may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage:

Contact OhioHealth Corporation at (614) 533-8888

NOTE: You'll get this notice each year. You will also get it before the next period You can join a Medicare drug plan, and if this coverage through OhioHealth Corporation changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer Prescription Drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare Prescription Drug Coverage:

Visit www.medicare.gov. Call Your State Health Insurance Assistance Program (see the inside back cover of Your copy of the "Medicare & You" handbook for their telephone number) for personalized help. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If You have limited income and resources, extra help paying for Medicare Prescription Drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: Keep this Creditable Coverage notice. If You decide to join one of the Medicare drug plans, You may be required to provide a copy of this notice when You join to show whether or not You have maintained creditable coverage and, therefore, whether or not You are required to pay a higher premium (a penalty).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & **Child Health Plan Plus (CHP+)**	**IOWA – Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

Phone: 1-800-657-3739	
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor	U.S. Department of Health and Human Services
Employee Benefits Security Administration	Centers for Medicare & Medicaid Services
www.dol.gov/agencies/ebsa	**www.cms.hhs.gov**
1-866-444-EBSA (3272)	1-877-267-2323, Menu Option 4, Ext. 61565

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Discrimination is Against the Law

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law

OhioHealthy complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. OhioHealthy does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Optima Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact

OhioHealthy
4417 Corporation Lane, Virginia Beach, VA 23462 1-855-687-6260, 757-552-7116 Fax
languagehelp@sentara.com

If you believe that OhioHealthy has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Sharon Dajon, Section 1557 Coordinator
4417 Corporation Lane, Virginia Beach, VA 23462 1-844-801-3779, 757-552-7116 Fax
languagehelp@sentara.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator (above) is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at hhs.gov/ocr/office/file/index.html

If you are visually impaired and need large Print or other assistance to view this document, please contact us at 1-844-801-3779.