

STATE OF OHIO

Summary Plan Description

The Health Plan HMO Option

July 1, 2009 to June 30, 2010

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SECTION 1

SCHEDULE OF BENEFITS

Benefits are subject to a contract year deductible that must be paid by the participant before benefits are payable under this plan. Only expenses that you and your eligible dependents incur for covered services count toward satisfying your annual deductible. To help employees with several covered dependents, the deductible you pay for the entire family, regardless of family size, is specified as a family deductible maximum. To meet the family deductible maximum, you can count the eligible expenses incurred by two or more family members.

Primary care physician (PCP), Ob/gyn physician, specialty physician (including secondary care physician (SCP), certain diabetic services, and emergency room and urgent care visit co-pays do not apply towards the deductible.

	Individual	Family
Deductible Maximum	\$200	\$400

The deductible amount contributed by any one family member shall not exceed that of an individual deductible maximum amount.

To determine the maximum amount of expenses you or your family can incur in one year, refer to the annual out-of-pocket maximum listed below. Expenses you incur for copays, not to include supplemental services (i.e., prescription copays) count toward satisfying the out-of-pocket maximum.

The copay amounts contributed by any one family member shall not exceed that of an individual annual out-of-pocket maximum amount.

	Individual	Family
Annual Out-of-Pocket Maximum	\$1,500	\$3,000

The annual out-of-pocket maximum refers to the amount of money you pay out of your pocket for eligible health care expenses. Copays, both fixed dollar amounts and percentages, which you pay for covered services, count toward your out-of-pocket maximum. There is an annual individual out-of-pocket maximum and an annual family out-of-pocket maximum. To meet the annual family out-of-pocket maximum, you can count the annual eligible expenses incurred by two or more family members.

SERVICES REQUIRING PREAUTHORIZATION

- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET)
- Bariatric Surgery

<p align="center">BENEFIT DESCRIPTION</p> <p>These services are covered when they meet Plan guidelines, are provided or arranged for by a Plan physician, deemed medically necessary and appropriate, and approved by the Plan. There may be specific limitations (see "Limitations and Exclusions").</p>	<p align="center">PARTICIPANT COST</p>
<p align="center">INPATIENT HOSPITAL SERVICES</p>	
<ul style="list-style-type: none"> Hospitalization: semi-private room, ICU/CCU, nursing care, maternity and birthing room (48 hrs. normal, 96 hrs. cesarean), nursery, operating room, therapy (oxygen and respiratory, physical, occupational and speech), laboratory, therapeutic and diagnostic x-ray, observation bed, other services and supplies. 	<p>After Deductible, 20% coinsurance/admission</p>
<ul style="list-style-type: none"> Physician visits and services 	<p>After Deductible, 20% coinsurance/admission</p>
<ul style="list-style-type: none"> Rehabilitation 	<p>After Deductible, 20% coinsurance/admission</p>
<ul style="list-style-type: none"> Skilled Nursing Facility: there may be instances where a non-contracting facility may be covered, for additional information call (740) 695-7902 or (888-847-7902. 	<p>After Deductible, 20% coinsurance/days 1-180, days 181 + 40% coinsurance/admission</p>
<p align="center">PHYSICIAN OFFICE VISITS</p>	
<ul style="list-style-type: none"> Audiology: audiological exam, one per contract year 	<p>\$20 copay/visit</p>
<ul style="list-style-type: none"> Chiropractic care: limited services, subject to Plan review, limited to a maximum of 20 visits per contract year 	<p>\$20 copay/visit</p>
<ul style="list-style-type: none"> Maternity care: pre and post-natal care/obstetrical visits* Laboratory and Diagnostics (including ultrasound) <p>*Post delivery follow-up visits: 40 hrs. normal, 96 hrs. cesarean, if mother and physician determine that the hospital stay is to be shortened, 72 hrs. of follow-up care will be provided at no charge and deductible waived.</p>	<p>\$0</p> <p>After Deductible, 20% coinsurance</p>
<ul style="list-style-type: none"> Ob/gyn care 	<p>\$20 copay/visit</p>
<ul style="list-style-type: none"> Podiatry care 	<p>\$20 copay/visit</p>
<ul style="list-style-type: none"> Primary care physician ("PCP") 	<p>\$20 copay/visit</p>
<ul style="list-style-type: none"> Specialist care 	<p>\$20 copay/visit</p>
<p>DIABETIC COVERAGE (Treatment and/or management for insulin or non-insulin dependent diabetes, diabetes during pregnancy or those known to have risk factors)</p>	
<ul style="list-style-type: none"> Annual retinal exam by Optometrist or Ophthalmologist * <p>If the exam reveals an abnormal condition, future treatment may require Preauthorization and applicable participant costs will apply.</p>	<p>\$0</p>
<ul style="list-style-type: none"> Diabetic supplies and equipment including insulin pumps and pump supplies 	<p>\$0 with participation in Take Charge! Live Well! chronic condition management program</p> <p>20% coinsurance without participation in the chronic condition management program</p>
<ul style="list-style-type: none"> Prescription Drugs 	<p>Covered under Prescription Benefit – through State of Ohio's Pharmacy vendor.</p> <p>Retail – limited to a 30-day supply Generic: \$10 copay Formulary Brand: \$25 copay Non-formulary Brand: \$50 copay</p> <p>Mail Order – limited to a 90-day supply Generic: \$25 copay Formulary Brand: \$62.50 copay Non-formulary Brand: \$125 copay</p>
<ul style="list-style-type: none"> Self Management education services: limited to 16 visits (maximum of eight individual and eight group) per contract year, medically appropriate education on proper self-management, treatment and diet 	<p>\$0</p>

OTHER SERVICES (PHYSICIAN'S OFFICE, HOSPITAL, HOME SETTING, OTHER PLAN OR APPROVED PROVIDER) <i>Note: applicable office visit copay may apply</i>	PARTICIPANT COST
<ul style="list-style-type: none"> • Allergy Injections • Ambulance service: emergency transportation, medically necessary only* <p>*Scheduled transportation will be reviewed for medical necessity and appropriateness</p>	\$20 copay/visit After Deductible, 20% coinsurance/incident
<ul style="list-style-type: none"> • Ambulette service: will be reviewed for medical necessity and appropriateness 	After Deductible, 20% coinsurance/incident
<ul style="list-style-type: none"> • Biofeedback therapy: for urinary or fecal incontinence only • Bariatric Surgery (Subject to pre-approval and care management guidelines) 	After Deductible, 20% coinsurance/visit After Deductible, 20% coinsurance
<ul style="list-style-type: none"> • Cardiac rehabilitation: limited to a maximum of 12 weeks or 36 visits per heart attack or heart surgery 	After Deductible, 20% coinsurance/visit
<ul style="list-style-type: none"> • Durable medical equipment (“DME”) and DME supplies: rental or purchase is the option of the Plan, limited to Plan’s basic allowance 	After Deductible, 20% coinsurance
<ul style="list-style-type: none"> • Emergency care: copay waived if admitted* <p>*Emergency Medical condition is a medical condition that manifests itself by acute symptoms of severity such 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: 1) placing the health of the individual in serious jeopardy; 2) serious impairment to bodily function; or 3) serious dysfunction to any bodily organ or part.</p>	\$75 copay; After Deductible, 20% coinsurance/incident
<ul style="list-style-type: none"> • Family planning: contraceptive injections (such as Depo Provera), IUD, diaphragm 	After Deductible, 20% coinsurance/visit/injection
<ul style="list-style-type: none"> • Hearing aid: limited to Plan’s basic allowance, one per lifetime, approved referral required 	After Deductible, 20% coinsurance
<ul style="list-style-type: none"> • Home Health: limited to 100 visits or 180 days whichever is greater per contract year, serviced for intermittent skilled care only (home health aide not covered) 	After Deductible, 20% coinsurance/visit
<ul style="list-style-type: none"> • Home IV Therapy/Infusion Therapy 	After Deductible, 20% coinsurance/visit
<ul style="list-style-type: none"> • Hospice 	\$0
<ul style="list-style-type: none"> • Infertility testing 	After Deductible, 20% coinsurance
<ul style="list-style-type: none"> • Laboratory, therapeutic and diagnostic x-ray: to include ultrasound, MRI, MRA, CAT and PET scans 	After Deductible, 20% coinsurance
<ul style="list-style-type: none"> • Oral surgical services: accidental or injury only, repair limited to gums only 	After Deductible, 20% coinsurance
<ul style="list-style-type: none"> • Orthotics: limited to Plan’s basic allowance 	After Deductible, 20% coinsurance
<ul style="list-style-type: none"> • Outpatient surgery: to include office setting 	After Deductible, 20% coinsurance
<ul style="list-style-type: none"> • Preventive care: injections, immunizations (pediatric/childhood, adolescent and adult); child health supervision services (review of physical and emotional status birth to age 9), physical exam (one per calendar year), screenings and well child care. • Non-immunization preventive coverage subject to U.S. Preventive Services Task Force Guidelines. Immunization coverage is subject to the CDC guidelines. 	\$0
<ul style="list-style-type: none"> • Prosthetic and prosthetic supplies: limited to Plan’s basic allowance 	After Deductible, 20% coinsurance/visit
<ul style="list-style-type: none"> • Pulmonary rehabilitation: limited to a maximum of 12 weeks or 36 visits per contract year 	After Deductible, 20% coinsurance/visit
<ul style="list-style-type: none"> • Radiation and Chemotherapy 	After Deductible, 20% coinsurance/visit
<ul style="list-style-type: none"> • Temporomandibular Joint Dysfunction (“TMJ”): non-experimental, medically necessary services 	After Deductible, 20% coinsurance/visit

<p align="center">BENEFIT DESCRIPTION</p> <p>These services are covered when they meet Plan guidelines, are provided or arranged for by a Plan physician, deemed medically necessary and appropriate, and approved by the Plan. There may be specific limitations (see “Limitations and Exclusions”)</p>	<p align="center">PARTICIPANT COST</p>
<ul style="list-style-type: none"> • Urgent Care: copay waived if admitted • Laboratory, screenings, testing and diagnostic services 	<p>\$25 copay/incident</p> <p>After Deductible, 20% coinsurance</p>
<p>MENTAL HEALTH/SUBSTANCE ABUSE SERVICES, DENTAL AND VISION SERVICES, LIFE INSURANCE BENEFIT</p>	
<ul style="list-style-type: none"> • Mental Health/Substance Abuse Services for all State employees in HMOs or Ohio Med will be provided by United Behavioral Health. For more information call (800) 852-1091 	
<ul style="list-style-type: none"> • Dental and Vision services, life insurance benefit are provided for State employees through either the Ohio Department of Administrative Services or OCSEA Benefits Trust 	
<p>OTHER INFORMATION</p>	
<p>If services fall in more than one copay category the higher copay shall be applicable</p>	
<p>When services are limited to a maximum number of days, treatments, visits, etc. each visit, treatment, etc., must be medically necessary and appropriate to be covered.</p>	
<p>Percentage copays are based on the amount paid, allowed or negotiated by the Plan.</p>	
<p>Participants are responsible for any financial obligations for non-covered services.</p>	
<p>The State’s population health management vendor is APS Healthcare. For more information call (866) 272-5507.</p>	
<p>The State’s pharmacy benefit manger is Catalyst RX. For more information call (866-854-8850)</p>	

Free Exams and Screenings

Procedure	\$0 Co-Pay Guideline
Well-baby, well-child exam	Various for birth to 2 years; then annual to age 18
Well-person exam (annual physical)	1/yr
Hemoglobin, hematocrit, or CBC	1/yr
Urinalysis	1/yr
Lipid profile or total and HDL cholesterol	1/yr
Glucose	1/yr
Stool for occult blood	1/yr
Pre-natal office visits	As needed; based on physician's ability to code claims separately from other maternity-related services
GYN exam	1/yr
Clinical breast exam	1/yr
Pap	1/yr
Mammogram	1 base line between ages 35-39; 1/yr for 40+
PSA	1/yr starting at age 40
Flexible sigmoidoscopy	Every 10 years starting at age 50
Colonoscopy	Every 10 years starting at age 50

Free Immunizations

Procedure	\$0 Co-Pay Guideline
Hepatitis B (HepB)	Birth; 1-2 mos; 6-18 mos
Rotavirus (Rota)	2/4/6 mos
Diphtheria, tetanus, pertussis (DTaP)	2/4/6/15-18 mos; 4-6 yr
Tetanus, diphtheria, pertussis (Td/Tdap)	11-12 yrs; Td booster every 10 yrs, 18 and older
Haemophilus influenzae b (Hib)	2/4/6/12-15 mos
Pneumococcal	2/4/6 mos; 12-15 mos; annually at age 65 and older; high risk groups
Poliovirus (IPV)	2 and 4 mos; 6-18 mos; 4-6 yrs
Influenza	1/yr
Measles, mumps, rubella (MMR)	12-15 mos, then at 4-6 yrs; adults who lack immunity
Varicella (Chickenpox)	12-15 mos; 4-6 yrs; 2 doses for adult susceptibles
Hepatitis A (HepA)	2 doses b/w 1-2 yrs
Meningococcal (MCV4)	1 dose between 11-12 years or start of high school or college
Human Papillomavirus (HPV)	3 doses for females age 9 through age 26 years
Zoster (shingles)	1 dose for age 60+

These services are covered at **no copayment, coinsurance or deductible**. Other preventive care services are available at the normal copayments, coinsurance and deductibles.

SECTION 2

Plan Limitations and Exclusions

Limitations

A. HOSPICE CARE

Members who are diagnosed as having a terminal illness with a life expectancy of six months or less may elect home-based hospice care. The focus in hospice is care, not a cure. Treatment is provided for symptom and pain management. Care must be provided by hospice provider under the supervision of a physician and with participation of a Plan case manager.

B. PLASTIC SURGERY

Plastic surgery procedures are covered **ONLY** for the reasons stated below:

Trauma/Accidental Injury Congenital Birth Defect.

Payment will be made for hospital/medical services incurred in connection with these conditions for plastic surgery only under the following circumstances.

- The requested procedure is required as a direct result of injury secondary to trauma or accident (i.e. motor vehicle accident).
- The requested procedure is required to correct a congenital birth defect (i.e. cleft lip or palate).
- Surgery required as result of an injury caused by the act of a person convicted of a crime involving family violence.

Coverage is subject to specific Plan restrictions.

Mastectomy/Breast Implants and Removal/Replacement of Implants.

Benefits for reconstructive surgery after a mastectomy will be covered under inpatient services by the Plan. The following benefits are included:

- Coverage for reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

No payment is made for surgical procedures for insertion of breast implants unless it is necessary for breast reconstruction with mastectomy specifically related to breast cancer or fibrocystic breast disease.

No payment is made for the removal/replacement of breast implants except for those inserted for reconstructive purposes specifically related to mastectomy for breast cancer or fibrocystic breast disease. Consideration will be given to those that have been deemed medically necessary by the Plan to remove/replace.

C. ORAL SURGICAL SERVICES

Oral surgical coverage is **limited** and will only be covered as indicated:

Mandible/Maxillary/Jaw Structure

Conditions related to malposition of the bones of the jaw are **not** covered (i.e., orthognathic procedures).

Impacted wisdom teeth and full mouth extraction.

Impacted wisdom teeth, full mouth extraction and general anesthesia are **not** covered.

Odontogenic dentigerous cysts.

Cysts that form in the mouth and/or jaw area will be covered only if they are medical (non-dental) in nature.

Diseases of the gums, that are non-dental in nature and deemed medically necessary and appropriate, are covered

Accident/Injury.

Oral surgical and hospital services resulting directly from acute trauma or an accident/injury (i.e., car accident) are limited to the following:

- Coverage is subject to specific Plan restrictions.
- Services must have been initiated and rendered within six months of the accident.
- Oral surgical services are limited to repair of hard or soft tissues of the face **excluding** the direct repair of teeth.
- Must require the expertise of an oral surgeon, be medically necessary and approved by the Plan.

Injuries to the gums, that are non-dental in nature and deemed medically necessary and appropriate, are covered.

Congenital Birth Defects.

Payment will be made for medically necessary oral surgery and/or hospital/medical services to correct congenital birth defects (not developmental) such as cleft lip or palate.

Coverage is subject to specific Plan restrictions.

D. HEARING AIDS

The Plan will cover one hearing aid per lifetime. Eligibility is determined by review of the member's hearing loss in conjunction with Plan criteria. See "Exclusions".

Exclusions

1. Hospital and medical services, or items, that are not medically necessary and/or appropriate as determined by the Plan. Non-medical treatment, including special education and training for dyslexia, global developmental delay, speech therapy for developmental delay of speech, mental retardation, learning disabilities or behavioral disorders.
2. Cosmetic, plastic or reconstructive surgery or other services done primarily to improve, alter or enhance appearance, salabrasion, chemosurgery or other such skin abrasions procedures to remove scars or tattoos or services related to body piercing (other than complications) whether or not for psychological or emotional reasons, unless required by law. Cosmetic/plastic surgery **is covered only** to correct conditions resulting from the following.
 - (a) Acute trauma directly related to accidents/injury (i.e., car accident).

- (b) Congenital defects (not developmental).
- (c) Reconstructive surgery following a mastectomy.

Services must be deemed medically necessary and appropriate by the Plan. A second opinion may be required. See "Limitations".

- 3. Dental care (including plates, crowns, bridges, dental implants, endodontia, periodontia, prosthodontia, orthodontia and dentistry). Extraction of all teeth including wisdom teeth regardless of the cause and/or condition. Osteotomies of the maxilla or mandible (considered dental procedure) regardless of the cause or condition, whether congenital or acquired.

Limited benefits exist for treatment to diseased gums and cysts or abscesses. See "Limitations".

- 4. Custodial or domiciliary care, respite care, private duty nursing, intermediate care, home health aid services, rest cures or other services primarily to assist in the activities of daily living and personal comfort items.
- 5. Items or medical and hospital services deemed to be investigational or experimental by the Plan in conjunction with its specialty consultants, appropriate governmental agencies and other regulatory agencies as interpreted by the Plan. If medically acceptable and conventional techniques or treatment are available, new ones may **not** be covered. At such time as these new procedures, techniques or treatments become non-experimental or investigational and are medically necessary and appropriate, then they may be covered.
- 6. If otherwise standard treatment items such as human tissues, anatomic structures and blood or blood derivatives are prohibited in the treatment of an individual based only by non-medical considerations (i.e., relating to religious restrictions or personal preferences) the alternative products used as substitutes are not a covered benefit.
- 7. Private rooms except when medically appropriate and authorized by the Plan. Personal or comfort items and services (i.e., guest meals and lodging, radio, television and phone).
- 8. Hospital or medical care for conditions that state or local law requires to be treated in a public facility.
- 9. Any injury or sickness to the extent any benefits, settlement, award or damages are received or payable (or could reasonably be expected to be received or payable if claim was made) by reason of Workers' Compensation, employer's liability or similar law or act. This provision applies even if you have waived your rights to Workers' Compensation, employer's liability or similar laws or acts.
- 10. Reversal of voluntary sterilization and associated services and/or expenses.
- 11. Sex transformation surgery and associated services and/or expenses except when medically necessary and appropriate. Procedures, services and supplies related to sexual dysfunction, including but not limited to, penile implants.
- 12. Services not provided, arranged or authorized by your physician, except in an emergency or when allowed in this Certificate. Elective pre-surgery testing on an inpatient basis without the authorization of the Plan's Medical Director.
- 13. Medical equipment, appliances, devices or supplies of the following types.
 - . Equipment or supplies that are mainly for patient comfort or convenience. Items such as bathtub lifts or seats, massage devices, elevators, stair lifts, escalators, hydraulic van or car lifts, orthopedic mattresses, walking canes with seats, trapeze bars, child strollers, lift chairs, recliners, contour chairs, adjustable beds or back cushions.
 - . Exercise equipment such as exercycles, parallel bars, walking, climbing or skiing machines, health spas and hydrospray jet injectors.
 - . Educational equipment including augmentive communication devices.

- . Environmental control equipment such as air conditioners, humidifiers or dehumidifiers, air cleaners or filters, portable heaters or dust extractors.
 - . Hygienic products or supplies and equipment such as bed baths and toilet seats.
 - . Whirlpool pumps or equipment.
 - . Supplies such as tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags.
 - . Professional medical equipment such as blood pressure kits or stethoscopes.
 - . Nutritional products or supplements, food liquidizers or food processors and enterals.
 - . Wigs or wig styling, vibrators or bathroom scales.
 - . Home modifications or supplemental DME equipment, enhancers or modifiers beyond the Plan's basic allowance.
 - . Duplicate equipment or repairs to duplicate equipment; the replacement of medical equipment, prosthetics or orthotics if required due to loss, theft or destruction.
 - . Limited replacement or repairs to medical equipment, prosthetics or orthotics only when required because of wear or because of a change in the member's condition.
 - . Any over the counter items such as stockings, collars or supports.
 - . Medic Alert bracelets/devices, Count-a-Dose magnifiers and insulin carrying devices.
 - . Replacement batteries for durable medical equipment.
14. Physical, psychiatric, or psychological exams, testing, or treatments not otherwise covered under the Plan when such services are as follows.
- . Related to employment or school.
 - . To obtain or maintain insurance.
 - . Needed for marriage or adoption proceedings.
 - . Related to judicial or administrative proceedings or orders.
 - . Conducted for purposes of medical research.
 - . To obtain or maintain a license or official document of any type.
 - . To participate in sports.
15. Infertility services are limited to basic health care services. This means diagnostic and exploratory procedures to determine infertility including surgical procedures to correct medically diagnosed disease or condition of the reproductive organs. Services must be deemed medically necessary by the Plan.
- Services such as in-vitro fertilization and gamete intrafallopian transfer ("GIFT"), zygote intrafallopian transfer ("ZIFT"), embryo transport, surrogate parenting, donor semen, sperm washing, artificial insemination, drugs (oral, topical or injectable) and experimental services are not covered.
16. Elective termination of pregnancy, except when determined medically appropriate.
17. Therapy and related services for a patient showing no progress. **Speech therapy is not a covered benefit** except when medically indicated as a result of a congenital defect (i.e., cleft palate), stroke or physical trauma.
18. Acupuncture, acupressure, hypnosis, electrolysis, Christian Science treatment and autopsy. Any education or training classes including Lamaze and smoking cessation. Patches for smoking cessation, birth control implants (i.e., Norplant), Estrogen and Androgen pellet implants, paternity testing, massage and vision therapy.
19. Work hardening programs including functional capacity evaluations.
20. Marriage counseling. Mental health and substance abuse services.
21. Routine foot care including the following except for the diagnosis of diabetes.
- . Cutting, trimming or partial removal of toenails.
 - . Treatment of flat feet, fallen arches or weak feet.
 - . Strapping or taping of the feet.

- . Arch supports.
 - . To remove in whole or in part of the following.
 - (a) Corns, calluses (thickening of the skin due to friction, pressure or other irritation).
 - (b) Hyperplasia (overgrowth of the skin).
 - (c) Hypertrophy (growth of tissue under the skin).
 - . Hygienic and preventive maintenance care. This includes cleaning and soaking the feet and the use of skin creams to maintain skin tone of either ambulatory or bedfast patients. Any other service performed in the absence of localized illness, injury or symptoms involving the foot.
22. Safety devices. Devices used specifically for safety or to affect performance including sports-related activities.
23. Hepatitis B vaccine coverage limited to “direct exposure” defined as transmission that occurs through inadvertent percutaneous inoculation, mucosal absorption or sexual contact with a source currently infected with acute Hepatitis B virus. Vaccines when related to occupation or occupational, professional and educational requirements and dependent immunizations beyond their 21st birthday. Injections and immunizations required for travel outside the USA and associated with natural disasters (including Hepatitis A).
24. Organ transplants are covered but limited to the following.
- | | | |
|--------------|----------|-----------|
| Liver. | Corneal. | Kidney. |
| Bone Marrow. | Heart. | Pancreas. |
| Heart/Lung. | Lung. | Bowel. |
- Transplants must be deemed medically necessary and appropriate by the Plan and meet Plan criteria. Experimental and investigational transplants and related procedures (as determined by the Plan) are not covered. Services and expenses related to all aspects of organ or tissue procurement rendered or incurred prior to the presentation to the donee, including all donor expenses.
25. Optical services,-routine vision exams/screenings, refractions, radial keratotomy and other surgery to correct vision, eyeglasses, contact lenses and fittings unless otherwise provided by a supplemental rider.
26. Non-medical ancillary services and long-term rehabilitation services for the treatment of chemical dependency.
27. Physical exams or medical care required by court order or obtained in anticipation of judicial action.
28. Other limitations that are specifically stated in the Schedule of Benefits of this document.
29. Prescription drugs, unless otherwise provided in a supplemental rider. Any over the counter medications including but not limited to laxatives, antacids and vaginal yeast products.
30. Any services for which the Insured has no legal obligation to pay in the absence of this or similar coverage.
31. Services rendered by a provider with the same legal residence as a covered person or who is a member of the covered person’s family. This includes spouse, brothers, sister, parent or child. Services received or rendered by a provider to themselves.
32. Services rendered outside the scope of a provider’s license.
33. Treatment in a state or federal hospital for military or service-related injuries or disabilities and/or services furnished, with or without charge, by any government agency or program, including incarceration, Medicare, military agencies, National Guard or Reserves.

- 34. Rehabilitation therapy that is primarily educational or cognitive in nature.
- 35. Non-medical services related to the treatment of Temporomandibular Joint Dysfunction (“TMJ”), Craniomandibular Joint Dysfunction (“CMD”) and stylomandibular ligament including but not limited to braces, non-invasive conditions, experimental procedures, splints or other appliances.
- 36. Podiatrists performing procedures are limited by the Plan guidelines in accordance with experience, training and certification.
- 37. Services that in the judgment of your physician are not medically appropriate or not required by accepted standards of medical practice or the Plan rules governing services.
- 38. Cochlear implant systems.
- 39. Megavitamin therapy, psychosurgery and nutritional based therapy.
- 40. Services performed after your physician has advised the Insured that further services are not medically appropriate or not covered services.
- 41. Homeopathic treatments
- 42. Weight loss services and associated expenses including but not limited to, liposuction, panniculectomies, abdominoplasty (surgical removal of fatty tissue), wiring of the jaw, weight control programs, weight control drugs or products, nutritional products or supplements, screening for weight control programs and services of a similar nature.

SECTION 3 Eligibility Guidelines

Eligible Employees

You are eligible for health care benefits if you are a permanent full-time or permanent part-time employee, which includes established-term regular, established-term irregular, a judge or other elected or appointed official.

The employee health plans offered by the State of Ohio do not contain pre-existing condition exclusions; therefore, coverage is available to you and your eligible dependents regardless of current health or health history.

Employees classified as student help or college interns, or whose appointments are temporary, seasonal, interim or intermittent are not eligible for health coverage.

Married State Employees

When a husband and wife are both employed by the state, both employees cannot carry family coverage for medical. You have the following options:

Both may carry single coverage;

Both may be covered by one family plan; or

One employee may carry family coverage and the other single, but the spouse with single coverage may not be listed as a dependent under the family plan.

Eligible Dependents

The following people are eligible to enroll as dependents:

1. **Spouse.** Your current legal spouse as recognized by Ohio law.
2. **Unmarried Children under Age 19.**
 - You and your legal spouse's unmarried children (including legally adopted children, children for whom either has been appointed legal guardian and dependent stepchildren and foster children who normally reside with you until the end of the month in which they reach age 19).
 - *You must complete an Affidavit of Dependent Status (ADM 4729) for foster children and for legal guardianship.*
 - Children of divorced or separated parents who are not residing with you but who you are required by law to support, who are under the age of 19.
3. **Unmarried Children over Age 19**
 - Your unmarried children age 19 or older, who are attending an accredited school and are primarily dependent on you for maintenance and support, are eligible until the end of the month in which they either reach age 23 or cease being a student – whichever occurs first.
 - *Student coverage is not automatic. The State will periodically request proof of school enrollment along with a completed Affidavit of Dependent Status (ADM 4729) form. When you provide this proof, your dependent will continue to be covered. If the requested proof is not provided to the State, their coverage ends on the last day of the birthday month.*
 - *To be considered primarily dependent, the dependent must receive the majority of his/her essentials such as food, clothing and shelter from the employee and must be enrolled in an accredited school. Attendance at an accredited school may be either full-time or part-time. Students are permitted to miss one quarter/semester per school year and still retain their coverage.*
 - *You must also provide a copy of your most recent tax return showing the child as a claimed dependent.*

- Under all health plans, coverage for your dependents ends no later than the last day of the month in which they turn 23, unless they have been granted an extension as described below.

In accordance with Michelle's Law, this Plan's definition of Dependent is revised to the extent that this Plan shall not terminate coverage of a Dependent student due to medically necessary leave of absence before the date that is the earlier of: (1) the date that is one year after the first day of the medically necessary leave of absence; or (2) the date on which coverage would otherwise terminate under the terms of the Plan.

In keeping with the requirements of Michelle's Law, a Dependent child shall be entitled to the same benefits during a medically necessary leave of absence as if the child continued to be a covered student at the institution of higher education and was not on a medically necessary leave of absence.

As allowable under the provisions of Michelle's Law, the Plan will require written certification by a physician of a serious illness or injury and that the Dependent student's leave of absence (or other change of enrollment) is medically necessary.

4. Unmarried Children Incapable of Self-Care

- Unmarried children of any age who are incapable of self-support due to mental retardation, severe mental illness, or physical handicap, whose disability began before age 23 and who are primarily dependent upon you. When there is an unsuccessful attempt at independent living, a child covered pursuant to this provision may be re-enrolled for coverage, provided that the application is submitted within five (5) years following loss of coverage.
 - *This coverage is not automatic. You must complete an Affidavit of Dependent Status (ADM 4729) and a Request to Extend Limiting Age for Mentally Retarded, Severely Mentally Ill, or Physically Handicapped Dependent Child (ADM 4730) and give these to your payroll or personnel officer. The forms must be completed and returned no later than 31 days prior to the dependent's 19th birthday, or upon being diagnosed with a disabling condition between the ages of 19 and 23. Periodically, but not more than once a year, proof of continued incapacity and dependence must be provided upon request.*

5. Adopted Children

- Adopted children have the same coverage as children born to you or your spouse, whether or not the adoption has been finalized. Coverage begins upon placement/custody for adoption.

6. Stepchildren

- Current stepchildren living in the employee's home more than 50 percent of the time.

7. Children of Divorced Parents

- Dependents of divorced State of Ohio employees may be enrolled on both parents' family plan pursuant to a court order or joint custody agreement. However, health plans do not allow duplicate payments for services and may not coordinate benefits. Check details with your plan(s).

8. Married State Employees with Legally Separate Dependents

- In cases of two state employees who are married and who have legally separate dependents, the employee who has coverage as a spouse may be included as a covered dependent as well as children not residing with the employee, but for whom the spouse is required by law to provide health insurance. (e.g. a natural child or children that either state employee had from a prior relationship.)

Examples of Persons NOT Eligible for Coverage as A Dependent:

- A spouse from whom the employee is legally divorced or legally separated
- Dependents age 19 to 23 not enrolled in an accredited school who are capable of self-support
- A spouse or child currently in the military service
- Children age 23 or older who are not disabled
- Married children
- Same sex partners
- Live-in boyfriends or girlfriends
- Parents or parents-in-law
- Grandchildren (unless employee is the court-appointed legal guardian)
- Adults who are not the employee's or spouse's child under guardianship of employee (brother, sister, aunt, uncle, etc.)
- Common law spouse in which the relationship began after October 10, 1991
- A child who is eligible as an employee of the state or who receives health care coverage through their own employment

- Current and former stepchildren who do not reside with the employee more than 50 percent of the time
- Any other members of your household who do not meet the definition of an eligible dependent

Changes Outside of Open Enrollment

Changes from single to family/family to single may occur if requested within thirty-one (31) days of any of the following events:

1. After marriage, death of a spouse, divorce, legal separation, or annulment, in which case coverage becomes effective the first day of the month following the month of application.
2. Birth, adoption, placement for adoption, or death of a dependent, in which case coverage becomes effective with the birth, adoption, or placement of a child or date of death.
3. Termination or commencement of employment by the employee, spouse or dependent, in which case coverage becomes effective the first day of the month following the month of application.
4. Reduction or increase in hours of employment by the employee (including layoff or reinstatement from layoff), spouse, or dependent, including a switch between part-time and full-time, strike, lockout, or commencement, return to work from an unpaid absence, or change in work site in which case coverage becomes effective the first day of the month following the month of application.
5. Return to work through order of arbitration or settlement of a grievance, or any administrative body with authority to order the return to work of an employee.
6. The employee's dependent satisfies or fails to satisfy the requirement of the definition of dependent due to attainment of age, student status or any similar circumstance as provided in the Health Plan under which the employee receives coverage.
7. If the plan receives a Qualified Medical Child Support Order (QMED) pertaining to an employee's dependent, the employee may elect to add or drop the child to the plan depending upon the requirement of the QMED.
8. If an employee, spouse, or dependent who is enrolled in a health plan becomes entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).
9. If an employee, spouse, or dependent is no longer entitled to coverage (i.e., enrolled) under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

Requests for changes pursuant to Sections (1) through (9) must be supported by proper documentation.

10. An employee may change health plans if the employee either no longer resides or no longer works in the service area of the employee's current health plan.

SECTION 4

CLAIM AND APPEAL PROCEDURE

Definitions. The following terms have the meanings given to them below:

- (a) Post-service Claim means any claim filed for benefits after the medical care has been received.
- (b) Pre-service Claim means any claim for services for which the Plan requires the Participant to obtain preauthorization before receiving treatment, but is not an Urgent Claim. Services requiring pre-authorization are listed in the Section captioned Preauthorization. After the treatment is received the claim will become a Post-Service Claim.
- (c) Urgent Claim means any claim for services for which the Plan requires the Participant to obtain preauthorization before receiving treatment, if a delay in receiving the requested treatment could seriously jeopardize the life or health of the Participant or ability to regain maximum function, or, in the opinion of a physician with knowledge of the Participant's medical condition, could subject the Participant to severe pain that cannot be managed without the treatment that is the subject of the claim. After the treatment is received the claim will become a Post-service Claim.

Claim Forms. Participants generally are not required to file claim forms to obtain benefits. Most Providers will file claims for payment directly with the Claims Supervisor. If the Provider is not in the Network and does not accept assignment, or if the Participant is requesting reimbursement for an Eligible Expense paid by the Participant, the Participant may be required to file a claim with the Claims Supervisor. Please contact The Health Plan at 800-624-6961 for a claim form.

If a provider does not file the claim on your behalf, then you are responsible for mailing the itemized copy of the medical bill to the address shown on the back of the Employee identification card. An *itemized billing* includes all of the following information:

- Employer's name
- Employee's name
- Employee's Social Security number
- Patient's name
- Date of treatment
- Type of services or supplies furnished
- Diagnosis
- Procedure codes
- Name, address, & telephone number of the Physician or provider

Canceled checks, cash register receipts, personal itemizations or statements will not give the Third Party Administrator the information needed to process a claim.

**SEND ALL CLAIMS TO:
THE ADDRESS SHOWN ON THE BACK OF YOUR I.D. CARD**

Claim Determinations. All claims will be determined by the Claims Supervisor. The time limit for deciding claims will depend on whether the claim is a Post-service Claim, a Pre-service Claim or an Urgent Claim.

- (a) Post-service Claims. If a Post-service Claim is denied, the Participant will be given written notice within 30 days from receipt of the claim if the Claims Supervisor received all information necessary to decide the claim. If additional time (up to 15 days) and/or additional information is required to determine the claim, the Participant will be notified within the 30-day period. If additional information is requested, the Participant will have 45 days to provide the information to the Claims Supervisor. A determination will be made within 15 days after the requested information is submitted. The claim will be denied if the information is not provided within 45 days unless the Participant or Provider has requested additional time to submit the information.
- (b) Pre-service Claims. If a Pre-service Claim is submitted with all necessary information, the Participant will be given written notice that the claim has been approved or denied within 15 days from receipt of the claim. If the claim was filed improperly, the Participant will be notified within 5 days. If additional time (up to 15 days) and/or additional information is required to determine the claim, the Participant will be notified within the first 15-day period. If additional information is requested, the Participant will have 45 days to provide the information to the Claims Supervisor. A determination will be made within 15 days after the requested information is submitted. The claim will be denied if the information is not provided within 45 days unless the Participant or Provider has requested additional time to submit the information.

- (c) **Urgent Claims.** If an Urgent Claim is submitted with all necessary information, the Participant will be notified that the claim has been approved or denied within 72 hours. The notice may be made orally or in writing, but any oral notice will be confirmed in writing within 3 days. If the claim was filed improperly or if additional information is required to determine the claim, the Participant will be notified within 24 hours after the claim was received. The Participant will have 48 hours to provide the requested information. A determination will be made no later than 48 hours after the requested information is submitted.
- (d) **Concurrent Care Claims.** If an extension is requested for an ongoing course of treatment which was previously approved for a specific period of time or number of treatments, and the request is an Urgent Claim, the request will be decided within 24 hours, provided the request is made at least 24 hours before the end of the approved treatment. If the request for extended treatment is not made at least 24 hours before the end of the approved treatment, the request will be treated as a new Urgent Claim. If a request is made to extend an ongoing course of treatment in a non-urgent circumstance, the request will be considered a new claim and decided as a Post-service or a Pre-service Claim, as appropriate.

Notice of Adverse Claim Decision. If a claim is denied, in whole or in part, the Participant will receive a written notice including the following information:

- (a) The specific reason or reasons for the decision;
- (b) Reference to the specific Plan provision(s) on which the decision was based;
- (c) A description of any additional information necessary to perfect the claim and an explanation of why the information is necessary;
- (d) A description of the Plan's appeal procedures and applicable time limits;
- (e) If the decision was based on an internal rule, guideline or protocol, a statement that a copy of the rule, guideline or protocol will be provided free of charge upon request;
- (f) If the decision was based on a determination of medical necessity or an exclusion for Experimental treatment or similar exclusion, a statement that an explanation of the scientific or clinical judgment for the decision, as applied to the Participant's medical circumstances, will be provided free of charge upon request.

If the Participant does not receive notice within the applicable time limit, the Participant may assume the claim has been denied and proceed to file an appeal.

Voluntary Informal Review. If the Participant does not believe his/her claim was decided correctly, the Participant may contact the Claims Supervisor to request reconsideration by the Claims Supervisor. This review may be initiated by calling or writing to the Claims Supervisor explaining the reasons the Participant believes the claim was not decided correctly. The Participant may submit any additional information he/she believes may be relevant to the claim. This informal review process is entirely voluntary. The Participant may skip this step and may at any time proceed directly to filing an appeal with the Administrator. Failure to request reconsideration by the Claims Supervisor will not prejudice the Participant's claim on appeal.

Right to Appeal. If the Participant is not satisfied with the decision of the Claims Supervisor, the Participant may appeal the decision by filing a written request directed to the Administrator.

- (a) An appeal must be filed within 180 days after receiving notice that a claim has been denied.
- (b) The Participant may submit written comments, documents, records and other information relating to the claim, including information not submitted with the original claim.
- (c) The Participant will be provided, upon request and free of charge, copies of all documents, records and other information considered in making the claim decision.
- (d) The Participant may authorize a representative to act on his/her behalf in making the appeal by signing a form provided by the Claims Supervisor.

- (e) It is understood and agreed by both the State of Ohio and The Health Plan that the State retains complete authority and responsibility for the Plan, its operation, and the benefits provided there under and that The Health Plan is empowered by the State in connection with the Plan only to the extent expressly stated in the Administrative Service Agreement or as agreed to in writing by The Health Plan and the State.
- (f) The State of Ohio has the sole and complete authority to determine eligibility of persons to participate in the Plan and to override The Health Plan's decision on an appeal if it is deemed warranted.

Appeal Process. The Participant will receive a full, fair and independent review of a claim on appeal. No deference will be given to the determination made by the Claims Supervisor. Individuals involved in making the initial determination will not participate in the decision on appeal. All information submitted by the Participant relating to the claim will be considered. If an appeal is based on a medical judgment (including determinations with regard to whether a treatment is Experimental or Medically Necessary), the Administrator will consult with a health care professional who has appropriate training and experience and was not involved in the initial claim determination. Any experts consulted in connection with the appeal will be identified to the Participant upon request.

- (a) **Post-service Claims.** For Post-service Claims, the Participant will be notified of the determination on appeal within 60 days after receipt of the appeal.
- (b) **Pre-service Claims.** For Pre-service Claims, the Participant will be notified of the determination on appeal within 30 days after receipt of the appeal.
- (c) **Expedited Appeal of Urgent Claims.** An appeal involving an Urgent Claim may be submitted orally or in writing and will be determined on an expedited basis. A decision will be made as soon as possible, taking into account the urgency of the claim, but not later than 72 hours after receipt of the appeal.

Notice of Decision on Appeal. The Participant will receive a written notice of the decision on appeal. The decision of the Administrator on appeal will be final. The written notice will include:

- (a) The specific reason or reasons for the decision;
- (b) Reference to the specific Plan provision(s) on which the decision was based;
- (c) A statement that the Participant is entitled to receive, upon request and free of charge, copies of all documents and other information relevant to the claim;
- (d) If the decision was based on an internal rule, guideline or protocol, a statement that a copy of the rule, guideline or protocol will be provided free of charge upon request;
- (e) If the decision was based on a determination of medical necessity or an exclusion for Experimental treatment or similar exclusion, a statement that an explanation of the scientific or clinical judgment for the decision, as applied to the Participant's medical circumstances, will be provided free of charge upon request.

Complaints Against Providers. The Claims Supervisor is obligated to hear and resolve complaints against Network Physicians and other health delivery entities providing health services under contract with The Health Plan under this Plan in an equitable manner according to the following procedures:

- (a) Any Participant with a complaint must file a formal complaint with the Claims Supervisor on forms which will be available from the Claims Supervisor.
- (b) The Claims Supervisor has 30 days to take one of the following actions and communicate that action in writing to the Participant:
 - Decide that the complaint merits a specific response and make corresponding recommendations to the Participant or Provider involved;
 - Request further information from the Participant, in which case the Claims Supervisor will make and communicate its decision to the Participant or Provider within 30 days after receiving the requested information.

Quality of Care. Any written complaints relating to the quality of care will be handled by The Health Plan's Quality Improvement Department. Participants will be informed of their rights to submit formal written complaints to The Health Plan Quality Improvement Committee.

SECTION 5

SUBROGATION

The State of Ohio Health Plan agrees that it will not enforce or seek to enforce a right to subrogation until the insured has been fully compensated and made whole for the insured's illness and/or injury, including without limitation, pain and suffering, consequential, punitive, exemplary and other damages. Subrogation language contrary to this make whole doctrine contained in any of The State of Ohio Health Plan's documents, policies and procedures will have no force or effect and is superseded by the language in this Agreement. The State of Ohio Health Plan agrees that it will not require or request insured to waive insured's right to being made whole.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits which exceed expenses. It applies when the Employee or any eligible dependent that is covered by this Plan is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full ("*Primary*") and the other plan pays a reduced benefit ("*Secondary*"). This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. Only the amount paid by the Plan will be charged against the Plan maximums.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plans or plans.

As permitted by law, the Plan may, without your consent:

1. Obtain information from all plans involved.
2. Reimburse such other plans, if it is determined that benefits have been paid.
3. Release to other plans any information necessary to coordinate benefits.
4. Obtain reimbursement from any other plan when benefits have been paid from this plan that should have been paid by any other plan.
5. Obtain a refund of any amount, which exceeded 100% of allowable expenses.

COORDINATION PROCEDURES: Any plan which does not have a Coordination of Benefits or similar provision will pay its benefits first. If a plan does contain a Coordination of Benefits or similar provision, the rules establishing the order of benefit determination are:

The benefits of a plan, which covers the individual for whom, claim is made other than, as a Dependent will be determined before the benefits of a plan, which covers the individual as a dependent.

1. The benefits of a plan, which covers the individual for whom, claim is made, as a dependent will be determined by what is called the "birthday rule". Under this rule the plan which covers the parent whose birthday occurs earlier in the Calendar Year (month and day only) will be primary. If the parents have the same birthday, the plan that covered the parent longer will pay first and the other plan will pay second. However, if this Plan is coordinated with a plan that contains the gender-based rule and as a result the plans do not agree on the order of benefits, the gender-based rule will determine the order. However, if the dependent is a dependent child of divorced or separated parents, the order of payment will be as follows:
 - if the parent with custody has not remarried, his or her plan will be payable before the plan of the parent without custody.
 - if the parent with custody has remarried, his or her plan will be payable before the plan of the stepparent or the parent without custody; and the stepparent's plan will be payable before the plan of the parent without custody.
 - however, if there is a court decree which sets forth a financial duty for the child's health care expenses, the plan of the parent with such financial duty will be payable first.
2. If the above rules do not decide which plan's benefits are payable first, the plan which has covered the person for the longest time will be payable first except that a plan that covers a person other than as a COBRA beneficiary, laid-off Employee or retired Employee, or dependent of such person, will determine the benefits that will pay first. A plan that covers a person as a COBRA beneficiary, laid-off Employee or retired Employee, or dependent of such person, will determine its benefits second.
3. Benefits under Medicare after the first 30 months of End Stage Renal Disease will be payable before this Plan's benefits are payable. If a Covered Person has Medicare coverage for End Stage Renal Disease as of August 5, 1997, this Plan will be

primary to Medicare for eligible charges incurred from the period of August 5, 1997 to the date that the Covered Person has had 30 months of Medicare coverage.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION: For the purpose of determining the applicability of and implementing the terms of this provision of the Plan or any provision of similar purpose of any other plan, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information with respect to any person, which the company deems to be necessary for such purpose. Any person claiming benefits under this Plan will furnish to the Plan Administrator such information as may be necessary to implement this provision.

SECTION 6

Continuation of Coverage (COBRA)

BENEFITS MAY BE EXTENDED UPON REQUEST FOR COVERED EMPLOYEES AND/OR THEIR COVERED DEPENDENTS IF QUALIFIED PER ONE OF THE FOLLOWING "QUALIFYING EVENTS":

EMPLOYEE: For a Covered Employee to be qualified, the Covered Employee must become ineligible for group coverage because of termination of employment (other than because of gross misconduct), because of reduction in the number of hours worked, or the Employer filing for reorganization under Chapter XI of the Bankruptcy Law.

DEPENDENT: For a covered spouse or covered child to be qualified, they must become ineligible for group coverage because of one of the following:

1. Death of the Employee;
2. Termination of the Employee's employment (other than because of gross misconduct) or reduction in the number of hours of employment;
3. Divorce or legal separation;
4. The Covered Employee becoming "entitled to" Medicare benefits;
5. A dependent child ceasing to meet the definition of "dependent";
6. The Employer files for reorganization under Chapter XI of the Bankruptcy Law.

The Covered Person must notify the Plan Administrator within 60 days of either of these events that his spouse or children are no longer eligible Dependents. For all other qualifying events, the Employer must notify the Plan Administrator within 30 days of the event. The Plan Administrator must then notify the qualified beneficiary of his or her right to continue during the next 14 days.

The term "*Qualified Beneficiary*" is a Covered Employee and/or the spouse or child of a Covered Employee, who on the date immediately before a qualifying event occurred, was covered for benefits under this group health Plan. Also, a qualified beneficiary is a child who is born to or placed for adoption with the Covered Employee during the period of continuation of coverage (COBRA).

The continuation coverage will be identical to the coverage provided under the Plan to similarly situated persons who have not experienced a qualifying event. The qualified beneficiary does not have to provide evidence of good health to continue coverage, nor will such person be required to satisfy a new Pre-Existing Condition Limitation, as defined herein.

Each qualified beneficiary can elect coverage independently. Benefits under the Plan will be offered on the same basis as it is to Active Employees and their covered dependents. For example, if medical coverage, dental coverage and vision coverage are offered to Active Employees as a "package", the qualified beneficiary can elect coverage as a package or elect medical coverage only. If medical coverage, dental coverage and vision coverage are offered to Active Employees as separate options, the qualified beneficiary can elect such coverage as separate options.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), is intended to make it easier for an individual who has or has had health coverage to become covered by a new employer's health plan even if the employee (or covered spouse or dependent) has a Pre-Existing Condition. Group health plans must comply with all HIPAA pre-existing condition requirements and crediting of prior health coverage requirements at the beginning of the first plan year starting after June 30, 1997.

Under HIPAA, credit will be given for continuous health coverage under this Plan (including COBRA) to reduce, month for month, the new employer's plan's pre-existing conditions exclusions providing: 1) the individual has not had a break in coverage which exceeds sixty-two (62) days (excluding the new employer's plan's waiting period; it is not considered a break in coverage); and 2) the individual makes written application for coverage within the time periods specified under the new employer's plan; and 3) provides the new employer with the necessary documentation to certify the individual's prior coverage. If there is a break in coverage of sixty-three (63) days or more, the pre-existing conditions exclusion under the new employer's plan's will apply to that individual; the plan is not required to give pre-existing limitation credit for prior coverage when there is a break of sixty-three (63) days or more.

The employee should check with his/her new employer to see when the new employer's plan year begins and to find out what the pre-existing conditions requirements are for that plan.

If coverage has terminated under this Plan and the individual purchases individual coverage, he/she should check with the insurance company to find out if he/she is eligible for credit for continuous coverage for pre-existing conditions.

If coverage has terminated under this Plan, the Third Party Administrator will provide a certificate of Creditable Coverage to the Covered Person(s) who terminated coverage under this Plan.

WHEN MUST I ELECT COBRA COVERAGE? The Covered Person must elect coverage within 60 days of the latest of the following dates: The date coverage terminates or the date shown on the Plan Administrator's notice of the right to elect continuation.

If Continuation of Coverage is elected, the qualified beneficiary is required to pay a premium for his/her continuation coverage. This premium generally equals the Employer's cost of providing coverage for similarly situated beneficiaries, plus a two (2%) percent fee for administrative costs.

IF CONTINUATION OF COVERAGE IS ELECTED, PREMIUMS ARE DUE FROM THE QUALIFIED PERSON AS FOLLOWS:

1. The first premium payment(s) may be deferred. However, such deferred payment period cannot exceed the 45-day period immediately following the date you send the election form to the Plan Administrator.
2. Payment for any subsequent month of continued coverage must be paid as of the premium due date.
3. If payment is not made by the premium due date there is a 31-day grace period for such payment. If the premium is not paid during that 31-day period, continued coverage will terminate as of the end of the last date for which a premium payment was made.

WHEN WILL COVERAGE FOR QUALIFIED EMPLOYEES END?

1. The date on which coverage ceases under the Plan due to failure to make the required premium, in full, on time; or
2. The date the qualified Employee becomes covered, after electing Continuation coverage under this Plan, under any other health plan which does not impose a "pre-existing condition exclusion clause" (which limits or excludes coverage) or the date any "pre-existing condition clause" under any other group health plan no longer limits or excludes coverage on a pre-existing condition; or
3. The end of 18 months from the date the Continuation began if Continuation was due to the Employee becoming ineligible for group benefits, due to termination of employment, or reduction of hours; or
4. The date that the qualified Employee becomes "entitled to" Medicare benefits (under Part A, Part B, or both) after electing continuation coverage under this Plan; or
5. The date on which the Group Plan is terminated in its entirety.

WHEN WILL COVERAGE FOR QUALIFIED DEPENDENTS END?

1. The date on which coverage ceases under the Plan due to failure to make the required premium, in full, on time; or
2. The date the qualified dependent becomes covered, after electing Continuation coverage under this Plan, under any other group health plan which does not impose a "pre-existing condition clause" which limits or excludes coverage) or the date any "pre-existing condition exclusion clause" under any other group health plan no longer limits or excludes coverage on a pre-existing condition; or
3. The end of 18 months from the date the Continuation began if Continuation was due to the Employee becoming ineligible for group benefits due to termination of employment or reduction of hours; or
4. The end of 36 months from the date the Employee becomes "entitled" to Medicare benefits (under Part A, Part B, or both) after electing Continuation coverage under this Plan, but not less than the end of 18 months from the date the Continuation began; or
5. The end of 36 months from the date the Continuation began if Continuation was for other qualifying reasons; or

6. The date that the qualified dependent becomes "entitled to" benefits (under Part A, Part B, or both) after electing Continuation coverage under this Plan; or
7. The date on which the Group Plan is terminated in its entirety.

EXTENSION OF THE LENGTH OF COBRA CONTINUATION COVERAGE: If you elect Continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or if a second qualifying event occurs. You must notify the Plan Administrator, in writing, within 60 days of a disability or a second qualifying event in order to apply to extend the period of Continuation coverage. Failure to provide written notice within the 60-day period may affect the right to extend the period of Continuation coverage.

SPECIAL PROVISIONS FOR A TOTALLY DISABLED BENEFICIARY: A disabled qualified beneficiary may elect to extend existing COBRA coverage for himself and for his covered spouse and/or covered dependents, from 18 months up to 29 months provided all of the following conditions are met:

1. the qualified beneficiary's COBRA continuation coverage is due to the Covered Employee's loss of coverage under this Plan because of termination of employment (other than gross misconduct) or due to a reduction in the number of hours worked;
2. the qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled; and, the disability must have started at some time before the 60th day of COBRA Continuation coverage and the disability must be ongoing at least until the end of the 18-month period of Continuation coverage;
3. the qualified beneficiary must give the Plan Administrator a copy of the Social Security disability determination notice within sixty (60) days of the latest of the following dates: a) date of the SSA's disability determination; b) date of the qualifying event; c) date on which the qualified beneficiary would lose coverage under the Plan; or d) date on which the qualified beneficiary is informed of the obligation to provide the disability notice through the Plan's summary plan description or through the initial COBRA Continuation notice provided by the Employer;
4. the qualified beneficiary must provide a copy of the Social Security disability determination notice to the Plan Administrator before the end of the first 18 months of his/her Continuation period; and
5. he/she must notify the Plan Administrator that he/she elects the extension before the end of the first 18 months of his/her Continuation period; he/she must also specify if his/her covered spouse and/or covered dependents elect to extend their coverage. (If the disabled qualified beneficiary is a dependent, also refer to the paragraph entitled "Second Qualifying Event".)

The cost of coverage for months 1 through 18 will be at the rate of up to 102% of the Employer's cost for such coverage; the cost of coverage for months 19 through 29 will be at the rate of up to 150% of the Employer's cost for providing such coverage to similarly situated beneficiaries.

If Social Security determines during the extended 11-month period that the beneficiary is no longer disabled, the beneficiary must notify the Plan Administrator within 30 days of Social Security's final determination. Continuation will then be terminated in the month that begins more than 30 days after the final determination is made by Social Security.

If an extension of the maximum COBRA coverage period is going to be denied, the Plan Administrator must provide you with a written notice of unavailability within 14 days after receiving any notice from a qualified beneficiary that is a notice of a determination of disability. A termination notice will be provided to you as soon as practicable following the Plan Administrator's determination that Continuation coverage will terminate.

SECOND QUALIFYING EVENT: An 18-month extension of coverage will be available to spouses and to dependent children who elect Continuation coverage if a second qualifying event occurs during the first 18 months of Continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event, but only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan Administrator in writing within 60 days after a second qualifying event occurs if you want to extend your Continuation coverage. Failure to notify the Plan Administrator in writing within the 60-day period may affect the right to extend the period of Continuation coverage.

If an extension of the maximum COBRA coverage period for a second qualifying event is going to be denied, the Plan Administrator must provide you with a written notice of unavailability within 14 days after receiving any notice from a qualified

beneficiary that is a notice of a second qualifying event. A termination notice will be provided to you as soon as practicable following the Plan Administrator's determination that Continuation coverage will terminate.

Termination Notice: After receiving written notice of a qualifying event, the Plan Administrator must notify you under the following circumstances: 1) if an individual does not qualify for COBRA continuation coverage. A notice explaining why the individual is not entitled to such coverage must be provided to the individual within 14 days of receiving the written notice from the employee or the qualified beneficiary; 2) if COBRA coverage is terminated earlier than the time period for which COBRA Continuation coverage is normally available for the applicable qualifying event. This notice will be provided as soon as administratively practicable after the termination decision is made; it will explain why and when the Continuation coverage was terminated. A HIPAA certificate of creditable coverage will also be provided with this notice.

Trade Act of 2002: The Trade Act of 2002 may extend the COBRA election period, but only if you meet the following requirements related to a job loss: 1) you are receiving trade adjustment, as defined by the Trade Act; 2) you lost group health coverage under this Plan because of the Trade Act; and 3) you did not elect COBRA Continuation coverage under this Plan during the regular COBRA election period for that job loss. If you meet the requirements under the Trade Act shown here, and you were an eligible Employee and you lost coverage because of the Trade Act and did not elect COBRA in the regular 60-day election period for COBRA Continuation under this Plan, then you may qualify for a second 60-day COBRA Continuation period. The new second 60-day COBRA Continuation election period will begin on the first day of the month in which you begin receiving trade adjustment assistance, but only if you make the election within six months after you initially lost group health coverage under this Plan.

COBRA coverage elected during second election period begins on the first day of the new election period. Retroactive coverage for the period from the initial loss of coverage until the first day of the new Trade Act election period will not be provided. If you elect COBRA continuation coverage under this provision, the COBRA maximum coverage period begins on the first day of the additional election period and ends no later than 18, 29 or 36 months thereafter, depending on qualifying events. Any day between your initial loss of group health coverage under this Plan and the first day of your new second election period does not count towards the 63-day break in coverage under HIPAA.

CAN I ADD AN ELIGIBLE DEPENDENT DURING MY CONTINUATION? Any qualified person may elect coverage for a dependent (spouse, newborn child, adopted child, etc.) acquired during a period of continuation. The acquired dependent must be a person who would have been an eligible dependent had he or she been acquired by an active Employee enrolled under the normal terms of the Plan. Qualified persons must apply for coverage for the acquired dependent(s) under the same provision as those in effect for similarly situated Covered Employees. An acquired dependent is a "qualified beneficiary".

CAN I WAIVE COBRA COVERAGE DURING THE ELECTION PERIOD? If a qualified beneficiary signs a waiver of his rights to continuation of coverage during his election period, he cannot revoke his waiver unless he does so within 60 days from the later of: 1) the date coverage terminates; or 2) the date shown on the Plan Administrator's notice of the right to elect continuation.

If the qualified beneficiary revokes the waiver within such time periods shown above: 1) the maximum period of continuation will be the same as it would have been had the individual not waived continuation of coverage; and 2) claims incurred from the date the individual lost coverage to the date the individual revoked the waiver will not be covered under the Plan.

WHAT HAPPENS IF I AM (OR BECOME) INCAPACITATED? If a qualified beneficiary is or becomes physically or mentally incapacitated and cannot waive coverage or make an election to continue coverage for himself/herself within the 60-day election period, then the election period will be tolled (suspended) until a legally-appointed guardian or representative is designated to act on behalf of the qualified beneficiary, providing the guardian or representative is designated within 30 days after the date the qualified beneficiary becomes incapacitated or dies. For example, if the qualified beneficiary becomes incapacitated (or dies) with 10 days remaining in a COBRA election period and the qualified beneficiary has not made an election, then the legally-appointed guardian or representative will have 10 days from the date of his or her appointment to elect the continuation of coverage on behalf of the beneficiary, providing the appointment is within the specified time period.

If the qualified beneficiary elects the continuation of coverage and later becomes incapacitated (or dies) and misses a premium deadline under the continuation of coverage due to the incapacitation, then the deadline for that premium payment will be tolled (suspended) until 30 days from the date a legally-appointed guardian or representative is designated to act on behalf of the qualified beneficiary, providing the guardian or representative is designated within 30 days after the date the beneficiary becomes incapacitated or dies.

SECTION 7

DEFINITIONS

THE FOLLOWING ARE DEFINITIONS OF TERMS THAT MAY BE USED IN THE WORDING OF THIS SUMMARY PLAN DESCRIPTION. THESE DEFINITIONS ARE NOT MEANT TO IMPLY COVERAGE UNDER ANY BENEFIT UNLESS SPECIFICALLY PROVIDED UNDER THE PLAN.

ADVERSE BENEFIT DETERMINATION: An Adverse Benefit Determination of a claim means any denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit for which a claim must be submitted. An Adverse Benefit Determination includes a failure to cover an item or service because the item or service is determined to be Experimental or not Medically Necessary or not appropriate.

ALCOHOL; DRUG ABUSE; OR PSYCHIATRIC TREATMENT FACILITY: "*Alcohol; Drug Abuse; or Psychiatric Treatment Facility*" means an institution which complies with licensing and other legal requirements in the jurisdiction where it is located; is engaged mainly in providing services for the treatment of alcoholism; drug abuse; or mental and nervous disorders in return for compensation; the services include room, board and 24-hour-a-day nursing services; the services are supervised by a Physician or by a registered nurse. If the services are not supervised by a Physician, the institution must have a Physician available on a prearranged basis; it maintains daily clinical records; and it must not be mainly a place of rest, a place for the aged, or a nursing or convalescent home.

AMBULANCE: "Ambulance" means a specially designed or equipped vehicle which is licensed for transferring the sick or injured. It must have customary patient care, safety, and life-saving equipment, and must employ trained personnel.

AMBULATORY SURGICAL CENTER: "*Ambulatory Surgical Center*" means an institution or facility, either free standing or as part of a Hospital with permanent facilities, equipment and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a twenty-four (24) hour period. An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of Pregnancy, will not be considered to be an ambulatory surgical center.

AMENDMENT: "*Amendment*" means a formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Administrator.

CHILD BIRTHING CENTER: "*Child Birthing Center*" means an Out-Patient facility which meets all of these requirements: It complies with licensing and other legal requirements in the jurisdiction where it is located; it is engaged mainly in providing a comprehensive birth service program to pregnant persons who are considered normal low risk patients; it has organized facilities for birth services on its premises; the birth services are performed by a Physician specializing in obstetrics and gynecology or, at his direction, by a Nurse midwife; it has 24-hour-a-day registered nursing services; and it maintains daily clinical records.

CLAIM FOR BENEFITS: A "*Claim for Benefits*" is any request for a plan benefit or benefits, made by a Covered Person (or by an authorized representative of the Covered Person) that complies with the Plan's reasonable procedure for making benefit claims. A claim for group health benefits includes "Pre-Service" Care Claims and "Post-Service" Claims.

COLLEGE / UNIVERSITY: The term "*College or University*" means an institution accredited in the current publication of accredited institutions of higher education..

COMPLICATION OF PREGNANCY: "*Complication of Pregnancy*" means that part of a Pregnancy during which abnormal conditions or concurrent disease significantly affect the Pregnancy's usual medical management. A complication may exist during the Pregnancy; during the delivery; or after the delivery. But a complication of Pregnancy does not include an elective caesarean section.

COSMETIC PROCEDURE: "*Cosmetic Procedure*" means a procedure performed solely for the improvement of a Covered Person's appearance rather than for the improvement or restoration of bodily function.

COVERED EMPLOYEE: "*Covered Employee*" means any Employee meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

COVERED PERSON: "*Covered Person*" means any Employee or dependent of an Employee meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

CUSTODIAL CARE: "*Custodial Care*" means that type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person, whether or not Disabled, in the activities included, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

DURABLE MEDICAL EQUIPMENT: "*Durable Medical Equipment*" means equipment which is able to withstand repeated use; and used to serve a medical purpose; and not generally useful to a person in the absence of Illness or Injury.

ELIGIBLE EXPENSES: The term "*Eligible Expenses*" means any Medically Necessary treatment, services, or supplies that are not specifically excluded from coverage elsewhere in this Plan.

EMERGENCY: "*Emergency*" means a sudden and unexpected condition requiring immediate medical attention to prevent death or serious harm to health. (Examples: heart attacks, suspected heart attacks, coma, loss of respiration, stroke, asthmatic attack, dehydration, high fevers, acute appendicitis, fractures, concussions, and broken bones.)

EMPLOYEE: The term "*Employee*" means a person directly employed in the regular business of, and compensated for services by the Employer.

EMPLOYER: "*Employer*" means The State of Ohio.

EXPERIMENTAL OR INVESTIGATIVE: A drug, device or medical treatment or procedure is Experimental or Investigative if:

1. the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. medical treatment is deemed experimental and not therapeutic by the American Medical Association;
3. reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
 - a. Maximum tolerated dose
 - b. Toxicity
 - c. Safety
 - d. Efficacy
 - e. Efficacy as compared with the standard means of treatment or diagnosis; or
4. reliable evidence shows that the consensus among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
 - a. Maximum tolerated dose
 - b. Toxicity
 - c. Safety
 - d. Efficacy
 - e. Efficacy as compared with the standard means of treatment or diagnosis

Reliable will mean:

- a. Only published reports and articles in the authoritative medical and scientific literature;
- b. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or
- c. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

FAMILY: The term "*Family*" means a Covered Employee and his eligible dependents.

HOME HEALTH CARE AGENCY: "*Home Health Care Agency*" means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

1. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services.
2. It has policies established by a professional group associated with the agency or organization. This professional group must have at least one Physician and at least one registered nurse (R.N.) to govern the services provided and it must provide full-time supervision of such services by Physician or registered nurse.
3. It maintains a complete medical record on each individual.
4. It has a full-time administrator.

HOME HEALTH CARE PLAN: "*Home Health Care Plan*" means a program for continued care and treatment established and approved in writing by the Covered Person's attending Physician following termination of a Hospital confinement as a resident In-Patient or in lieu of a Hospital confinement, and is for the same or related condition for which he was hospitalized or would have been hospitalized. The attending Physician must certify that the proper treatment of the Illness or Injury would require confinement or continued confinement as a resident In-Patient in a Hospital in the absence of the services and supplies provided as part of the Home Health Care Plan.

HOSPICE BENEFIT PERIOD: "*Hospice Benefit Period*" means the specified amount of time during which the Covered Person undergoes treatment by a hospice. Such time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminally ill and the Covered Person is accepted into a hospice program.

HOSPICE CARE: "*Hospice Care*" means a prearranged, written outline of the care that will be provided for Palliative Care and management of an individual's terminal Illness. In-Patient Hospice Care means treatment certified by the attending Physician that it is Medically Necessary to be received in a facility which may or may not be part of a Hospital and meets all of the following requirements: it complies with licensing and other legal requirements in the jurisdiction where it is located; it is mainly engaged in providing In-Patient Palliative Care for the terminally ill on a 24-hour basis under the supervision of a Physician or a registered nurse. If the care is not supervised by a Physician, the In-Patient hospice facility must have a Physician available on a prearranged basis; it provides bereavement counseling; it maintains clinical records on all terminally ill individuals; it is not mainly a place for the aged or a nursing or a convalescent home; and is approved for payment of Medicare Hospice benefits.

HOSPICE TEAM: "*Hospice Team*" means a group of service providers who must include at least a Physician and a registered nurse (R.N.) but may also include a social worker, counselor, or psychologist.

HOSPITAL: "*Hospital*" means an institution which meets all of the following conditions:

1. it is licensed and operated in accordance with the laws of jurisdiction in which it is located which pertains to Hospitals; is engaged primarily in providing medical care and treatment to ill and injured persons on an In-Patient basis at the patient's expense; maintains on its premises all the facilities necessary to provide for diagnosis and medical and surgical treatment of an Illness or an Injury; and such treatment is provided by under the supervision of Physicians with continuous twenty-four (24) hour nursing services by registered nurses; and
2. it qualifies as a Hospital, an alcohol or drug abuse or psychiatric Hospital, or a tuberculosis Hospital and is accredited by the Joint Commission on the Accreditation of Hospitals Organization (JCAHO);
3. it is a provider of services under Medicare; and
4. it is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics or a nursing home.

The provisions shown above under items #2 and #3 do not apply when a Covered Person is visiting, traveling or temporarily residing in a foreign country and must be hospitalized during such absence from the United States due to medical necessity. Charges for translation services are not covered under the Plan.

HOSPITAL MISCELLANEOUS EXPENSES: "*Hospital Miscellaneous Expenses*" means the actual charges made by a Hospital in its own behalf for services and supplies rendered to the Covered Person which are Medically Necessary for the treatment of such Covered Person. Hospital Miscellaneous Expenses do not include charges for room and board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

ILLNESS: "*Illness*" means a bodily disorder, disease, physical sickness, mental and/or nervous disorder, alcohol and/or drug abuse. All such disorders existing simultaneously, which are due to the same or related causes, will be considered one Illness.

INCURRED EXPENSES: The term "*Incurred Expenses*" means those services and supplies rendered to a Covered Person. Such expenses will be considered to have occurred at the time or date the service or supply is actually provided.

INJURY: "*Injury*" means a condition caused by accidental means, which results in damage to the Covered Person's body from an external force. Any loss which is caused by or contributed to by hernia of any kind will be considered a loss under the definition of Illness, and not as a loss resulting from accidental Injury.

IN-PATIENT: "*In-Patient*" refers to the classification of a Covered Person when that Person is admitted to a Hospital, hospice, or convalescent facility for treatment, and charges are made for room and board to the Covered Person as a result of such treatment.

INTENSIVE CARE UNIT: "*Intensive Care Unit*" means a section, ward, or wing within the Hospital which is separated from other facilities and is operated exclusively for the purpose of providing professional medical treatment for critically ill patients; it has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; provides constant observation and treatment by registered nurses (RNs) or other highly-trained Hospital personnel.

LIFETIME: Wherever the word "*Lifetime*" appears in this Plan in reference to benefit maximums and limitations, it is understood to mean, "while covered under this Plan". Under no circumstances does "*Lifetime*" mean during the lifetime of the Covered Person.

MEDICALLY NECESSARY: "*Medically Necessary*" means health care services, supplies or treatment for a covered illness or injury which, in the judgment of the attending Physician, is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

MEDICARE: The term "*Medicare*" means the programs established by Title I of Public Law 89-98 (79 Statutes 291) as amended entitled "Health Insurance for the Aged Act", and which includes Parts A and B and Title XVIII of the Social Security Act (as amended by Public Law 89-97, 79) as amended from time to time.

NETWORK PROVIDER: The term "*Network Provider*" means a provider of health care services that holds a valid Provider Agreement with The Health Plan Network.

NURSE: "*Nurse*" means a Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or a Licensed Practical Nurse (L.P.N.).

ORTHOTIC APPLIANCE: "*Orthotic Appliance*" means an external device intended to correct any defect in form or function of the human body.

OUT-PATIENT: "*Out-Patient*" refers to the classification of a Covered Person when that Covered Person receives medical care, treatment, services or supplies at a clinic, a Physician's office, or at a Hospital or other facility when not a registered bed patient.

PHYSICIAN: A "*Physician*" is a legally licensed medical or dental doctor or surgeon, chiropractor, osteopath, chiropractist, podiatrist, optometrist, certified consulting psychologist, psychologist (Ph.D.), physical therapist, physiotherapist, audiologist, speech language pathologist, midwife or any other health care provider that is licensed and regulated by a state or federal agency, and acting within the scope of their license, are permitted to administer or order services covered under this Plan.

PLAN: The term "*Plan*" means, without qualification, the State of Ohio Employee Health Plan, the provisions of which are set forth in the Plan Document, upon which this Summary Plan Description is based.

PLAN SPONSOR: The "*Plan Sponsor*" is The State of Ohio. The Plan Sponsor has established the Plan to provide benefits as described herein for its eligible Employees and their eligible dependents.

PLAN YEAR: "*Plan Year*" means a period of time commencing with the effective date of this Plan or the Plan Anniversary, and terminating on the date of the next succeeding Plan Anniversary.

POST-SERVICE CLAIM: A "*Post-Service*" claim is any claim for benefits after the services have been rendered or incurred.

PREGNANCY: "*Pregnancy*" means that physical state which results in childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state.

PRE-SERVICE CARE CLAIM: If the Plan requires pre-certification for hospitalization, then the pre-certification will be considered a Pre-Service Care Claim for benefits. A claim will be considered a "Pre-Service" Care Claim only if the Plan requires pre-certification for the service being rendered. Refer to the section entitled "Cost Containment" for information on Pre-Service Care Claims (Non-Urgent and Urgent).

ROOM AND BOARD: "*Room and Board*" refers to all charges by whatever name called, which are made by a Hospital, Hospice, or Skilled Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians nor intensive nursing care by whatever name called.

SEMI-PRIVATE: "*Semi-Private*" refers to a class of accommodations in a Hospital or Skilled Nursing Facility in which at least two patients' beds are available per room.

SKILLED NURSING FACILITY: "*Skilled Nursing Facility*" means a licensed institution, or distinct part of one, operated according to law and one, which meets all of the following conditions:

1. it provides In-Patient care for persons convalescing from Injury or Illness, professional nursing services rendered by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N.) and physical restoration service to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities; and
2. its services are provided for compensation from its patients and under the full time supervision of a Physician or registered graduate nurse; and
3. it provides 24-hour-per-day nursing service by licensed Nurses, under the direction of a full-time registered graduate nurse; and
4. it maintains a complete original record on each patient; and
5. it has an effective organization review plan; and
6. it is not other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardation, custodial, or educational care, or care of mental disorders; and
7. it is approved and licensed by Medicare.

This term will also apply to expenses incurred in an institution referring to itself as a Convalescent Nursing Facility, Extended Care Facility, Convalescent Nursing Home, or any other similar name.

SURGERY: "*Surgery*" means any cutting procedure or procedure which involves the insertion of an instrument into an internal organ (such as cystoscopy and colonoscopy) or "underwater shock wave treatment".

TERMINAL ILLNESS: "*Terminal Illness*" means a disease or sickness where the Covered Person is expected to live six (6) months or less. This must be certified by the attending Physician.

THIRD PARTY ADMINISTRATOR: "*Third Party Administrator*" will mean the person or firm employed by the Plan Sponsor who is responsible for the processing of claims and payment of benefits, administration, accounting, reports and other services contracted for by the Plan Sponsor.

PLAN SPECIFICATIONS

Employer	State of Ohio
Plan Administrator, Plan Sponsor and Named Fiduciary	State of Ohio 30 East Broad Street, 27 th Floor Columbus OH 43215
Agent for Legal Service	State of Ohio
Type of Plan	Self-Funded Medical and Prescription Drug Plan.
Administration	Self-Administered by the Employer: The Employer has appointed a Third Party Administrator to handle the day to day operation of the Plan.
Third Party Administrator	The Health Plan 52160 National Road St. Clairsville OH 43950 Phone: (800) 624-6961
Funding	Self-funded with Employer Contributions <u>Employer Contributions</u> The Employer makes contributions, as needed, to pay benefits from its general assets and purchase reinsurance as reimbursement for catastrophic claims. <u>Employee Contributions</u> Established as required, from time to time, by the Employer
Plan Participants	Employees of State of Ohio as defined herein
Plan Year	July 1-June 30
Plan Number	501