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**PLAN DOCUMENT AND  
SUMMARY PLAN DESCRIPTION  
FOR**

**SOUTHERN LOCAL SCHOOLS HEALTH BENEFIT PLAN  
EFFECTIVE DATE: JULY 1, 2008**

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

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## INTRODUCTION

This document is a description of Southern Local Schools Health Benefit Plan (the Plan). No oral interpretations can change this Plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Claim Provisions.** Explains the rules for filing claims.

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

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

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

## SCHEDULE OF BENEFITS

For **Verification of Eligibility** please refer to the telephone number on the employee's identification card.

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

### MEDICAL BENEFITS

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

Only a general description of health benefits covered by this Plan is included in this document. A more detailed schedule of coverage is available to any Plan Participant, at no cost, who requests one from the Plan Administrator.

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

#### Home Infusion Therapy

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

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

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

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

- Covered radiology/pathology interpretations performed by a Non-Network Provider for a Covered Person receiving care.
- Covered lab services performed by a Non-Network independent lab facility in connection with and as a result of a Covered Person's care.
- For any Covered Dependent child who resides outside the Network service area due to such child attending an educational institution outside of the Network area or residing with the Employee's former spouse.

#### Deductibles/Copayments payable by Plan Participants

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

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required.

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

**MEDICAL BENEFITS SCHEDULE**

	<b>NETWORK PROVIDERS</b>	<b>NON-NETWORK PROVIDERS</b>
<b>MAXIMUM LIFETIME BENEFIT AMOUNT</b>	\$5,000,000	
<p><b>Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.</b></p>		
<b>DEDUCTIBLE, PER CALENDAR YEAR</b>		
Per Covered Person	none	\$300
Per Family Unit	none	\$900
<b>COPAYMENTS</b>		
Physician visits	\$10	none
Allergy serum and injections	\$5 (copay not applicable if billed with an office visit)	none
Urgent Care Facility	\$50	\$50
Emergency room	\$150	\$150
<p>The Emergency room copayment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator, ACMS should be notified at (877) 304-0761 within 48 of the admission, even if the patient is discharged within 48 of the admission.</p>		
<b>MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR</b>		
Per Covered Person	none	\$2,000
Per Family Unit	none	\$4,000
<p>The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.</p>		
<p>The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%.                      Non-Precertification Penalties                      Amounts over Usual and Reasonable Charge                      Expenses incurred under the Prescription Drug Benefits                      Non-Network Organ and Tissue Transplant services</p>		
<b>COVERED CHARGES</b>		
<b>Inpatient Hospital Services</b>		
Room, Board, and Miscellaneous Expenses	100%	80% after deductible
Intensive Care Unit	100%	80% after deductible
<b>Outpatient Hospital Services</b>		
Surgical Facilities	100%	80% after deductible
Other Outpatient Services	100%	80% after deductible
<b>Emergency Room Visit</b>		
Medical Emergency	100% after copayment	100% after copayment
<b>Urgent Care Facility</b>	100% after copayment	100% after copayment
<b>Skilled Nursing Facility</b>	100% 90 day Calendar Year maximum	80% after deductible 90 day Calendar Year maximum
<b>Physician Services</b>		
Inpatient visits	100%	80% after deductible
Office visits (including any services related to the visit)	100% after copayment	80% after deductible
Surgery	100%	80% after deductible
Allergy testing	100%	80% after deductible

	<b>NETWORK PROVIDERS</b>	<b>NON-NETWORK PROVIDERS</b>
Allergy serum and injections	100% after copayment (copay not applicable if billed with an office visit)	80% after deductible
<b>Diagnostic Testing (X-ray &amp; Lab)</b>	100%	80% after deductible
<b>Home Health Care</b>	100% 90 visit Calendar Year maximum	80% after deductible 90 visit Calendar Year maximum
<b>Outpatient Private Duty Nursing</b>	100% \$50,000 Calendar Year maximum \$100,000 Lifetime maximum	80% after deductible \$50,000 Calendar Year maximum \$100,000 Lifetime maximum
<b>Hospice Care</b>	100%	100%
Bereavement Counseling	100%	100%
<b>Ambulance Service</b>	100%	100%
<b>Wig After Chemotherapy</b>	100% 1 Per Calendar Year \$4,000 Calendar Year maximum combined with Prosthetics	80% after deductible 1 Per Calendar Year \$4,000 Calendar Year maximum combined with Prosthetics
<b>Occupational Therapy</b>	100% 20 visit Calendar Year maximum	80% after deductible 20 visit Calendar Year maximum
<b>Speech Therapy</b>	100% 20 visit Calendar Year maximum	80% after deductible 20 visit Calendar Year maximum
<b>Physical Therapy</b>	100% 20 visit Calendar Year maximum	80% after deductible 20 visit Calendar Year maximum
<b>Durable Medical Equipment</b>	100% \$4,000 Calendar Year maximum combined with Orthotics	80% after deductible \$4,000 Calendar Year maximum combined with Orthotics
<b>Prosthetics</b>	100% \$4,000 Calendar Year maximum combined with Wig After Chemotherapy	80% after deductible \$4,000 Calendar Year maximum combined with Wig After Chemotherapy
<b>Orthotics</b>	100% \$4,000 Calendar Year maximum combined with Durable Medical Equipment	80% after deductible \$4,000 Calendar Year maximum combined with Durable Medical Equipment
<b>Spinal Manipulation Chiropractic</b>	100% 12 visit Calendar Year maximum	80% after deductible 12 visit Calendar Year maximum
<b>Mental Disorders</b>		
Inpatient	100% 30 Day Calendar Year maximum combined with In-Network Inpatient Substance Abuse	80% after deductible 30 Days Calendar Year maximum
Partial Hospitalization, Day Treatment, and Intensive Outpatient Care	2 for 1 Calendar Year maximum, Paid Same as Inpatient	2 for 1 Calendar Year maximum, Paid Same as Inpatient
Outpatient	100% after copayment 30 visit Calendar Year maximum combined with In-Network Outpatient Substance Abuse	80% after deductible 10 visits Calendar Year maximum
<b>Substance Abuse</b>		
Inpatient	100% 30 Days Calendar Year maximum combined with In-Network Inpatient Mental Health	80% after deductible

	<b>NETWORK PROVIDERS</b>	<b>NON-NETWORK PROVIDERS</b>
Partial Hospitalization, Day Treatment, and Intensive Outpatient Care	2 for 1 Calendar Year maximum, Paid Same as Inpatient	2 for 1 Calendar Year maximum, Paid Same as Inpatient
Outpatient	100% after copayment 30 visit Calendar Year maximum combined with In-Network Outpatient Mental Health	80% after deductible
Inpatient / Outpatient Combined	Two Rehabilitation Programs Lifetime maximum	\$550 Calendar Year maximum Two Rehabilitation Program Lifetime maximum
<b>Preventive Care</b>		
Routine Well Adult Care	100% after copayment	80% after deductible
Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory tests, hearing tests, vision tests, immunizations/flu shots, colonoscopies, bone density scans, stress tests and sigmoidoscopies.		
Routine Well Newborn Care	100%	80% after deductible
Routine Well Child Care	100% after copayment	80% after deductible
Includes: office visits, routine physical examination, laboratory tests, x-rays, hearing tests, vision tests and immunizations through age to the end of the calendar year in which the dependent turns 19.		
<b>Organ Transplants</b>	100%	50% after deductible
Maximum Benefit of \$30,000 for unrelated donor searches for bone marrow/stem cell transplants per transplant per Covered Person.		
<b>Temporomandibular Joint (TMJ)</b>	Services related to TMJ will be covered at the benefits based on the setting where Covered Services were received.	
<b>Other Medical Services and Supplies</b>	100%	80% after deductible

**PRESCRIPTION DRUG BENEFIT SCHEDULE**

<b>PRESCRIPTION DRUG BENEFIT</b>		
	<b>NETWORK</b>	<b>NON-NETWORK</b>
<b>Pharmacy Option (30 Day Supply)</b>		
Generic Drugs	\$10 copayment	\$30 copayment
Preferred Brand Name Drugs	\$20 copayment	\$30 copayment
Non-Preferred Brand Name Drugs	\$30 copayment	\$30 copayment
<b>Mail Order Option (90 Day Supply)</b>		
Generic Drugs	\$20 copayment	Not Covered
Preferred Brand Name Drugs	\$40 copayment	Not Covered
Non-Preferred Brand Name Drugs	\$60 copayment	Not Covered
<b>Refer to the Prescription Drug Section for details on the Prescription Drug benefit.</b>		

If you obtain services from a Non-Network Pharmacy, Caremark will provide 50% of the Prescription Drug, after the Prescription Drug Copayment, as indicated in the above Schedule. You must pay the full amount of the bill for the Prescription Drug at the time of purchase. Then you must file a Standard Claim Form, which can be obtained from Caremark, and payment will be made directly to you. You may be responsible for any amount in excess of the Prescription Drug Covered Charges.

## **ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS**

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

### **ELIGIBILITY**

**Eligible Classes of Employees.** All Active Employees of the Employer.

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

- (1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.
- (2) is in a class eligible for coverage.

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

- (1) A covered Employee's Spouse and unmarried children from birth to the end of the calendar year in which they reach the age of 19. The Dependent children must be primarily dependent upon the covered Employee for support and maintenance. However, a Dependent child will continue to be covered after age 19, provided the child is a full-time student at an accredited school, primarily dependent upon the covered Employee for support and maintenance, is unmarried and under the limiting age of 24. When the child reaches either limiting age, coverage will end at the end of the Calendar Year. If the child does not maintain full-time status or graduates, coverage terminates at the end of the month in which the child loses eligibility status.

Full-time student coverage continues between semester/quarters only if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

Upon turning age 24, a dependent student must satisfy the IRC Section 152 definition of Dependent (other than the gross income test) to continue coverage under the Plan.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural children or adopted children (living in the same household as the Employee). Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.

If a covered Employee is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents.

- (2) Covered Children (as defined above) who reach limiting age and are Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

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

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

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

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

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

## **FUNDING**

**Cost of the Plan.** Southern Local Schools shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization.

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

## **PRE-EXISTING CONDITIONS**

**NOTE:** The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan even if that coverage is still in effect. The Plan will reduce the length of the Pre-Existing Condition Limitation period by each day of Creditable Coverage under this or a prior plan; however, if there was a significant break in the Creditable Coverage of 63 days or more, then only the coverage in effect after the break will be counted.

An eligible person may request a certificate of Creditable Coverage from his or her prior plan within 24 months after losing coverage and the Employer will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan.

A Covered Person will be provided a certificate of Creditable Coverage from this Plan if he or she requests one either before losing coverage or within 24 months of coverage ceasing.

If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

All questions about the Pre-Existing Condition Limitation and Creditable Coverage should be directed to the Plan Administrator, Southern Local Schools, 920 Elm Street, Racine, Ohio, 45771, (740) 949-2611.

Covered Charges incurred under Medical Benefits for Pre-Existing Conditions are not payable unless incurred 12 consecutive months after the person's Enrollment Date. This time, known as the Pre-Existing Conditions Limitation period, may be offset if the person has Creditable Coverage from his or her previous plan.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the person's Enrollment Date under this Plan. Genetic Information is not, by itself, a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to Pregnancy, to a newborn child who is enrolled in the Plan within 31 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and is enrolled in the Plan within 31 days of the adoption or placement of adoption.

The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first 63-consecutive day period during all of which the individual was not covered under any Creditable Coverage.

## **ENROLLMENT**

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

### **Enrollment Requirements for Newborn Children.**

A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

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

## **TIMELY OR LATE ENROLLMENT**

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

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee as long as coverage has been continuous.

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

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

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on July 1.

## **SPECIAL ENROLLMENT RIGHTS**

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

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

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, Southern Local Schools, 920 Elm Street, Racine, Ohio, 45771, (740) 949-2611.

## **SPECIAL ENROLLMENT PERIODS**

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. This means that any Pre-Existing Condition will be determined on the basis of the look back period prior to the Enrollment Date, and the period of the Pre-Existing Conditions Limitation will start on the Enrollment Date.

- (1) Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to any of the following conditions:
  - (a)** The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
  - (b)** If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
  - (c)** The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
  - (d)** The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
  - (e)** For purposes of these rules, a loss of eligibility occurs if:
    - (i)** The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.
    - (ii)** The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).
    - (iii)** The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
    - (iv)** The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

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

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

**(2) Dependent beneficiaries. If:**

- (a) The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

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

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

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

- (a) in the case of marriage, the date of the marriage;
- (b) in the case of a Dependent's birth, as of the date of birth; or
- (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

**EFFECTIVE DATE**

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

- (1) The Eligibility Requirement.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

**Active Employee Requirement.**

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

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

## TERMINATION OF COVERAGE

**When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. Please contact the Plan Administrator for a copy of these procedures and further details.**

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

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

- (1) The date the Plan is terminated.
- (2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.
- (3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (4) The earliest date the Employee has a claim that is denied in whole or in part because the Employee has met or exceeded a lifetime limit on all benefits.
- (5) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

**Continuation During Family and Medical Leave.** This Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

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

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

**Rehiring a Terminated Employee.** A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy Pre-Existing Conditions provision.

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

- (1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:
  - (a) The 24 month period beginning on the date on which the person's absence begins; or
  - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Southern Local Schools, 920 Elm Street, Racine, Ohio, 45771, (740) 949-2611. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

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

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)
- (3) The date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)
- (4) On the last day of the Calendar Year in which a Dependent child reaches the limiting age as defined by the Plan.
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (6) The earliest date the Dependent has a claim that is denied in whole or in part because it meets or exceeds a lifetime limit on all benefits.
- (7) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

## **OPEN ENROLLMENT**

### **OPEN ENROLLMENT**

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

During the annual open enrollment period (as determined by the Employer), Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices made during the open enrollment period will become effective July 1 and remain in effect until the next July 1 unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, Pre-Existing Conditions Limits will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective July 1.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

## MEDICAL BENEFITS

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

### DEDUCTIBLE

**Deductible Amount.** This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

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

### BENEFIT PAYMENT

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

### OUT-OF-POCKET LIMIT

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

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

### MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person. The Maximum Benefit applies to all plans and benefit options offered under the Southern Local Schools Health Benefit Plan, including the ones described in this document.

### COVERED CHARGES

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

- (1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. A stay for 24 hours or more will be considered an inpatient confinement.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

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

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

- (2) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:
- (a) the patient is confined as a bed patient in the facility; and
  - (b) the attending Physician certifies that the confinement is needed for further care of the Illness; and
  - (c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

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

- (3) **Physician Care.** Surgical benefits are payable as shown in the Schedule of Benefits and include operative and cutting procedures when performed by a Physician acting within the scope of his license who is not an employee of the Hospital where the surgery is performed. Vasectomy and tubal ligation—but not reversals of sterilization—and certain oral surgical procedures will also be covered, including:
- Repair of Injury to teeth within 12 months from the injury, or as reasonably soon thereafter as possible, and includes all examinations and treatment to complete the repair.
  - Excision of tumors and cysts of the mouth and oral cavity

*Note: ACMS may recommend a Second Surgical Opinion during the pre-admission review process. Obtaining a Second Surgical Opinion is entirely voluntary on the part of the Covered Person.*

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

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

This mammoplasty coverage will include reimbursement for:

- (i) reconstruction of the breast on which a mastectomy has been performed,
- (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- (iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

- (4) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:
- (a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
  - (b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

Charges for Private Duty Nursing Care are subject to the limits as described in the Schedule of Benefits.

- (5) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

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

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

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

- (7) **Other Medical Services and Supplies.** These following services are covered as shown in the Schedule of Benefits under Other Medical Services and Supplies, unless otherwise listed individually as a separate benefit:

- (a) Charges for professional land and air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or to a Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.
- (b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
- (c) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.
- (d) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.
- (e) Initial **contact lenses** or glasses required following cataract surgery.
- (f) Rental of **durable medical or surgical equipment** if deemed Medically Necessary, not to exceed the purchase price. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.
- (g) **Kidney Dialysis**
- (h) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

- (i) Treatment of **Mental Disorders and Substance Abuse**. Covered Charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

Physician's visits are limited to one treatment per day.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

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

1. Three visits per lifetime for the Covered Person newly diagnosed with **Diabetes**.
2. One visit per lifetime as determined by ACMS for the Covered Person newly diagnosed with a specific qualifying health condition.

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

Charges for Occupational therapy are subject to the limits as described in the Schedule of Benefits.

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

**ACMS** — Out-of-Network care will be considered at the In-Network level if ACMS has coordinated the treatment.

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

**Donor Costs** —

- 1) When the donor is a Covered Person and the recipient is not a Covered Person, benefits are payable for donor costs only to the extent that such expenses are not paid by the recipient’s plan. In the event the recipient’s plan has a similar provision to 2) below, benefits are then payable for donor costs.
- 2) When the donor is not a Covered Person, and the recipient is a Covered Person, only those expenses of the donor not paid by the donor’s plan will be recognized as eligible expenses. Benefits will be payable only to the extent that benefits remain available under the individual Lifetime maximum outlined below.

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

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

**Maximum Lifetime Benefit** — All combined benefits (recipient and donor) paid directly or indirectly as the result of any and all transplant procedures, including prescription drugs and all follow-up care, are subject to a Maximum Lifetime Benefit per Covered Person as shown in the Schedule of Benefits.

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

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

**Limitations** — If the donor is not a Covered Person, benefits for donor costs are limited to those directly related to the transplant procedure itself, including complications, and do not include any medical care costs related to other treatment of the donor. No benefits are payable for:

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

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

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

Charges for Physical therapy are subject to the limits as described in the Schedule of Benefits.

(o) Routine **Preventive Care**. Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

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

**Charges for Routine Well Child Care**. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

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

(q) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.

Charges for Speech therapy are subject to the limits as described in the Schedule of Benefits.

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

(s) **Sterilization** procedures.

- (t) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
- (u) **Temporomandibular Joint Syndrome.** Diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.
- (v) Covered charges incurred at an **Urgent Care Facility**.
- (w) Coverage of **Well Newborn Nursery/Physician Care**.

**Charges for Routine Nursery Care.** Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Usual and Reasonable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

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

**Charges for Routine Physician Care.** The benefit is limited to the Usual and Reasonable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

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

Charges for wig after chemotherapy are subject to the limits as described in the Schedule of Benefits.

- (y) Diagnostic **x-rays**.

## COST MANAGEMENT SERVICES

### Cost Management Services Phone Number:

ACMS  
(877) 304-0761

The provider, patient, or family member must call this number to receive certification of certain Cost Management Services. This call should be made at least 7 days in advance of services being rendered or within 48 after an emergency.

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

### UTILIZATION REVIEW

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

The program consists of:

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

#### **Home Infusion Therapy**

- (b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
- (c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- (d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

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

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

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

In order to maximize Plan reimbursements, please read the following provisions carefully.

### **Here's how the program works.**

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

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator ACMS at (877) 304-0761 **at least 7 days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Employee Identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician should contact ACMS **within 48** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

**If the Covered Person does not receive authorization as explained in this section, Allowable Charges will be reduced to 0% of the Covered Charges.**

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

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

## **CASE MANAGEMENT**

ACMS also performs Case Management services for the Plan. Case Management applies if the nature of a patient's condition is, or is expected to become catastrophic or chronic, or when the cost of treatment is expected to be significant. Examples of conditions that might prompt case management intervention include transplants, amputations, multiple fractures, spinal cord injury, cerebral vascular accident, cancer, head trauma, AIDS, multiple sclerosis, severe burns, severe psychiatric disorder, or high risk pregnancy/high-risk infant. Additional information is available from ACMS.

Subject to the approval of the Plan Sponsor and with the assistance of medical case management, an alternative plan of care which is beneficial to both the Plan and the Covered Person may be considered for reimbursement.

Office hours for ACMS are 8:00 a.m. to 5:00 p.m. (Eastern Time), Monday through Friday. An answering system will take messages during the hours when ACMS is closed. The toll-free telephone number for ACMS is:

**932-6374 (In Columbus, Ohio)  
1-877-304-0761 (Toll Free - Outside Columbus, Ohio)**

## DEFINED TERMS

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

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

**Ambulatory Surgical Center** is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

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

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

**Brand Name** means a trade name medication.

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

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

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

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

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

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

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

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

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

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

**Employer** is Southern Local Schools.

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

**Experimental and/or Investigational** means any drug, medical device or procedure that:

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

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

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

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

**Formulary** means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

**Generic drug** means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

**Genetic Information** means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

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

**Home Health Care Plan** must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

**Home Health Care Services and Supplies** include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care

Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

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

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

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

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

**Hospital** is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

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

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

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

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

**Inpatient** means a person is assigned to a bed in a Hospital or other licensed facility for a duration of 24 hours or more.

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

**Late Enrollee** means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

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

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

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

**Medical Emergency** means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

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

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

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

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

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

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

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

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

**Outpatient Care and/or Services** is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

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

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

**Plan** means Southern Local Schools Health Benefit Plan, which is a benefits plan for certain Employees of Southern Local Schools and is described in this document.

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

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

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

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

**Sickness** is a person's Illness, disease or Pregnancy (including complications).

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

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

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

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

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

**Total Disability (Totally Disabled)** means: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

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

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

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

## PLAN EXCLUSIONS

**Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.**

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

- (1) For **Alternative or complementary medicine** including, but not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy.
- (2) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.
- (3) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
- (4) **Dental.** Services for dental services or treatment, except as described herein.
- (5) **Educational or vocational testing.** Services for educational or vocational testing or training.
- (6) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.
- (7) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (8) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.
- (9) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as otherwise described herein.
- (10) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).
- (11) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.
- (12) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- (13) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except as otherwise described herein.
- (14) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as otherwise described herein.
- (15) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (16) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a felonious illegal act, or a riot or public disturbance. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (17) **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization.

- (18) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.
- (19) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (20) **Non-emergency** medical care received in an Emergency Room care.
- (21) **No obligation to pay.** Charges incurred for which the participant has no legal obligation to pay.
- (22) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (23) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
- (24) **Nutritional Therapy.** Nutritional supplements and therapies are not covered except for enteral and parenteral nutrition therapies when medically necessary. Medical necessity is determined on a case by case basis and the treatment plan and a detailed explanation of the medical necessity must be submitted to the ACMS for review and approval. Not covered are:
- a) Enteral tube feedings for individuals who are capable of adequate oral intake.
  - b) Food supplements, specialized infant formula, vitamins and/or minerals taken orally
  - c) Parenteral nutrition for individuals with a functioning gastrointestinal tract whose need for parenteral nutrition is only due to:
    - swallowing disorder
    - Temporary defect in gastric emptying
    - psychological disorder
    - hemodialysis
    - Disorders inducing anorexia such as cancer
    - Peritoneal dialysis (intrapertoneal amino acid (IPPA) supplementation for individuals on peritoneal dialysis may be considered if certain criteria are met.)
- (25) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals.
- (26) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit if benefits are available under any Worker's Compensation Act, or similar legislation.
- (27) **Orthoptic Training.**
- (28) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
- (29) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (30) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

- (31) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.
- (32) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (33) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (34) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (35) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.
- (36) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.
- (37) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (38) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges and as otherwise described herein.
- (39) **War.** Any loss that is due to a declared or undeclared act of war.

## PRESCRIPTION DRUG BENEFITS

### Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. CVS/Caremark is the administrator of the pharmacy drug plan.

### Copayments

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

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

### Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, CVS/Caremark, the mail order pharmacy, is able to offer Covered Persons significant savings on their prescriptions.

### Covered Prescription Drugs

- (1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.
- (2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (3) Insulin and other diabetic supplies when prescribed by a Physician.

### Limits To This Benefit

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

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills up to one year from the date of order by a Physician.

### Expenses Not Covered

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

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Appetite suppressants.** A charge for appetite suppressants.
- (3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

- (5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.
- (6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
- (7) **FDA.** Any drug not approved by the Food and Drug Administration.
- (8) **Immunization.** Immunization agents or biological sera.
- (9) **Impotence.** A charge for impotence medication.
- (10) **Infertility.** A charge for infertility medication.
- (11) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- (12) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (13) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- (14) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- (15) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
- (16) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- (17) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.
- (18) **Smoking cessation.** A charge for Prescription Drugs, such as nicotine gum or smoking deterrent patches, for smoking cessation.

## HOW TO SUBMIT A CLAIM

The Covered Person's health plan identification card indicates to providers and Covered Persons how to file a claim.

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

Complete and current information must be provided for:

- 1) **Accident or Injury Claims** — Explain how, when and where the Injury occurred and whether any other party was involved or responsible for the accident.
- 2) **Other Coverage** — List the name, address and telephone number of any other coverage or payer that may provide coverage, including, but not limited to, COBRA, Medicare and any other benefit plan.
- 3) **Full-Time Student** — If the Plan provides coverage for Full-Time Students, send a grade card, letter or invoice that proves enrollment when the claim was incurred. Full-time status will be the number of hours stipulated by the accredited university or college per quarter or semester.
- 4) **Prescription Drugs** — If the Plan has a pharmacy Network indicated on the Covered Person's health plan identification card, present the card when filling a prescription and pay any required co-payment. If the prescription is rejected at the pharmacy or through a mail-order drug program, if applicable, the Covered Person or the pharmacist should call the telephone number for the drug program shown on the health plan identification card for an explanation. If still not resolved, the Covered Person may file a written claim for benefit consideration. In the event the claim is denied, an explanation will be sent to the Covered Person in writing. The Covered Person has 180 days in which to file a written appeal and the Plan will respond in writing within 60 days.
- 5) **Pre-Existing Conditions** — If a Certificate of Prior Creditable Coverage is not submitted to reduce the Plan's Pre-Existing Conditions Limitation time period, the Plan may request additional information from a Covered Person and/or his Physician. This information will be regarding any Pre-Existing Condition treated within the time frame described herein prior to the person's Effective Date. (See the "Pre-Existing Conditions Limitation" section of this booklet.)

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

## WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 365 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

- (a) it's not reasonably possible to submit the claim in that time as determined by the Claims Administrator; and
- (b) this one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a written notice of this denial. This written notice will be provided within 90 days after receipt of the claim. The written notice will contain the following information:

- (a) the specific reason or reasons for the denial;
- (b) specific reference to those Plan provisions on which the denial is based;
- (c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and
- (d) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

A Plan Participant will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim and if not notified within 90 days, the claim shall be deemed denied.

If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

#### **CLAIMS REVIEW PROCEDURE**

In cases where a claim for benefits payment is denied in whole or in part, the Plan Participant may appeal the denial. This appeal provision will allow the Plan Participant to:

- (a) Request from the Plan Administrator a review of any claim for benefits. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.
- (b) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator or Claims Administrator within 60 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Participant with a written response within 60 days of the date the Plan Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the Plan Participant of the delay within the 60 day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the Plan Participant's written request for review.

The Plan Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits.

## COORDINATION OF BENEFITS

The Plan has been designed to help meet the cost of Illness or Injury. Since it is not intended that greater benefits be received than the actual medical expenses incurred, the amount of benefits payable under the Plan will take into account any coverage under other plans and be coordinated with the benefits of the other plans.

The Plan will always pay either its regular benefits in full if it is determined to be the Primary Plan (plan primarily responsible for payment) or, if the Plan is determined to be the Secondary Plan, a reduced amount which, when added to the benefits payable by the Primary Plan, will not exceed 100% of Allowable Expenses.

In no event, however, will payment exceed the maximum benefits payable under this Plan.

### **PRIMARY PLAN**

"Coordination of benefits" is the procedure used to pay health care expenses when a person is covered by more than one plan. The Plan follows rules established by Ohio law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills.

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

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

### **Plans That Do Not Coordinate**

The Plan will pay benefits without regard to benefits paid by the following kinds of coverage:

- Individual (not group) policies or contracts;
- Medicaid;
- Group hospital indemnity plans which pay less than \$100 per day;
- School accident coverage;
- Some supplemental sickness and accident policies;

### **How This Plan Pays As Primary Plan**

When this Plan is the Primary Plan, it will pay the full benefit allowed under the terms of the Plan as if you had no other coverage.

### **How This Plan Pays As Secondary Plan**

When this Plan is the Secondary Plan, payments from this Plan will be based on the balance left after the Primary Plan has paid. This Plan will pay no more than that balance. In no event will this Plan pay more than it would have paid had it been the Primary Plan.

This Plan will pay only for health care expenses that are covered by the Plan. This Plan will only pay if you have followed all of its procedural requirements. This Plan will pay no more than the Allowable Expenses for the health care involved. If this Plan's Allowable Expenses is lower than the Primary Plan's, this Plan will use the Primary Plan's Allowable Expenses. That may be less than the actual bill.

### **Which Plan Is Primary?**

To determine which plan is the Primary Plan, the Plan must consider both the coordination provisions of the other plan and which member of your family is involved in a claim. The Primary Plan will be determined by the first of the following which applies:

1. Non-coordinating Plan. If you have another group plan which does not coordinate benefits, it will always be the Primary Plan.

2. Employee. The plan which covers you as an employee (neither laid off nor retired) is always the Primary Plan.
3. Children (Parents Divorced or Separated). If the court decree makes one parent responsible for health care expenses, that parent's plan is the Primary Plan. If the court decree gives joint custody and does not mention health care, the Plan follows the "birthday rule." If neither of those rules applies, the order will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.
4. Children and the Birthday Rule. When your children's health care expenses are involved, the Plan follows the "birthday rule." The plan of the parent with the first birthday in a calendar year is always primary for the children. If your birthday is in January and your spouse's birthday is in March, your plan will be the Primary Plan for all of your children.
5. Other Situations. For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

### **COORDINATION DISPUTES**

If you believe that the Plan has not paid a claim properly in accordance with these coordination of benefits rules, you should first attempt to resolve the problem by contacting the Plan in accordance with the claims procedures described in this booklet. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-686-1526.

### **ALLOWABLE EXPENSES**

"Allowable Expenses" means any necessary Usual, Customary and Reasonable expenses incurred while eligible for benefits under the Plan, part or all of which would be covered under any of the plans, but not including any expenses contained in the list of General Limitations.

With regard to any Covered Person eligible to elect Medicare except those described in the next paragraph, Medicare benefits will be considered as having been paid whether or not the Covered Person has applied for Medicare coverage or submitted a claim for Medicare benefits. It is the Covered Person's responsibility to apply for and maintain both Part A and Part B Medicare coverage.

With regard to an actively-at-work Eligible Employee age 65 or older, or an eligible covered dependent spouse of an active Eligible Employee also over age 65, either of whom has elected in writing to be covered under this Plan, the benefits of this Plan will be primary.

This Plan will also be primary for military retirees and their Eligible Dependents for Inpatient Hospital charges in military medical Hospitals as required by law and in accordance with this Plan. The Claims Administrator has the right to request and release any information which is necessary in order to determine the Primary Plan.

The Plan pays secondary to any and all PIP (Personal Injury Protection), Med-Pay (medical payments coverage) or No-Fault coverage. The Plan has no duty or obligation to pay any claims until PIP, Med-Pay or No-Fault coverage is exhausted. In the event the Plan pays claims under this provision that should have been paid by PIP, Med-Pay or No-Fault coverage, then the Plan has a right of recovery from the PIP, Med-Pay or No-Fault carrier.

## **RECOVERY PROVISION**

### **INTRODUCTION**

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

### **RIGHT OF REIMBURSEMENT**

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

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

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

### **SUBROGATION**

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

The Covered Person's failure to comply with the requirements of this section may, at the Plan Administrator's discretion, result in a forfeiture of benefits under the Plan.

### **IN GENERAL**

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

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

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

## CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

The Plan Administrator is Southern Local Schools, 920 Elm Street, Racine, Ohio, 45771, (740) 949-2611. COBRA continuation coverage for the Plan is administered by Employee Benefit Management Corp, 4789 Rings Road, Dublin, Ohio 43017, (877) 304-0761. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

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

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

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

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

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

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

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

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (4) A covered Employee's enrollment in any part of the Medicare program.
- (5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

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

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

**What factors should be considered when determining to elect COBRA continuation coverage?** You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

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

**What is the election period and how long must it last?** The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family

members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at [www.doleta.gov/tradeact](http://www.doleta.gov/tradeact).

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

- (1) the end of employment or reduction of hours of employment,
- (2) death of the employee,
- (3) commencement of a proceeding in bankruptcy with respect to the employer, or
- (4) enrollment of the employee in any part of Medicare.

#### **IMPORTANT:**

**For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.**

#### ***NOTICE PROCEDURES:***

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

Southern Local Schools  
920 Elm Street  
Racine, Ohio 45771

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

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

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

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

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

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

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

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

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
  - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
  - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

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

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

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

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
  - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
  - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

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

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

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

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

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

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

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

**Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?** If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan.

#### **IF YOU HAVE QUESTIONS**

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

#### **KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES**

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

## **RESPONSIBILITIES FOR PLAN ADMINISTRATION**

**PLAN ADMINISTRATOR.** Southern Local Schools Health Benefit Plan is the benefit plan of Southern Local Schools, the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by Southern Local Schools to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Southern Local Schools shall appoint a new Plan Administrator as soon as reasonably possible.

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

### **DUTIES OF THE PLAN ADMINISTRATOR.**

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

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

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

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

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

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation

of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

- (3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.
- (a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
  - (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
  - (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
    - (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
    - (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
    - (iii) Mitigating any harm caused by the breach, to the extent practicable; and
    - (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- (4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:
- (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
  - (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
  - (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
  - (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
  - (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
  - (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

- (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
- (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
- (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

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

- (1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

#### **FUNDING THE PLAN AND PAYMENT OF BENEFITS**

The cost of the Plan is funded as follows:

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

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

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

#### **PLAN IS NOT AN EMPLOYMENT CONTRACT**

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

## **CLERICAL ERROR**

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

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

## GENERAL PLAN INFORMATION

### TYPE OF ADMINISTRATION

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

### PLAN NAME

Southern Local Schools Health Benefit Plan

**TAX ID NUMBER:** 31-1770705

**PLAN EFFECTIVE DATE:** July 1, 2008

**PLAN YEAR ENDS:** June 30

### EMPLOYER INFORMATION

Southern Local Schools  
920 Elm Street  
Racine, Ohio 45771  
(740) 949-2611

### PLAN ADMINISTRATOR

Southern Local Schools  
920 Elm Street  
Racine, Ohio 45771  
(740) 949-2611

### CLAIMS ADMINISTRATOR

Employee Benefit Management Corp  
4789 Rings Road  
Dublin, Ohio 43017  
(877) 304-0761

BY THIS AGREEMENT, Southern Local Schools Health Benefit Plan is hereby adopted as shown.

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

By \_\_\_\_\_  
Southern Local Schools

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

Revision Date: 10/15/08lap