**SUMMARY OF MATERIAL MODIFICATION**
**AND AMENDMENT #1-11**
**TO THE**
**WOOD COUNTY EMPLOYEES PLAN**
**(Health and Prescription Only)**

This Summary of Material Modification and Amendment describes changes to the Wood County Employees Plan. **These changes are effective as of January 1, 2011, unless otherwise stated below,** and will remain in effect until amended in writing by the Plan Sponsor.

You should read this document carefully and staple this Summary of Material Modification to your Plan Document and Summary Plan Description. Please contact your Plan Administrator identified in your Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

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Wood County (the "Plan Sponsor") is amending the Wood County Employees Plan (the "Plan") as follows:

- The Wood County Employees Plan will comply with certain provisions of the Patient Protection and Affordable Care Act (the "Affordable Care Act") and the State of Ohio law regarding a continuation of coverage for Dependent children for Health and Prescription only, as follows:

## 1: Grandfathered Health Plan Status

The following provision is added to the Plan with respect to its status as a grandfathered health plan:

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at:

Wood County Commissioners
One Courthouse Square
Bowling Green, OH 43402
419-354-9100

You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

## 2: Definitions

The following term is added to the Plan and has the following meaning as set forth below:

"Essential Health Benefit" has the meaning found in section 1302(b) of the Affordable Care Act and as may be further defined by the Secretary of the United States Department of Health and Human Services. Essential Health Benefits includes the following general categories and the items and services covered within such categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

## 3: Lifetime Dollar Limits

The Plan is amended to remove any lifetime dollar limit under the Plan imposed on any Essential Health Benefit.

### *Enrollment*

The Plan is amended to provide that if an individual's coverage or benefits under the Plan had terminated due to reaching a lifetime dollar limit prior to the Effective Date of this Summary of Material Modification and Amendment; such individual will have an opportunity to re-enroll in the Plan during a special enrollment period. This special enrollment period is the first 30 days of the Plan Year that begins on or after September 23, 2010. For the purposes of this Plan, the special enrollment period is November 15, 2010 through December 15, 2010, with an effective date of January 1, 2011.

## 4: Annual Dollar Limits (for Health and Prescription)

The Plan is amended to remove any specific annual dollar limit imposed on any Essential Health Benefit and instead apply an overall annual dollar limit of $1,000,000 (1/1/2011); $1,250,000 (1/1/2012) and $2,000,000 (1/1/2013) to all benefits (including health care and prescription drug expenses combined). Effective as of 1/1/2014 this overall annual dollar limit is eliminated.

The Plan is further amended to apply an overall annual dollar limit of $1,000,000 for non-Essential Health Benefit plan costs.

## 5: Dental Benefits

The following Note will be added after the Dental Schedule of Benefits:

**NOTE:** The dental benefits provided under this Plan are limited-scope benefits and are offered separately from any medical coverage offered under the Plan. You have a separate right to enroll in the dental benefits under the Plan. If you choose to enroll in such dental benefit, you will be charged an employee contribution amount that is separate from what you are charged from any other benefit offered under the Plan. The amount of an employee contribution will be communicated to you prior to the annual open enrollment period.

## 6: Vision Benefits

The following Note will be added after the Vision Schedule of Benefits:

**NOTE:** The vision benefits provided under this Plan are limited-scope benefits and are offered separately from any medical coverage offered under the Plan. You have a separate right to enroll in the vision benefits under the Plan. If you choose to enroll in such vision benefit, you will be charged an employee contribution amount that is separate from what you are charged from any other benefit offered under the Plan. The amount of an employee contribution will be communicated to you prior to the annual open enrollment period.

## 7: Rescission

Any provision of the Plan that describes the right of the Plan Administrator to rescind coverage under the Plan is amended to permit the Plan Administrator to rescind or void the coverage of an individual only if (1) the individual (or person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud; or (2) the individual (or person seeking coverage on behalf of the individual) makes an intentional misrepresentation of a material fact.

The Plan is further amended to provide that in the event of a rescission of coverage the Plan Administrator will provide 30-days advance written notice of such rescission to each affected individual.

For purposes of this section the terms "to rescind" or "rescission" shall mean a cancellation or discontinuance of coverage retroactively, but does not include a retroactive cancellation for non-payment of premiums.

## 8: Prohibition on Pre-Existing Conditions for Children

Any provision under the Plan with respect to a pre-existing condition limitation is amended to provide that such provision does not apply to any covered individual under the age of 19.

## 9: Extension of Dependent Coverage to Age 26 (for Health and Prescription Only)

To the extent that the Plan defines a Dependent Child to include any of the children listed below, coverage for such child shall continue until the end of the month in which such child attains age 26 (the "limiting age") regardless of the child's financial dependency on the covered Employee; tax dependency; marital status; residency with the covered Employee or any other person; student status; or employment status; provided such child is not eligible for other employer sponsored coverage (other than through that of a parent).

The previous sentence applies to a covered Employee's (a) natural born son or daughter, (b) legally adopted child, or (c) eligible child for whom the Employee is legal guardian, to the extent that the Plan's definition for Dependent Child already includes such child.

Any provision of the Plan that indicates eligibility for coverage for a child listed above is based on any factor other than the relationship between the child and a covered employee is hereby deleted. The "Eligible Classes of Dependents" and "When Dependent Coverage Terminates" subsections of Section II. Eligibility, Funding, Enrollment, Effective Date and Termination Provisions are revised as shown in Exhibit A.

*Special Enrollment*

The Plan is further amended to provide that if a covered Employee's natural born son or daughter, legally adopted child or an eligible child for whom the Employee is legal guardian was terminated from the Plan prior to the Effective Date of this Summary of Material Modification and Amendment due to failure to satisfy the dependent eligibility requirements under the Plan; or was denied or was not eligible for enrollment in the Plan due to failure to meet such eligibility requirements; then such child and his/her parent-employee (if not already enrolled) will have an opportunity to enroll in the Plan during a special enrollment period. This special enrollment period is the first 30 days of the Plan Year beginning on or after September 23, 2010. For the purposes of this Plan, the special enrollment period is November 15, 2010 through December 15, 2010, with an effective date of January 1, 2011.

**10: The Schedule of Benefits**

The Schedule of Benefits is amended to read as indicated on Exhibit B, attached hereto and made a part hereof.

**11. Internal Appeals (for Health Only)**

As of the Effective Date of this Summary of Material Modification and Amendment, all claimants shall be required to submit all internal appeals to the following:

For medical claims: Meritain Health, Inc.<br>Appeals Department<br>P. O. Box 1380<br>Amherst, NY 14226-1380

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- **A new subsection will be added for health and prescription eligibility only following the subsection entitled "When Dependent Coverage Terminates" to read as follows:**

  **Extended Coverage for Dependents to Age 28.** Ohio law requires the Plan to provide continuation of coverage for the natural children and adopted children of an Employee who are eligible Dependents as of the date such children cease to be eligible for coverage under the Plan due to reaching the limiting age. Upon ceasing to be an eligible Dependent as described above, the eligible Dependent Child will be given the opportunity to continue coverage under the Plan until the date he/she attains age 28 if all of the following are true:

  - the Dependent Child is covered under the Plan;
  - the Dependent Child is unmarried;
  - the Dependent Child is a resident the State of Ohio or a full-time student at an accredited public or private institution of higher education;
  - the Dependent Child is not employed by an employer that offers any health benefit plan under which such child is eligible for coverage; or
  - the Dependent Child is not eligible for Medicare or Medicaid.

This extension of coverage for a Dependent Child shall not terminate upon attainment of age 28 if the child is and continues to be both of the following:

- Incapable of self-sustaining employment by reason of mental retardation or physical handicap;
- Primarily dependent upon the eligible Employee for support and maintenance.

The eligible Employee must make an election to continue coverage for the Dependent Child, on a form prescribed by the Employer, within thirty-one (31) days following the date such child attains the limiting age. If an eligible Employee fails to make an election to continue coverage under this provision within the required timeframe or if coverage under this provision terminates, the child will be eligible to make an election to continue coverage in accordance with the COBRA Continuation Options section of this Plan.

The eligible Employee or Dependent Child is required to pay the entire amount of the cost of coverage for the Dependent Child, at a dependent coverage rate determined by the Plan. The cost of coverage will be determined by the Employer and communicated to the Employee and/or the Extended-Coverage Child. Any required contribution for this extension of coverage must be paid on an after-tax basis to the Plan Administrator no later than the last day of each month such child is eligible for coverage. Failure to make such payment within the required timeframe may result in a loss of coverage under this provision.

The Employer, in its sole discretion, may request at anytime (but not more frequently than annually) proof of eligibility for continuation of coverage under this provision. Failure to provide proof within thirty-one (31) days of such request will result in termination of coverage under this provision.

## EXHIBIT A

**Eligible Classes of Dependents**

Dependent is any one of the following persons:

**(1)** A covered employee's lawful Spouse. Lawful Spouse shall mean the legally recognized marital partner of a covered employee, who is neither divorced nor legally separated from the employee. The Plan Administrator may require documentation proving a legal marital relationship.

The following rules apply to Spouses seeking primary coverage with the Wood County Employees' Health, Prescription, Vision & Dental Plans ("Plans"):

**(a)** Spouses whose annual adjusted gross income is less than (See the Summary Plan Description) may remain with the Plans for primary coverage at no additional cost;

**(b)** Spouses whose annual adjusted gross income is (See the Summary Plan Description) may remain with the Plans for primary coverage by paying a spousal premium, called a Family Plus Rate, collected on a monthly basis through the employee's payroll deduction for each type of insurance coverage (i.e., health, prescription, vision and/or dental);

**(c)** Spouses whose annual adjusted gross income is greater than (See the Summary Plan Description) are not eligible for primary coverage under the Plans. Spouses may be carried as secondary under the employee's family contract if primary coverage is verified by the Spouse.

Employees seeking to cover their Spouse must provide proof of spousal income on an annual basis in a form acceptable to the Plan Administrator. Failure to provide satisfactory proof will result in loss of eligibility under the Plan.

The Employer has the right to recover benefit payments made during a period of time a Spouse failed to meet the requirements of an eligible Dependent.

See the Hardship Review Committee's Policy and Procedure for additional information.

* See current year's Summary Plan Description for annual rates.

**(2)** (A) With respect to Health and Prescription Drug benefits only, a covered Employees Dependent Child until the end of the calendar month in which he/she attains the limiting age of 26, provided such child is not eligible for coverage through another employer-sponsored group health plan, other than one available through his or her parent's employer.

**NOTE:** Please see the section entitled "Extended Coverage for Dependents to Age 28" for continuation of coverage under the Plan beyond the limiting age described above.

A Dependent Child shall mean a covered Employee's natural born son, daughter, legally adopted child (or a child placed with the covered Employee in anticipation of adoption), or an eligible child for whom the covered Employee is legal guardian. Coverage for a child for whom the covered Employee is legal guardian will remain in effect until such child no longer meets the age requirements of an eligible Dependent under the terms of the Plan, regardless of whether or not such child has attained age 18 (or any other applicable age of emancipation of minors).

(B) With respect to Dental and Vision benefits only, a covered employee's children are eligible for coverage from birth until the end of the Calendar Year in which they reach the limiting age of 19 years, or if they are a Full-time Student at an accredited school, until the end of the Calendar Year in which they reach the limiting age of 23.

Full-time Student coverage continues only between semesters/quarters if the student is enrolled as a Full-time Student in the next regular semester/quarter. The Plan Administrator will require proof of status on an annual basis in a form acceptable to the Plan Administrator.

A Full-Time Student will remain covered during any regular scheduled break in the educational institution's full-time curriculum (such as spring or summer break), as long as the Dependent Child was a Full-Time Student the quarter/semester before the break and is a Full-Time Student again he quarter/semester following the break. If the student is not enrolled as a Full-Time Student in the next regular term or at any time drops below the minimum number of credit hours during a semester to maintain Full-Time Student status, coverage under the Plan will be terminated retroactively to the last day of the calendar month in which the last attended school term ended, unless such student applies for and is approved for a Medically Necessary Leave of Absence. If a student is approved for a Medically Necessary Leave of Absence coverage under the Plan will continue until the earlier of (1) one year after the first day of the approved Medically Necessary Leave of Absence or (2) the date under which coverage under the Plan would otherwise terminate (refer to the section of the Plan entitled "When Dependent Coverage Terminates").

For purposes of this section a Medically Necessary Leave of Absence with respect to a Dependent Child is a leave of absence or any other change in enrollment of such child from a postsecondary educational institution (including an institution of higher education as defined in Section 102 of the Higher Education Act of 1965) where such leave is considered Medically Necessary and begins when the Dependent Child is suffering from a serious Illness or Injury which causes the Dependent Child to lose his or her full-time student status under the Plan.
A Dependent Child must submit a written request to the Plan Administrator in order to continue coverage under the Plan due to a Medically Necessary Leave of Absence. Such request must include a certification from the Dependent Child's treating Physician indicating that the child is suffering from a serious Illness or Injury and that the leave of absence or change in enrollment from a postsecondary educational institution is Medically Necessary.

The Employer has the right to recover benefit payments made during a period of time a Dependent Child failed to meet the requirements as a Full-Time Student, for reasons other than an approved Medically Necessary Leave of Absence.

A Dependent Child shall include natural children and children under the legal guardianship of a covered employee or a covered employee's Spouse, legally adopted children or children placed with a covered employee in anticipation of adoption who are:

- **(a)** unmarried; and
- **(b)** not employed on a regular full-time basis; and
- **(c)** not covered under the Plan as an employee; and
- **(d)** dependent on the covered employee or the covered employee's Spouse for more than 50% of their financial support; and
- **(e)** dependents for tax exemption purposes under Section 152 of the Internal Revenue Code.

**(3)** A child for whom the covered Employee is required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO may be obtained from the Plan Sponsor at no cost.

For purposes of this section, the term "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 an individual that is placed with such person by judgment, decree, or other order of any court of competent jurisdiction.

The Plan Administrator may require proof of legal guardianship/adoption status in a form acceptable to the Plan Administrator.

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 (even when a court order has been issued requiring the covered employee to provide health insurance for the divorced Spouse); a Spouse who is on active duty in any military service of any country; or any person who is covered under the Plan as an employee.

No person may be covered under this Plan as both an employee and a Dependent. 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 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. No person may be covered as a Dependent of more than one employee.

## 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 a continuation of coverage under State or Federal Law, as applicable. For a complete explanation of continuation of coverage options, as well as when such options are available, see the sections entitled Continuation Coverage Rights under COBRA and Extended Coverage for Dependents to Age 28):

**(1)** The date the Plan is terminated.

**(2)** The date that the employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Option.)

**(3)** The date Dependent coverage is terminated under the Plan.

**(4)** On the last day of the calendar month that a Dependent Child ceases to be a Dependent as defined by the Plan. (See the COBRA Continuation Option.)

**(5)** The date a covered Spouse loses coverage due to loss of dependency status.

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

As stated in the Eligibility section of this Plan for Dental and Vision benefits, Full-time Student coverage continues only between semesters/quarters 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 calendar month in which the last attended school term ended, unless such student applies for and is approved for a Medically Necessary Leave of Absence.

## Extended Coverage due to a Mental or Physical Handicap

Coverage for a Dependent Child will continue beyond the limiting age if such child is unable to be self supporting by reason of mental or physical handicap and is incapacitated; provided the child suffered such incapacity prior to the end of the month in which he/she attains the limiting age. The child must be unmarried

and primarily dependent upon the covered Employee for support. The Plan Sponsor may require subsequent proof of the child's disability and dependency, including a Physician's statement certifying the child's physical or mental incapacity.

The covered employee must provide satisfactory written proof of the child's incapacity to the Plan Administrator within 60 days following attainment of the limiting age or within 60 days after the employee first becomes a Covered Person under this Plan, whichever is later. 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 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.

**Extended Coverage for Dependents to Age 28 – this provision only applies to Health and Prescription Drug benefits.** Ohio law requires the Plan to provide continuation of coverage for the natural children and adopted children of an Employee who are eligible Dependents as of the date such children cease to be eligible for coverage under the Plan due to reaching the limiting age. Upon ceasing to be an eligible Dependent as described above, the eligible Dependent Child will be given the opportunity to continue coverage under the Plan until the date he/she attains age 28 if all of the following are true:

- the Dependent Child is covered under the Plan;
- the Dependent Child is unmarried;
- the Dependent Child is a resident the State of Ohio or a full-time student at an accredited public or private institution of higher education;
- the Dependent Child is not employed by an employer that offers any health benefit plan under which such child is eligible for coverage; or
- the Dependent Child is not eligible for Medicare or Medicaid.

This extension of coverage for a Dependent Child shall not terminate upon attainment of age 28 if the child is and continues to be both of the following:

- Incapable of self-sustaining employment by reason of mental retardation or physical handicap;
- Primarily dependent upon the eligible Employee for support and maintenance.

The eligible Employee must make an election to continue coverage for the Dependent Child, on a form prescribed by the Employer, within thirty-one (31) days following the date such child attains the limiting age. If an eligible Employee fails to make an election to continue coverage under this provision within the required timeframe or if coverage under this provision terminates, the child will be eligible to make an election to continue coverage in accordance with the COBRA Continuation Options section of this Plan.

The eligible Employee or Dependent Child is required to pay the entire amount of the cost of coverage for the Dependent Child, at a dependent coverage rate determined by the Plan. The cost of coverage will be determined by the Employer and communicated to the Employee and/or the Dependent Child. Any required contribution for this extension of coverage must be paid on an after-tax basis to the Plan Administrator no later than the last day of each month such child is eligible for coverage. Failure to make such payment within the required timeframe may result in a loss of coverage under this provision.

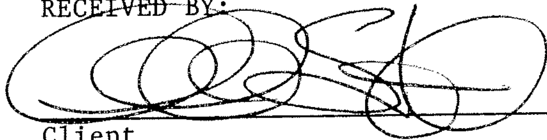
The Employer, in its sole discretion, may request at anytime (but not more frequently than annually) proof of eligibility for continuation of coverage under this provision. Failure to provide proof within thirty-one (31) days of such request will result in termination of coverage under this provision.

**Termination of Benefits While an Inpatient.** If Participants are an Inpatient of a Hospital or Skilled Nursing Facility on the day coverage stops, the benefits listed under the Inpatient Services section, subsections Bed, Board and General Nursing Services and Ancillary Services only, subject to any changes in the Plan's benefits, will continue until the earliest of:

- the Plan pays the maximum benefits; or
- discharge from the Hospital or Skilled Nursing Facility; or
- the end of the period for which payment was made; or
- another group health coverage is in effect for the condition that requires the Inpatient Hospital or Skilled Nursing Facility care; or
- the death of the subscriber.

EFFECTIVE DATE: January1, 2011

RECEIVED BY:



Client

1/23/2012
Date

## EXHIBIT B

# Schedule of Benefits

The Schedule of Benefits is merely an outline of the amount of benefits payable under the Plan for Covered Persons. **Subsequent pages describe how and when those benefits are payable and the limitations and exclusions applying to the benefits.**

**Maximum Lifetime and Annual Health and Prescription Expense Benefits**

| **Essential Health Benefits:** | |
|---|---|
| **Maximum overall Lifetime** | Unlimited |
| **Maximum Annual Per Covered Person on Essential Health Benefits for Health and Prescription Benefits** | $1,000,000 (1/1/2011)<br>$1,250,000 (1/1/2012)<br>$2,000,000 (1/1/2013)<br>Unlimited (1/1/2014) |
| **Maximum overall Annual benefit on all Non-Essential Health Benefits** | $1,000,000 |
| **Maximum Lifetime benefit for surgical procedures for weight control and any related complication or services following these procedures** (effective January 1, 2004) | $15,000 per Covered Person |
| **Maximum Lifetime benefit for vision therapy** | 1 course of treatment per Covered Person, maximum 32 visits |

**Comprehensive Health Expense Benefits**
For Employees and Dependents

Utilization Review – The covered employee is responsible for notifying the Medical Manager (see Summary Plan Description) about any Hospital confinement or Outpatient service requiring Pre-Certification for himself or his covered Dependents. If the Medical Manager is not notified, **the covered employee is responsible for paying the full amount of covered charges for the confinement or service.** The covered employee may appeal the claims by contacting the Medical Manager, upon appeal, all of the medical records will be reviewed, and if the services rendered are found to be Medically Necessary, charges may be paid at 50% of the benefit level. This additional out-of-pocket amount does not apply toward satisfying any Deductible or Co-insurance limit of the Plan.

| **Benefit Period** | Calendar Year |
|---|---|

| **Calendar Year Deductible Amount** | **Network Providers** | **Non-Network Providers** |
|---|---|---|
| Individual | $150 per Covered Person | $300 per Covered Person |
| Family | $450 per Family | $900 per Family |
| Network and Non-Network Deductible amounts each apply toward satisfying the other. | | |

| Co-insurance Limit per Calendar Year | Network Providers | Non-Network Providers |
| --- | --- | --- |
| Individual | $250 per Covered Person | $500 per Covered Person |
| Family | $750 per Family | $1,500 per Family |
| Once the Individual and Family Co-insurance amounts total the amounts shown above for a Covered Person or family during any one Calendar Year, the Plan will pay 100% of the benefit level as indicated under the Covered Benefits section. | | |
| The following charges do not apply toward meeting the Co-insurance limit, nor is the benefit percentage for these charges increased to the benefit level as indicated in the Schedule of Benefits once the Co-insurance limit is met:<br>• Any Calendar Year Deductible amount required by the Plan;<br>• Professional and Technical Service Fees;<br>• Any benefit penalty for non-compliance with Plan provisions;<br>• Charges not covered by the Plan;<br>• Charges in excess of the maximum Benefits payable by the Plan. | | |
| Network and Non-Network Co-insurance amounts each apply toward satisfying the other. | | |
| | **Network Providers** | **Non-Network Providers** |
| Professional Service Fee – for all Physician and specialist office visits | $10 | $10 |
| Technical Service Fee – for all emergency room visits | $35 | $35 |
| The Professional and Technical Service Fees do not apply toward the Deductible or Co-Insurance features of the plan. | | |

| Co-pays, Benefit Percentages and Co-insurance Amounts | | | |
| --- | --- | --- | --- |
| **Covered Charges** | **Network Providers** | **Non-Network Providers** | **Benefit Limits (Network and Non-Network combined)** |
| **Mental Disorders and Substance Use Disorders** | | | |
| Inpatient | After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit. | Daily room & board charges limited to the Hospital's Semi-Private room rate<br><br>Pre-Certification Required |

| Co-pays, Benefit Percentages and Co-insurance Amounts | | | |
|---|---|---|---|
| **Covered Charges** | **Network Providers** | **Non-Network Providers** | **Benefit Limits (Network and Non-Network combined)** |
| **Mental Disorders and Substance Use Disorders (continued)** | | | |
| Outpatient:<br>Physician's Office visit: | After $10 copay, paid 80% after deductible. You pay the other 20%, subject to the Co-insurance limit. | After $10 copay, paid 60% after deductible. You pay the other 40%, subject to the Co-insurance limit. | |
| Outpatient (all other items and services) | After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit. | |
| Emergency Care | After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | Paid at the Network Provider level of benefits | |
| **Other Services** | | | |
| Ambulance | After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | |
| Durable Medical Equipment | After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit. | Hearing Aids are limited to a maximum payment of $3,000 per Covered Person every 4 years |

| Co-pays, Benefit Percentages and Co-insurance Amounts | | | |
|---|---|---|---|
| **Covered Charges** | **Network Providers** | **Non-Network Providers** | **Benefit Limits (Network and Non-Network combined)** |
| Extended Care Facility/Skilled Nursing Facility | After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit. | Daily room & board limited to the facility's Semi-Private room rate<br><br>**Pre-Certification Required** |
| Home Health Care/ Hospice | After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit. | Home Health Care services are limited to 120 visits per Calendar Year |
| Hospital Services: | After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit. | Daily room & board charges limited to the Hospital's Semi-Private room rate<br><br>**Pre-Certification Required** |
| Hospital Services:<br><br>*Emergency room for Injury or Medical Emergency* | You pay a $35 technical service fee per visit, then after the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | You pay a $35 technical service fee per visit, then after the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit. | **Treatment must be rendered within 72 hours of onset of symptoms**<br><br>For a definition of Medical Emergency, refer to the Definitions section of this Booklet (*Section IX*) |
| Hospital Services:<br><br>Emergency Room for Illness that does not qualify as a Medical Emergency | Not covered. | Not covered. | |
| Hospital Services:<br><br>*Outpatient Services* | After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit. | |

| Co-pays, Benefit Percentages and Co-insurance Amounts | | | |
|---|---|---|---|
| **Covered Charges** | **Network Providers** | **Non-Network Providers** | **Benefit Limits (Network and Non-Network combined)** |
| Hospital Services: Pre-Admission Testing | The Plan pays 100% of Covered Charges. | | Not subject to Deductible or Co-insurance |
| Physician Services: Musculoskeletal Manipulations, Adjustments and Related Modalities (chiropractic care/ spinal manipulations) | After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit. | Limited to 12 visits per Calendar Year<br><br>Note: Professional service fee will apply if office visit charge is made |
| Physician Services: Second Surgical Opinions | The Plan pays 100% of Covered Charges. | | Not subject to Deductible or Co-insurance |
| Physician Services: Inpatient and Outpatient, including Office Surgical Procedures, | After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit. | Note: Professional service fee will apply if office visit charge is made |
| Private-Duty Nursing | After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit. | |
| Routine Preventive Care (Outpatient):<br><br>Well-Infant Care up to age 1 year | After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | After the Deductible and is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit. | Note: Professional service fee will apply if office visit charge is made |
| Routine Preventive Care (Outpatient):<br><br>Well-Child Care for ages 1 year through 16 years | After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit. | Note: Professional service fee will apply if office visit charge is made |

| Co-pays, Benefit Percentages and Co-insurance Amounts | | | |
|---|---|---|---|
| **Covered Charges** | **Network Providers** | **Non-Network Providers** | **Benefit Limits (Network and Non-Network combined)** |
| Routine Preventive Care (Outpatient):<br><br>Physician Charges for Pap Test, Mammogram, Gynecological Exam and Prostate Exam | You pay a $10 professional service fee per visit, then after the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | You pay a $10 professional service fee per visit, then after the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit. | Limited to 1 per Calendar Year |
| Routine Preventive Care (Outpatient):<br><br>Lab Charges for Routine Pap test and PSA | After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit. | Limited to 1 per Calendar Year |

| Co-pays, Benefit Percentages and Co-insurance Amounts | | | |
|---|---|---|---|
| **Covered Charges** | **Network Providers** | **Non-Network Providers** | **Benefit Limits (Network and Non-Network combined)** |
| Routine Preventive Care (Outpatient):<br><br>Routine Physical Exam from age 16 and above to include Routine Colonoscopies<br><br>Includes Diagnostic Services and Immunizations | After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit. | Note: Professional service fee will apply if office visit charge is made<br><br>Routine colonoscopies defined as:<br>• Under age 50 with routine diagnosis only<br>• Over age 50 if participant already had their colonoscopy within the 10 year period as stated below.<br><br>Routine Colonoscopies limited to a maximum Benefit of $500 per Calendar year<br><br>The following colonoscopies will be paid as a medical expense and not a routine benefit:<br>• Over age 50, once every 10 years<br>• Family history<br>• Medically Necessary colonoscopies<br>• Colonoscopies with diagnosis of any illness, when billed in conjunction with a routine diagnosis |

| Co-pays, Benefit Percentages and Co-insurance Amounts | | | |
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| **Covered Charges** | **Network Providers** | **Non-Network Providers** | **Benefit Limits (Network and Non-Network combined)** |
| Vision Therapy | After the Deductible is met, the Plan pays 50% of Covered Charges. You pay the other 50%, subject to the Co-insurance limit. | After the Deductible is met, the Plan pays 50% of Covered Charges. You pay the other 50%, subject to the Co-insurance limit. | Diagnosis of Strabismus is required for vision therapy services to be covered<br><br>Limited to 1 course of treatment per Lifetime, maximum of 32 visits<br><br>Note: Professional service fee will apply if office visit charge is made<br><br>No coverage for home therapy |
| All Other Therapy services | After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit. | Occupational and Physical Therapy Services are limited to 30 visits per Calendar Year<br><br>**Occupational and Physical Therapy services combined require Pre-Certification for any visits in excess of 15 per Calendar Year**<br><br>Note: Professional service fee will apply if office visit charge is made |

| Co-pays, Benefit Percentages and Co-insurance Amounts | | | |
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| **Covered Charges** | **Network Providers** | **Non-Network Providers** | **Benefit Limits (Network and Non-Network combined)** |
| All Other Covered Charges<br>- Diagnostic Services (non-Hospital)<br>- Medical Supplies<br>- Oxygen<br>- Prosthetics<br>- Diabetic Nutritional Counseling*<br>- Wig or Artificial Hairpiece** | After the Deductible is met, the Plan pays 80% of Covered Charges. You pay the other 20%, subject to the Co-insurance limit. | After the Deductible is met, the Plan pays 60% of Covered Charges. You pay the other 40%, subject to the Co-insurance limit. | * Diabetic Nutritional Counseling:<br>- Coverage limited to Covered Persons diagnosed with Diabetes only<br>- Limited to 2 sessions per Calendar Year<br>- Professional service fee will apply if office visit charge is made<br><br>** Wig or Artificial Hairpiece:<br>- Limited to 3 wigs per Lifetime |