Wayne County Employee Benefit Manual

Wayne County Employee Benefit Plan

The Decisions we make

as individuals

affect all of us!!

OUR
WAYNE COUNTY
EMPLOYEE BENEFIT PLAN
IS
SELF INSURED

Per Merriam-Webster.com, the definition of
"Self Insurance"
is
"Insurance of oneself or of one's own interests
by the setting aside of money at regular intervals
to provide a fund to cover possible losses"

Health Plan Fiscal Recap

Where our claims dollars are typically spent
23% Prescription Medicine
20% Inpatient Hospital Charges
17% Outpatient Facility Charges
15% Outpatient X-Ray and Lab
12% Doctors visits, including specialists
7% Dental
5% Emergency Room
.6% Chemotherapy and Radiation Therapy
.3% Mental Health Visits Outpatient
.1% Other

Wayne County Employee Benefit Plan

Emergency room visits cost about $900 each visit
- **Patient Average Out of Pocket = $100**
- **Employee Out of Paycheck = $160**

Physician Office visits cost about $60 each visit
- **Patient Average Out of Pocket = $20**
- **Employee Out of Paycheck = $8.00**

Wayne County Employee Benefit Plan

The Decisions we, as individuals, make on a daily basis affect what everyone else in this room pays, and what our Employer has available to fund our raises!!

Wayne County Employee Benefit Plan

We can all get involved and work to get healthier or stay healthy and try to keep our cost of Self Insurance down!!

Wayne County Employee Benefit Plan

Two areas of opportunity are:

- Becoming Smarter Consumers of Healthcare
- Wellness, reducing our use of Healthcare

Wayne County Employee Benefit Plan

Consumerism

- **Do you know your doctor's last customer satisfaction rating?**
- **Did you ask your doctor if there were alternatives to medicine?**
- **Did you take notes at your last doctors visit?**
- **Do you have a list of the medicine you take?**
- **Do you know there is a link between your Oral Health and your overall Health?**

Wayne County Employee Benefit Plan

Consumerism (cont.)

- Do you know your surgeons post operative rate of infection?
- Do you know your surgeons re-admission rate within one week of surgery?
- Do you know what you should have done/tested annually for your condition?
- Do you know what "Never" events are?

Wayne County Employee Benefit Plan

Wellness Programs

- Imagine the Medical Bills that you will never incur if the Wellness Program helps you to Stop Smoking, Lose Weight, Eliminate or Control Diabetes, High Blood Pressure or High Cholesterol!!
- You will feel better and have more quality time to spend with the ones you love, doing what you like to do!!

Health Clinic/ Incentives

- Employee Health Clinic
- Consumer Incentive (High-Ded)
- Health First Wellness Incentive (Low-Ded)
- Learn About Your Health Risks
- Engage In Your Health
- Wellness Website
- Forms

Wayne County Commissioners

Employee Health Clinic

The Wayne County Employee Health Clinic opened in August 2019 to help make acute and preventative care more available and affordable. The Wayne County Employee Health Clinic has partnered with Everside Health, the leading provider of onsite health clinics, workplace wellness programs, and health management solutions for companies and their employees. Everside Health acts as a third party to manage the Wayne County Employee Health Clinic, providing a Nurse Practitioner.

Goals of the Wayne County Employee Health Clinic:

- Help make acute and preventive care more available and more affordable.
- Early detection of potential health risks to improve quality of life.
- Engage employees, spouses and dependents on the health plan in health promotion, prevention and health risk management activities, resulting in a healthier population.
- Lower the cost of primary care with an on-site Nurse Practitioner.
- Assist in the reduction of healthcare cost you pay and Wayne County pays each year.

Why Participate?

- **BE HEALTHIER** – Easily access Primary Care services to improve your health.
- **LIVE LONGER** – Engaging in health promotion, disease prevention and health risk management activities can increase life expectancy and quality of life.
- **SAVE MONEY** – PREVENTIVE VISITS ARE FREE. Non-preventive visits are $20 for those on the High Deductible plan and FREE for those on the PPO plan. Medications carried in stock are FREE for the first 30-day supply through the clinic. The cost to see the Wellness Nurse is FREE.
- **SAVE TIME** – Pre-scheduled appointments to eliminate long waits.

Employees, spouses and dependents aged 2+ currently on the Wayne County Health plan may access the Wayne County Employee Health Clinic.

Scope of Services: Case management, colds/flu/strep throat, disease management, dispensation of certain medications at the point of care, first aid, flu shots, health programs, lab work, phlebotomy services, physicals, referrals to PCPs and specialists, screenings, sinus infections, stress management, tobacco cessation, UTIs, weight loss, and wellness initiatives.

The Wayne County Employee Health Clinic is staffed with a Nurse Practitioner (NP) and Registered Nurse (RN). The NP is licensed in the State of Ohio to diagnose, treat and prescribe/dispense medications. Misty White, RN and Wellness Nurse, will continue to be available to take your vitals, draw blood, act as a case manager, and assist the NP.

If you have a Primary Care Physician (PCP), you are encouraged to maintain your relationship with him/her. The Wayne County Employee Health Clinic coordinates care and shares results with your PCP, with your permission. You can use the Wayne County Employee Health Clinic for lab services at a lower cost.

The Wayne County Employee Health Clinic will be able to dispense certain medications at the point of care. These medications MUST be prescribed by the NP during a visit. The dispensary cannot fill prescriptions from outside providers. Formulary includes top utilized medications and the medications used most commonly for diagnosis in a Primary Care Office. NARCOTICS OR CONTROLLED SUBSTANCES WILL NOT BE STOCKED. If the NP cannot supply the medication you need, she will write a prescription for you to take to your pharmacy and you will be billed at rates through the Health Plan.

You may schedule an appointment with the NP for a sick and/or preventive service or with the Wellness Nurse/RN for wellness services, Know Your Numbers and lab draws. Schedule with the NP when you feel sick or are ready for your annual and preventative exams. Schedule with the Wellness Nurse to have labs done, participate in the Know Your Numbers program or any other Wayne County Wellness Service.

Scheduling Instructions

To schedule with the Nurse Practitioner or Wellness Nurse:

1. Call the Wayne County Employee Health Clinic at 330-287-5487
2. Email the Wayne County Employee Health Clinic at clinic1@wayneohio.org
3. Use your online patient portal to schedule with the Nurse Practitioner after your first clinic appointment

Location and Hours of Operation

428 W. Liberty Street, Wooster, OH 44691 on the Main Floor of the Administration Building

NP Hours

Monday – 7 a.m. to 11:30 a.m., 12 p.m. to 2:30 p.m.
Wednesday - 7 a.m. to 11:30 a.m., 12 p.m. to 2:30 p.m.
Friday - 7 a.m. to 10:30 a.m.

Wellness Nurse/RN Hours*

Monday – 7 a.m. to 3 p.m.
Tuesday - 7 a.m. to 3 p.m.
Wednesday - 7 a.m. to 3 p.m.
Thursday - 7 a.m. to 3 p.m.**
Friday - 7 a.m. to 3 p.m.

Wellness Nurse will be available for blood draws from 7 a.m. to 1 p.m. on Monday/Wednesday/Friday only*

****Please note the Wellness Nurse does normally work one day a week remote – she is available via the clinic phone during those times.***

Consumer Incentive (High-Deductible Plan)

This Consumer Incentive has been set up as an incentive for taking steps to either maintain or obtain a healthy lifestyle. Taking healthy actions and becoming a better consumer of your healthcare has its rewards.

Qualifying individuals who choose the Wayne County High-Deductible Health Plan will get $400(single)/$800(family) deposited into a Health Savings Account (HSA). In addition, you will also have the opportunity to earn *extra* dollars into your designated HSA** through wellness incentives. COBRA members on the high-deductible plan are not eligible for employer HSA cash contributions or wellness incentives. *Example (single): You are on the plan January 1 but leave on April 30. The last deposit made to your account would be the money you earned from the March Wellness Incentives plus $33.34 for your April cash contribution.*

To earn *additional* dollars, you will need to meet with the Wellness Nurse four (4) times per year and perform various tests. Passage of these tests will place dollars into your HSA! The $500(single)/$1,000 (family) Wellness Incentive is earned quarterly and paid quarterly following the end of the month of the quarterly incentive opportunity (i.e. Wellness Incentive opportunity will be March, June, September and December).

Below is a breakdown of these tests:

Wellness Incentives	Requirement	Reward	Quarter Tested
Waist Measurement	Women ≤35; Men ≤40	$25.00	Quarter 1, 2, 3, 4
Blood Pressure	≤130/85	$25.00	Quarter 1, 2, 3, 4
LDL	≤99	$50.00	Quarter 1*, 3*
Blood Sugar	Fasting ≤99	$50.00	Quarter 1*, 3*
Urine Tobacco	Negative test *If negative 1st quarter, you may sign a waiver for second quarter test.*	$50.00	Quarter 1, 3

*If your first lab values are within normal range, we will use the numbers from those labs and you will not need them drawn again until the next draw year which runs on a 3-year cycle. If the blood sugar or LDL is out of normal range, you will still have the opportunity on the draw quarters to have the test that was out of range redrawn for free. If your doctor needs labs, provide us with a copy of the order, and we will draw what your doctor orders. (You will have a $20 copay for labs from your doctor).

Important Things to Know:

Once you have opened a Health Savings Account (HSA) at the bank of your choice, notify your Payroll Department of your account number, and they will begin depositing directly into this HSA account You may also request a debit card from your bank. This account can only be used for health reasons, such as doctor's appointments, prescriptions, etc.

The Wellness Nurse will send quarterly reminder letters the month prior to the Wellness Incentive to all eligible plan members.

In the event a member/spouse would become pregnant during the benefit year, the last BMI and the last lipid (LDL) numbers will be used to determine the reward amount. The blood pressure, blood sugar, and urine test will still be done and subject to the reward requirements as per current policy. However, due to the lipid panel not being accurate during pregnancy and the BMI also not being validated, we will use the numbers from the last quarter the BMI and lipids where obtained prior to the pregnancy, and they will be used to justify the reward and or lack of reward due to requirements. If the member/spouse has not been tested in the last year or is new to the program, he/she will not be eligible for the lipid (LDL) or BMI rewards until after the pregnancy.

***The annual contribution must be deposited into an HSA account. However, earned dollars may go into an HSA account – or an account other than an HSA. Please keep in mind that any account other than an HSA will be subject to tax.*

Questions?

Contact the Wellness Nurse at 330-287-5487 or wellnessnurse@wayneohio.org.

Updated 12/30/23

Health First Wellness Incentive (Low-Ded Plan)

The Health First Wellness Incentive has been set up as a reward for taking steps to either maintain or obtain a healthy lifestyle. Taking healthy actions and becoming a better consumer of your healthcare has its rewards.

When you complete five (5) wellness incentive activities and update your HRA before November 15th, you will be eligible to earn the Wellness Incentive of lower co-pays, lower deductibles and lower co-insurance for the next year.

Are You New To The Insurance Plan?

If you are new to the insurance plan, you must complete your HRA within the first thirty (30) days of being insured in order to earn the Health First Wellness Incentive for the current year. In order to do this, you must have current lipid panel numbers, blood sugar number, and your current blood pressure reading. If you already had these done by your healthcare provider, you may use those numbers – but you will need to provide those numbers to the Wellness Nurse for verification. It is your responsibility to contact the Wellness Nurse to perform this necessary testing, which is free of charge.

If you are an employee that is pregnant when joining the plan or is joining the plan due to the qualifying event of giving birth, you must complete the HRA within the first thirty (30) days of joining the plan and schedule a blood draw for 4-6 weeks after the baby's birth. After the blood draw is done and your HRA has been completed, your plan will be changed to the incentive plan effective the date that your HRA was completed.

The Wellness Incentive is always earned one year ahead, so if you wish to be eligible for the incentives in the next year, you will need to earn points based on your first day of being insured (see dates below). Keep in mind that the Wellness Incentive is always optional; you may choose to not participate in the current year (by not completing your HRA in the first 30 days), but may choose to earn incentive points and complete the HRA for the next calendar year. Without the Wellness Incentive, you will be on the Base Plan Without Incentive and will pay higher co-pays, higher deductibles and higher co-insurance.

Follow this chart in order to be eligible for the incentive:

- November 16 through June 30 – Five (5) wellness points*
- July 1 through August 31- Three (3) wellness points*
- September 1 through September 30 – Two (2) wellness points*
- October 1 through November 15 – Zero (0) wellness points*

***In addition to the above points which must be earned, you must also submit verified labs and complete/update your HRA by the November 15th deadline.**

	Plan Start Date			
	Jan 1 – June 30	July 1 – Aug 31	Sept 1 - 30	Oct 1 – Dec 31
First 30 Days *Earns for current calendar year*	**Appointment**: Get verified labs at the Health Clinic **HRA**: Complete a Health Risk Assessment using your labs	**Appointment**: Get verified labs at the Health Clinic **HRA**: Complete a Health Risk Assessment using your labs	**Appointment**: Get verified labs at the Health Clinic **HRA**: Complete a Health Risk Assessment using your labs	**Appointment**: Get verified labs at the Health Clinic **HRA**: Complete a Health Risk Assessment using your labs
By Nov 15th of current year *Earns for next calendar year's insurance*	**5 Wellness Points** **Verified Labs**: Complete draw or have on file at the Health Clinic **HRA:** Complete or update your Health Risk Assessment	**3 Wellness Points** **Verified Labs**: Complete draw or have on file at the Health Clinic **HRA:** Complete or update your Health Risk Assessment	**2 Wellness Points** **Verified Labs**: Complete draw or have on file at the Health Clinic **HRA:** Complete or update your Health Risk Assessment	**0 Wellness Points** Must have completed requirements for First 30 days.
Nov 16th - Nov 15th every year *Earns for each following calendar year*	**5 Wellness Points** **Verified Labs**: Complete draw or have on file at the Health Clinic **HRA:** Complete or update your Health Risk Assessment	**5 Wellness Points** **Verified Labs**: Complete draw or have on file at the Health Clinic **HRA:** Complete or update your Health Risk Assessment	**5 Wellness Points** **Verified Labs**: Complete draw or have on file at the Health Clinic **HRA:** Complete or update your Health Risk Assessment	**5 Wellness Points** **Verified Labs**: Complete draw or have on file at the Health Clinic **HRA:** Complete or update your Health Risk Assessment

Yearly Incentive Opportunity

Every year after this, you must earn the full five (5) points, in addition to completing/updating your HRA!

Remember, we work one year ahead on points, so even if you do not have to earn points for the first full year of being an eligible member on the plan, you will need to earn points for the second year (if you want the incentive).

Points are earned between November 16th of one year and November 15th of the next year. For example, in order to be eligible for the incentive in the calendar year of 2025, you need to earn your five (5) points and update your HRA between November 16, 2023 and November 15, 2024.

How to Earn Incentive Points

Please refer to the wellness point chart for the specific requirements and limitations for each point. Below is a general listing of point options you may qualify for:

Preventative Health Check-Ups

Log on to the wellness website for the appropriate forms you'll need to take to your appointment:

- ☐ Routine physical exam
- ☐ Certain cancer screenings (based on age)
- ☐ One (1) Dental check-ups in 365 days
- ☐ Eye exam
- ☐ Flu shot
- ☐ And MORE!

Exercise

Join a league sport, take exercise or dance class, or simply log your daily activities – each will earn you wellness points!

Weight Management

Programs throughout the year with the Wellness Nurse or provided by your healthcare provider may qualify.

Wellness Education

- ☐ Attend on-site or off-site informational programs (example: brown bag or lunch and learn)
- ☐ Online learning opportunities
- ☐ Participate in the "Know Your Numbers" program (requires you have your blood drawn and the results reviewed with the Wellness Nurse) and the "Healthy Now" program (having BMI, blood sugar level, blood pressure, triglycerides and cholesterol levels within recommended ranges and being tobacco free earns extra points during the KYN program). These programs run May 1st through October 1st of each year. Your spouse MUST earn at least one (1) point but MAY earn a second point towards your incentive.

Changes For A Healthier Life

Earn wellness points when you achieve specific health goals. Becoming tobacco-free is one example. See the wellness point chart (at the back of this section or on the wellness website) for a complete listing.

Diagnosed Conditions

If you are diagnosed with diabetes, high cholesterol, high blood pressure or asthma, you can earn up to three (3) wellness points by focusing on your condition. You must notify the Wellness Nurse before following this option.

If you have further questions, contact the Wellness Nurse at 330-287-5487 or wellnessnurse@wayneohio.org

Learn About Your Health Risks

When it comes to your health, knowledge is the key. By taking a simple, 15-minute online Health Risk Assessment (HRA), you take a snapshot of your current health condition and then you are able to look at your current health risks and decide goals to help you either maintain or obtain a healthy lifestyle.

Here's How To Register To Take Your HRA:

1. You must have current verified blood draw numbers. These can be obtained for free with the Wellness Nurse at the Wayne County Employee Health Clinic.
2. Register on my.Cigna.com by creating a User ID and Password. You will need to enter your Social Security Number or Member ID from your ID card (it starts with "U") as part of the verification process.
3. Login to my.Cigna.com using the new User ID and Password.
4. There are two ways to get to the Health Risk Assessment (HRA). You can scroll to the bottom of the Home page and click on the box that says Take Health Assessment, or you can click on the Wellness tab and select Health Assessment from the drop down options.
5. Read the Health Assessment Privacy Notice and click "I agree" to accept.
6. Answer each question and section in the assessment. (You cannot move to the next section if you leave a blank). Once at the end, you will see an option to see your score. You can email a copy of the confirmation number to yourself for your records. Please write your name, confirmation number, and date at the top of the HRA Completion Verification form. Please make sure you name is included on all forms! Without a name, the Wellness Nurse will not be able to process your paperwork. Follow the instructions on the HRA Completion Verification Form on how to submit completed form to the Wellness Nurse. If this form is not submitted or is received without a name, it will not count.

   You can easily finish this in about 15 minutes.

Engage In Your Health

LAB SAVINGS PROGRAM

Lab orders obtained from your doctor can be faxed to the Wayne County Employee Health Clinic at **330-262-2054** (this is a secure line). Once labs are received, we will schedule your appointment for a blood draw. Please include contact information with lab orders. If a lab order is needed immediately, please call the Wayne County Employee Health Clinic at **330-287-5487**.

At the Wayne County Employee Health Clinic, we utilize LabCorp to provide you a reliable, inexpensive option that will save you money, as well as save money in our self-insured health care plan. Please note, any lab work through our Clinic will be at zero cost. If you choose to utilize Wooster Community Hospital or any other lab including LabCorp draw centers, there will be a co-pay. Once a lab order is received and reviewed, you will be advised on what preparation will be needed for your appointment.

Important! If you have labs done by anyone other than our Wellness Nurse, always check to determine if those labs are sent to an in-network or out-of-network facility. Even an in-network doctor may choose to send labs to an out-of-network facility, costing you additional dollars!

Questions?

Contact the Wayne County Employee Health Clinic at 330-287-5487 or email the Clinic Nurse at wellnessnurse@wayneohio.org. To schedule a lab draw with your doctor's order, email the Clinic Receptionist at clinic1@wayneohio.org. The Wayne County Employee Health Clinic is located on the main level of the Administration Building.

Updated 12/30/23

Wellness Website

http://www.wayneohio.org
(Click on "Wellness Entrance")

This site is designed to be a place for you to keep up-to-date on your wellness benefits. This is a secure website which you can access 24/7, from the comfort of your home or office. You will need to register for this site. However, once you are registered, you can find educational information and work on earning your wellness incentives right from your personal computer.

Here's What You Will Find On The Wellness Website:

- ☐ News from the Wellness Nurse
- ☐ Articles and Flyers
- ☐ Wellness Point Credits Information and Forms
- ☐ Current Program Information
- ☐ Online Tests to Earn Wellness Points (only a few – once utilized it will not be an option for future use)
- ☐ Individual Point Tracking (found under *Employee Account Info*)
- ☐ Health Risk Assessment Link
- ☐ Health-Related Web Sites
- ☐ Summary Plan Description

How To Register For The First Time OR To Log In To Your Account:

1. Visit http://www.wayneohio.org
2. At the bottom of the screen, click on *Wellness Entrance*.
3. Click *Log In.*
4. If logging in for the first time, use your Employee Number for BOTH your User Name and Password. This number needs to be 10 digits in length, so you will need to add zeros in front of your number to make it 10 digits. In other words, if your employee number is 4 digits, you will need to enter 6 zeros in front of it to make it a 10-digit number. If your employee number is 2 digits, you will need to enter 8 zeros in front of it to make a 10-digit number. For employees on the Wayne County payroll system, your employee number is 4 digits and is located on your paystub. If you are a sub-group participant, you can contact your payroll person, the Wellness Nurse or the HR Manager to get your employee number, if you do not already know it.

5. **Please change your password once you have logged in for the first time, for security purposes.** To change your password, click *Employee Account Info* at the top of the web page, enter your current password, then your new password and then you will need to confirm/re-enter your new password.
6. Click *Save* at the bottom of the screen.

How To Find Your HRA Status, Verified Labs, and Your Points:

Once you are on the Wellness home page, click on *Activity Tracker* at the top of the screen, then click on *Current Employee Points*. You will be able to see your name, as well as:

- Your HRA Date – If the HRA date is blank or has a date from a *prior year*, this means you have *NOT* completed and turned in your HRA for this year. If you see a date for the *current year*, this means the Wellness Nurse has received your completion page and you are up to date on your HRA for the incentive program.
- Verified Labs – Labs are drawn every three (3) years. If you see a date under the Lab section, this means you have verified labs on file for the current incentive period.
- Your Points – The web site will list the date which the point was completed and the point value that you earned. It will also show you the total points you have in the system.
- *IMPORTANT! If you think that the points listed are more than or less than what you think you have earned, please do not panic! Call the Wayne County Employee Health Clinic to help get things straightened out.*

Questions?

Contact the Wayne County Employee Health Clinic at 330-287-5487 or wellnessnurse@wayneohio.org

"Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity."

-World Health Organization, 1948

Forms

The following pages contain frequently used forms for your convenience!

Forms not contained in this section can be found at: https://www.wayneohio.org/employee-portal/health-benefits-manual/

Please photocopy all forms, keeping the originals in your binder, so that you can continue to use in future years.

POINT CHART for WELLNESS PROGRAM

Written Proof Required – Forms Available Through Wellness Web Site

To earn the wellness incentive, you must earn and turn in (5) Wellness Points plus complete or update your HRA. (If you have a spouse on your plan, please read the spouse mandate below). Please note the following: • Wellness Points must be earned and turned in between the dates of November 16 and November 15 to be on the incentive plan for the following calendar year. • HRA must be updated by November 15 of each year with numbers from the Wellness Nurse. You must receive these numbers from the KYN program or by verifying numbers, received by your doctor, with the Wellness Nurse ahead of time. Labs are drawn/re-verified every 3 years. Next draw year is 2025. • For new employees or those with special circumstances, please contact the Wellness Nurse.	**Point Value**	**Track Your Points!**

Spouse Mandate

If a spouse is on an employee's medical plan, in order for the family plan to be considered on the incentive, that spouse must earn 1 of the 5 points that are necessary for the incentive plan. The spouse may earn up to 2 points, but 1 point is required for the incentive plan. This means either 1) the spouse will earn one point and the employee will earn 4 points and complete the HRA, or 2) the spouse will earn two points and the employee will earn 3 points and complete the HRA. If an employee earns 5 points and his/her spouse earns zero points, they will not be eligible for the incentive plan and will remain or be transferred back to the basic plan. Again, this rule only applies to those employees who have a spouse on their plan. The four ways which spouses can earn points are as follows:

Eye Exam (one per year)	1	
Dental Checkup (one per year)	1	
Physical (one per year)	1	
Know Your Numbers (KYN) Program completion (Program runs May 1 – October 1; on draw years, runs January 1 – October 1) *see below for details*	1	
COVID Vaccination (complete the series) (boosters do not count for additional points at this time)	1	
Preventive Health Check-Ups (as age appropriate and recommended by Aetna) Be sure to check your insurance coverages so that you are aware of any charges for which you may be responsible		
Whole Body Skin Check by Dermatologist (one per year)	1	
Bone Density baseline screening for women (once after menopause then every 3-5 years as recommended by your physician for women without Osteopenia) (does not include health fair or public screenings)	1	
Colonoscopy (age 45 or over to get a baseline colonoscopy) (one per year; insurance only pays every 5 years)	1	
Dental Checkup (one per year)	1	
Eye Exam (one per year)	1	
Flu Shot (one per year – ½ point outside the clinic; 1 point at the clinic)	½ -1	
Mammogram (every 1-2 years for women over age 35)	1	
PAP Test or GYN Exam (recommended for women who have been sexually active and have a cervix) (one per year)	1	
Physical (one per year)	1	
Prostate Exam (yearly for males over age 50)	1	
COVID Vaccination (complete the series) (boosters do not count for additional points at this time)	1	
Wellness Education (up to two points per year for educational events)		
Brown Bag Lunch attendance	½	
Health Education Event attendance – contact Wellness Nurse in advance to verify event's qualification. Minimum of 30 minutes in length and proof of attendance via signature of speaker or notes taken are required.	½	
Learning Opportunity on the Wellness website (scoring 75% or higher on a test provided afterwards)	½	
Wellness Program completion (example – walking program) (points to be determined for each program)		
Discovery of a Billing Error which results in reimbursement to the Wayne County Health Plan	1	
Weight Management		
Food Diary completion for 3 months (up to two per year)	1	
Weight Loss Goal attainment set by Weight Loss Consultation with a Health Professional (one per year)	1	
Weight Watchers Member or similar program (one per year)	1	
Exercise		
Exercise Class attendance – 5-week session minimum (up to two per year). 5 weeks of Dance class is acceptable; however, attending regular dances do not count. Must have an instructor.	1	
Exercise Log completion for 3 months (exercising beyond normal daily routine) (up to two per year). You may include in your log: mountain climbing, dancing, bicycle riding (not motorcycle), swimming, golfing.	1	
Sleep Log (completion for 3 months, up to two per year) Questions? Call the Nurse.	1	
League Sport Participation (up to two per year) (subject to approval by Wellness Nurse; some are excluded like golf, dart, corn hole and bowling leagues to name a few).	1	
Changes for a Healthier Life		
Tobacco Products – Quit Use of or Remain Free of use for 6 months after initial test (urine test required as proof)	1	
Know Your Numbers (KYN) Program completion (program runs May 1st through October 1st) The Wellness Nurse can draw your blood for a lipid panel/cholesterol test anytime during the year for free. However, you will only earn point(s) during the KYN Program. If you have a medical reason why the Wellness Nurse cannot draw your blood for the lipid panel and have pre-approved the issue with the Wellness Nurse, you will still need to finish the other screenings in the KYN Program to earn point(s). Receive points for achieving or maintaining: 1) Waist Measurement: females <35", males <40' 2) Blood Pressure < or = 130/85, 3) Blood Sugar Fasting < or = 110, 4) LDL < or = 130, 5) Triglycerides < or = 150 and 6) Tobacco Free (negative urine test required). Points are awarded depending on the results; see the Wellness Nurse for details. Testing is offered in conjunction with the KYN Program.	1-3	

Diagnosed Conditions – If diagnosed with one or more of the following health conditions (you must provide proof), you have an opportunity to earn 1 wellness point, per condition, focusing on that condition (with the exception of Diabetes and Hypertension, which only has a total point award of 1). Details are below:		
Diabetes – Quarterly Blood Pressure Checks with your doctor or the Wellness Nurse (if by the doctor, a signed form is required)	1	
Hypertension – Monthly Blood Pressure Checks with your doctor or the Wellness Nurse (if by the doctor, a signed form is required)	1	
Asthma – Yearly Peak Flow Testing	1	
High Cholesterol – Yearly Lipid, drawn by the Wellness Nurse	1	

 All Future Programs and Point Values will be determined after being reviewed by the Health & Wellness Committee. If you have a point rejected by the Wellness Nurse, you may ask her to take it to the Committee for appeal. All decisions from the Committee are final.

 For any medical procedures completed, with the exception of a physical or dental visit, employees can use the basic Wellness Point Credit Form (located at http://www.wayneohio.org) and have the doctor or technician sign the form. Another option is to attach an Explanation of Benefits (EOB) or similar form of proof. You do not need to send blood work or any test results with the form.

Revised 10/5/2023

HRA Completion Verification Page

Name: _____

(Please Print-First and Last Name)

I have logged on to my.Cigna.com and completed the Health Assessment

Confirmation # _____

Date completed _____/_____/_____

I have verified labs on file in the clinic:

- ☐ I had my labs drawn with the Health and Wellness Nurse between 11/16/2021– 11/15/2024

OR

- ☐ I am turning in a copy of my lipids and blood sugar, drawn by another source. (If you choose this option, no points are issued nor can you participate in the KYN program offered through the Wellness program)

How to take your Health Assessment at my.Cigna.com:

Step 1: REGISTER on my.Cigna.com by creating a User ID and password. You will need to enter your SSN or member ID from your ID card (it starts with "U") as part of the verification process.

Step 2: LOGIN to my.Cigna.com using the new user ID and password.
What if I try to register, but my identity is not validated? We maintain high security standards. That means the registration information you provide must exactly match the information we have on file for you. Please try to register again. If you receive a Validation Data error, please call Cigna's Online Customer Service 1.800.853.2713 and we'll help you register.

Step 3: There are two ways to get to the Health Assessment. You can scroll to the bottom of the Home page and click on the box that says take Health Assessment, or you can click on the Wellness tab and select Health Assessment from the dropdown options.

Step 4: Read the Health Assessment Privacy Notice and click "I agree" to accept.

Step 5: Answer each question and section in the assessment. (You can't move to the next section if you leave a blank). Once at the end, you will see an option to see your score. You can then email a copy of the confirmation number to yourself for your records. Please write the confirmation number at the top of this form.

Step 6: Return this form to Nurse Misty.
This must be done every year! Turn it in when completed!

**** If you are a new to the plan, you only have 30 days to get the verified labs and HRA completion page turned in to earn the incentive.***

You can fax, email, or interoffice mail the form:
Wayne County Employee Health Clinic – Attn: Misty White
428 West Liberty Street Wooster, Ohio 44691
330-287-5487 Phone/ 330-262-2054 Fax
wellnessnurse@wayneohio.org

Nurse use only:

- ☐ **Date received __/__/__ by____**
- ☐ **Entered WS __/__/__by ____**
- ☐ **New employee as of __/__/__**
- ☐ **MS Notified __/__/__ by____**

Wellness Incentive Credit Form

This form is not for Dental, Eye, Covid or Physical Points.
Please submit those using the proper forms.
They can be found in your Red Notebook or on the wellness website.

(Please Print and Complete Entire Top of Form)

Name: _____ Date: _____

Email: _____

Phone Number you can be contacted: _____

Doctor's Name (if used to earn point): _____

What you have done for wellness point (Have person verifying the procedure or point sign this form or attach any documents required to this form):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date point completed: _____

Signature of person verifying procedure (or attach proof): _____

Office Use Only:
Date approved ____/____/____
____-1 pt earned approved by____
Entered into WS
_____/_____/_____ by ____

For wellness point credit.
Completed form must be returned to
Misty White, RN – Wayne County Employee Health Clinic – 330-287-5487
428 W. Liberty St., Wooster, OH 44691 or faxed to 330-262-2054
by the November 15th Deadline

Preventative Exam Incentive Credit Form

(form for Employees and physicals only for Spouses)

Please Print and fill out top of form completely

Name: _____ Date: ____/____/____

Phone: _____ Email: _____

If completing as a Spouse, list the full name of the Employee, so their incentive account can be updated: _____

Please check mark all items examined at visit

(Check list based on 2023 USPSTF recommendations)

This form is intended for use as a preventative guide and not directions for care by the employer or health care insurer.

- ☐ Weight
- ☐ Waist circumference
- ☐ Blood pressure
- ☐ Review individuals medical and social history
- ☐ Review of individuals for screenings/risk factors for:
  - ✓ Hypertension - B/P screening recommended for individuals 18 yo or older
  - ✓ High Cholesterol - lipid profile recommended every 5 years starting at age 35 for men and 45 for women.
  - ✓ Blood Sugar - screening recommended for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg).
  - ✓ Cardiovascular risk profile (smoking, sedentary lifestyle, obesity).
  - ✓ Breast cancer – mammogram is recommended every 1-2 years for females 35 yo or older.

  __ Mammogram completed today or on ___/___/___ for employee only. (if verified by someone else other than doctor) please sign _____
  - ✓ Cervical Cancer - screening pap is recommended for cervical cancer in women who have been sexually active and have a cervix.

  __ Pap/pelvic exam completed today or on ___/___/___ for employee only. (if verified by someone else other than doctor) please sign _____
  - ✓ Colon Cancer – screening colonoscopy recommended for individuals 45 yo or older.
  - ✓ Prostate Cancer – screening PSA- recommended for males 50 yo or older. (Please note: the county offers a free PSA blood draw yearly)

  __ PSA and/or Digital Exam completed today or on ___/___/___ for employee only (if verified by someone else other than doctor) please sign _____
  - ✓ Immunizations (see current CDC/ACIP recommendations).
  - ✓ Behavioral health screenings (verbal screenings for depression, alcohol abuse, substance abuse).
- ☐ Review of individual's quality of daily living
- ☐ Counseled patient during visit as needed (some USPSTF recommended areas):
  - ✓ Smoking cessation
  - ✓ Weight loss
  - ✓ Stress management
  - ✓ Physical activity
  - ✓ Other areas as needed
- ☐ Review blood work as appropriate
- ☐ Review current medications
- ☐ Pneumococcal vaccine offered as appropriate (recommended for patients 65 yrs or older).
- ☐ Flu shot recommended as appropriate (Please note: the county offers employee/family flu shots at no charge starting every October)
- ☐ Discussed Health Plan

GYN visit only, please check here

Mammogram only, please check here

NOTE:
The County has a discounted lab program, please send a doctor's order with your patient or fax it to the nurse and they can arrange to have it done with the Wayne Co Clinic Nurse. (If you have questions- please call the nurse 330-287-5487)

_____ ____/____/____

Signature of Physician Date

Office Use Only:

___ #1 Physical
___ #2 GYN
___ #3PSA
___ #4 Mammo
___ #39 Spouse Physical

Date approved ____/____/____

_____points earned approved by _____

Entered into WS

_____/_____/_____ by _____

For wellness point credit:
Completed form must be returned to Misty White, RN – Wayne County Employee Health Clinic – 330-287-5487 – 428 W. Liberty St., Wooster, OH 44691 or faxed to 330-262-2054 by the November 15th Deadline.

Revised 10/5/2023

Wellness Incentive COVID vaccine Credit Form

(This form is not for Dental, Eye, or Physical Points. Please submit those using the proper forms. They can be found in your Red Notebook or on the wellness website.)

(Please Print and Completely fill out this form)

Name: _____ Date: ____/____/____

Email: _____

Phone Number you can be contacted: _____

- ☐ I received the original COVID vaccine series and attached a copy of both the vaccines by attaching a copy of the vaccine card. (The initial Johnson and Johnson one dose vaccine will be accepted as well) *Note: Boosters are not required and have no point value.*
- ☐ I am receiving the vaccine for the first time, not a booster

  (new vaccine as of 09/2023)
- ☐ Date original series/1st time vaccine was completed: ___/___/___
- ☐ Copy of completed COVID vaccination card attached

Office Use Only:

___ #42 Covid
___ #43 Spouse

___ confirmed not used before

Date approved ____/____/____

1 pt earned approved by____
Entered into WS
_____/_____/_____ by ____

For wellness point credit.
Completed form must be returned to
Misty White, RN – Wayne County Employee Health Clinic – 330-287-5487
428 W. Liberty St., Wooster, OH 44691 or faxed to 330-262-2054 by the November 15th Deadline

Preventative Eye Exam Incentive Credit Form

(For Employees and/or Spouses)

(Please Print and fill out this form completely)

Name: _____ Date: ____/____/____

Email: _____

Phone Number you can be contacted: _____

If completing this as a Spouse: Please list the full name of the Employee, so their incentive account can be updated _____

Eye Doctor's Name: _____

As of ____/____/____, the patient named above had a complete annual eye exam.

Ophthalmologist or Optometrist/
Office staff Signature confirming: _____
(office stamp also permitted)

Office Use Only:
___ #5 Eye
___#38 Spouse

Date approved ____/____/____

1 pt earned approved by _____

Entered into WS
_____/_____/_____ by _____

For wellness point credit: Completed form must be returned to Misty White, RN – Wayne County Employee Health Clinic – 330-287-5487 – 428 W. Liberty St., Wooster, Ohio 44691, or fax to 330-262-2054 by the November 15th deadline

Preventative Dental Check Incentive Credit Form

(For Employees and/or Spouses)

(Please Print and fill out this form completely)

Name: _____ Date: ____/____/____

Email: _____

Phone Number you can be contacted: _____

If completing this as a Spouse: Please list the full name of the Employee, so their incentive account can be updated _____

Dentist Name: _____

As of ____/____/____, the patient named above had a preventative dental visit.

Dentist or Office Staff Signature to confirm: _____

(office stamp also permitted)

.

Office Use Only:

___ #6 Dental

___#22 Spouse

Date approved ____/____/____

1 pt earned approved by _____

Entered into WS

_____/_____/_____ by _____

For wellness point credit: Completed form must be returned to Misty White, RN – Wayne County Employee Health Clinic – 330-287-5487 – 428 W. Liberty St., Wooster, Ohio 44691, or fax to 330-262-2054 by the November 15th deadline

Allergies and reactions
(include food, drug, latex, environmental)

Fold Here

Other important informatiion

DATE THIS FORM LAST UPDATED: _____

Fold Here

What medications should I include?

- Prescription medicines
- Over-The-Counter medicines
- Vitamins
- Herbal remedies
- Nutrition pills
- Respiratory therapy medicines (such as inhalers)
- Blood factors (such as Factor VIII)
- IV solutions
- IV nutrition
- Patches
- Eye or ear drops
- Creams
- Ointments

Fold Here

WAYNE COUNTY Employee Health Clinic

Medication Card

Full Name: _____

Date of Birth: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Fold here first *Fold here first*

Start Date	Drug Name	Strength	Dose (pills, units, puffs, drops)	Route	When does you take this medicine? How many times a day? Morning & night? After meals?	Reason Why does your child take this medicine?	Start Date	Drug Name	Strength	Dose (pills, units, puffs, drops)	Route	When does you take this medicine? How many times a day? Morning & night? After meals?	Reason Why does your child take this medicine?
1/11/06	Amoxicillin	50mgs/ml	1 tsp	by mouth	Twice a day with meals	Ear infection							

Health Savings Account (HSA):

New or Change Request for employees on CDHP Plan only

This form must be completed and uploaded for all HSA changes. Additionally, if you are adding or changing your financial institution, routing number or account number, you must submit proof of your routing number and account number. This may be in the form of a screenshot, voided check, deposit slip, or bank document.

Name: _____ Department: _____

Date of Change (please allow 2 weeks: _____

Please indicate which of the following you are requesting:

For HSA contributions from Wayne County ONLY

For HSA contributions from Wayne County AND for HSA deductions to be deducted from my pay (County employees only). Deposit Amount (per pay): $ _____

It is the responsibility of the employee to make sure all earned, given and personal contributions do not exceed IRS maximum limits. Annual limits can be found at: https://www.irs.gov/pub/irs-pdf/p969.pdf.

I hereby authorize Wayne County Auditor to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account listed below.

Financial Institution Name: _____ Routing #: _____

Checking Account Savings Account Account #: _____

Terms:

- I agree to notify the County Payroll Department two (2) weeks in advance before closing a bank account which I have indicated as a direct deposit account.
- I take full responsibility for any mis-direction of funds due to changes in bank account information such as, closing of an account, incorrect account numbers, incorrect routing number, etc.
- This authority is to remain in full force until Wayne County has received written notification from me of any changes in such timely manner as to afford Wayne County and their Financial Institution a reasonable opportunity to act on it.

I have fully read and agree to the above terms of this HSA Direct Deposit agreement.

Signature: _____ Date: _____

DOCUMENTATION MUST BE UPLOADED BEFORE THIS CHANGE REQUEST WILL BE APPROVED.

Medical Insurance

- Cigna Member Website
- Coverage At A Glance
- Wellness and Discount Programs
- Enlist Professional Help
- Preventative Health Services
- Summary Plan Description

Wayne County Commissioners

Cigna Member Website

www.Cigna.com

You can access practically every tool, feature and program that Cigna has right from your secure myCigna® account. From programs that help improve your health to tools that help manage your health spending, there's so much you can do.

Get to know the full value of myCigna®:

- ☐ View, print and send ID cards
- ☐ Find in-network doctors, hospitals and medical services
- ☐ Compare quality of care information, including patient reviews from Cigna Healthcare℠ customers
- ☐ Manage and track claims
- ☐ See cost estimates for medical procedures
- ☐ Use the click-to-chat feature to connect with a live Cigna Healthcare rep

How To Register For The First Time:

Step 1 – Navigate to the Website

- Go to www.cigna.com
- Click "Register" under "Haven't created an account yet?"
- Be sure to have your Social Security number or Cigna ID number ready
- Click "Start Registration" at the bottom of the page.

Step 2 – Create an Account

- Complete all fields and click "Continue"
- Enter your Social Security number or Cigna ID number and click "Continue"
- Choose a Security Question and Answer and click "Continue"

Step 2 – Create Credentials

- Create a user name
- Create a password

- Continue with remaining fields
- Click “Continue”

Step 3 – Verify your Account

- Enter the code sent to your email address to verify, then click “Verify and Continue”
- Enter and verify your phone number OR click “do it later”
- View your Coverage Summary and click “Continue”
- Enter a Primary Care Provider (PCP), view Cigna’s programs and explore your new myCigna® account

Get the myCigna® App

Download the myCigna® App and log in for easy access to your benefits and Cigna resources.

Find a Doctor

Cigna’s online directory makes it easy to search for an in-network doctor.

- ☐ Step 1: If you’re already a Cigna member, log into myCigna.com or the myCigna® app to search your current plan’s network. If you’re not already a Cigna member, go to Cigna.com and click on “Find a Doctor” at the top of the screen. Then, under “How are you Covered?” select “Employer or School.”
- ☐ Step 2: Change the geographic location to the city/state or zip code you want to search. Select the search type and enter a name, specialty or other search term. Click on one of their suggestions or the magnifying glass icon to see your results.
- ☐ Step 3: Answer any clarifying questions, and then verify where you live.

Cigna One Guide®

Your Cigna One Guide® team is ready to answer all your health plan questions. Understanding and using your health plan isn’t always easy. Your Cigna One Guide® team is ready and waiting to help. It’s their highest level of personal support available.

Simply call them, click-to-chat on myCigna.com or use the myCigna® App. You’ll automatically be connected to a One Guide representative who will help guide you where you need to go. Helping you save money and stay healthy. Your Cigna One Guide® team can help you:

- ☐ Understand your plan
- ☐ Get Care including finding in-network care, connect you with health coaches, and connect you with dedicated one-on-one support for complex health situations
- ☐ Save and Earn by getting cost estimates to avoid surprises

Coverage At A Glance

Below is a snapshot of the Wayne County High-Deductible Health Plan. With this plan, you will need to set up a Health Savings Account (HSA) at the bank of your choice; after you do this, $400(single)/$800(family) will be deposited into this account annually, to be used for your health care needs. Additionally, if you decide to do a little work to either maintain or obtain a healthy lifestyle, you will be able to earn extra dollars as well! In fact, you can earn up to an extra $500 (single)/*$1,000 (family) each year by passing specific health tests! It is the reward for your work and dedication to your health! For more information on this opportunity, please refer to the Tab titled "Consumer Program".

Consumer Driven Health Plan Design

HIGH-DEDUCTIBLE

High-Deductible Plan Design **Cigna Open Access Plus** TYPE OF SERVICE	**High-Ded** IN-NETWORK	**High-Ded** OUT-OF-NETWORK
	single/family	single/family
Annual Deductible	$1,800/$3,600	$1,800/$3,600
Individual Deductible Limit	$3,200	$3,200
Preventative Care	100%	65%
After Annual Deductible	Plan Pays 85% of Covered Charges	Plan Pays 65% of Covered Charges
Annual Out-of-Pocket Maximums	$5,000/$10,000	$10,000/$20,000
Prescription Drugs:		
Preventative	Rx Program	You Pay 100%
Non-Preventative:		
Before Annual Deductible Met	You Pay 100%	You Pay 100%
After Annual Deductible Met	Rx Program	You Pay 100%
After Annual Out-of-Pocket Met	We Pay 100%	You Pay 100%
Cash Contributions To Your HSA Account[1]	$400/$800	
Wellness Incentives Annual Maximum[1]	$500/$1,000*	
*($1,000 family = up to $500 for employee and up to $500 for spouse)		
Total you can earn annually to help offset your deductible	$900/$1,800	

[1]COBRA members are not eligible for this benefit.

This is a short recap of your medical benefits, not your Summary Plan Description. Please see the Summary Plan Description for additional details and terms of your actual coverage. Wellness incentives and cash contributions to HSA accounts are determined annually. Co-pays, Co-insurance limits, Deductibles and Maximum out of pocket amounts indicated are only for covered services.

Updated 1/1/2024

On this page and the next page, you will see a snapshot of the Wayne County plan design. The first chart is the base plan design. If an incentive plan was not offered, these are the rates that everyone would be paying. However, if you decide to do a little work to either maintain or obtain a healthy lifestyle through the Wellness Program, then you will want to look at the chart on the next page (it is the reward for your work and dedication to your health). Keep in mind that without the Wellness Program, the second chart would not be available.

Health First Base Plan Design (Low-Ded Plan)

WITHOUT INCENTIVE

Low-Ded Plan Design **Cigna Open Access Plus** TYPE OF SERVICE	**Low-Ded** **Non-Incentive** IN-NETWORK	**Low-Ded** **Non-Incentive** OUT-OF-NETWORK
	single/family	single/family
Annual Deductible	$1,000/$2,000	$1,500/$3,000
Annual Out Of Pocket Maximum Including Deductible	$3,000/$6,000	$4,500/$9,000
Primary Office Visits	$40 copay then 100%	60% after deductible
Specialist Office Visits	$80 copay then 100%	60% after deductible
Preventative Care	100%	60% after deductible
Lab	$80 copay then 100%	60% after deductible
Radiology (CT, MRI, X-RAY, etc)	70% after deductible	60% after deductible
Inpatient Hospital	70% after deductible	60% after deductible
Outpatient Hospital	70% after deductible	60% after deductible
Emergency Room	$300 copay then 100%	$300 copay then 100%
Health Risk Assessment/ Wellness Participation Required?	No	No
This is a short recap of your medical benefits, not your Summary Plan Description. Please see the Summary Plan Description for additional details and terms of your actual coverage. Incentive rules are determined annually. Co-pays, Co-insurance limits, Deductibles and Maximum out of pocket amounts indicated are only for covered services.		
Updated 10/7/2022		

Health First Base Plan Design (Low-Ded Plan)

WITH INCENTIVE

Requires completion of 5 Wellness Points and Health Risk Assessment by November 15th

Low-Ded Plan Design **Cigna Open Access Plus** TYPE OF SERVICE	**Low-Ded** **+Incentive** IN-NETWORK	**Low-Ded** **+Incentive** OUT-OF-NETWORK
	single/family	single/family
Annual Deductible	$500/$1,000	$1,000/$2,000
Annual Out Of Pocket Maximum Including Deductible	$1,500/$3,000	$3,000/$6,000
Primary Office Visits	$20 copay then 100%	60% after deductible
Specialist Office Visits	$40 copay then 100%	60% after deductible
Preventative Care	100%	60% after deductible
Lab	$40 copay then 100%	60% after deductible
Radiology (CT, MRI, X-RAY, etc)	80% after deductible	60% after deductible
Inpatient Hospital	80% after deductible	60% after deductible
Outpatient Hospital	80% after deductible	60% after deductible
Emergency Room	$150 copay then 100%	$150 copay then 100%
Health Risk Assessment/ Wellness Participation Required?	Yes	Yes
This is a short recap of your medical benefits, not your Summary Plan Description. Please see the Summary Plan Description for additional details and terms of your actual coverage. Incentive rules are determined annually. Co-pays, Co-insurance limits, Deductibles and Maximum out of pocket amounts indicated are only for covered services.		
Updated 10/7/2022		

Attention!

SAVE $$$! If you have services performed at *Wooster Community Hospital*, your coinsurance will be reduced by 5%.

The following sub-groups may or may not provide coverage to spouses. If you are unsure about this, please contact your employer:

- ☐ Apple Creek

Cigna Programs and Resources

Cigna offers many programs and resources to plan members, including:

- ✓ **Virtual Care from MD Live**
- ✓ **Behavioral Health Programs**
- ✓ **Flexible Fitness Program**
- ✓ **Identity Protection**
- ✓ **Health Coaching for Chronic Conditions**
- ✓ **Medicare Option Reviews**

If you have any questions, please call Barb Winey, HR Director, at 330-287-5409 or Misty White, Employee Health Clinic Nurse at 330-287-5487.

HEALTH CARE THAT'S THERE FOR YOU WHEN AND WHERE YOU NEED IT

Head-to-toe virtual care[1] from MDLIVE.®

It's not always easy to find time for the health care you need. After all, doctors' appointments traditionally involve time and travel. That can lead to putting off care until problems become more serious, and potentially more expensive.

That's why Cigna has partnered with MDLIVE to offer a comprehensive suite of convenient virtual care options — available by phone or video whenever it works for you. MDLIVE board-certified doctors, dermatologists, psychiatrists and licensed therapists have an average of over 10 years of experience, and provide personalized care for hundreds of medical and behavioral health needs.

Now you don't have to wait — or travel — for the care you need.

Connect with video or phone, whenever it's convenient for you. Best of all, virtual care from MDLIVE board-certified doctors is available to you and your eligible dependents as part of your health benefits.

MDLIVE

Primary Care

Preventive care, routine care, and specialist referrals

- Preventive care checkups/wellness screenings available at no additional cost[2] to identify conditions early
- Routine care visits allow you to build a relationship with the same primary care provider (PCP) to help manage conditions
- Prescriptions available through home delivery or at local pharmacies, if appropriate
- Receive orders for biometrics, blood work and screenings at local facilities[3]

Urgent Care

On-demand care for minor medical conditions

- On-demand 24/7/365, including holidays
- Care for hundreds of minor medical conditions
- A convenient and affordable alternative to urgent care centers and the emergency room
- Prescriptions available, if appropriate

Behavioral Care

Talk therapy and psychiatry from the privacy of home

- Access to psychiatrists and therapists
- Schedule an appointment that works for you
- Option to select the same provider for every session
- Care for issues such as anxiety, stress, life changes, grief and depression

Dermatology[4]

Fast, customized care for skin, hair and nail conditions — no appointment required

- Board-certified dermatologists review pictures and symptoms; prescriptions available, if appropriate
- Care for common skin, hair and nail conditions including acne, eczema, psoriasis, rosacea, suspicious spots and more
- Diagnosis and customized treatment plan, usually within 24 hours

Cigna.

961333 11/21

Offered by: Cigna Health and Life Insurance Company or its affiliates.

3 easy steps to connect to care

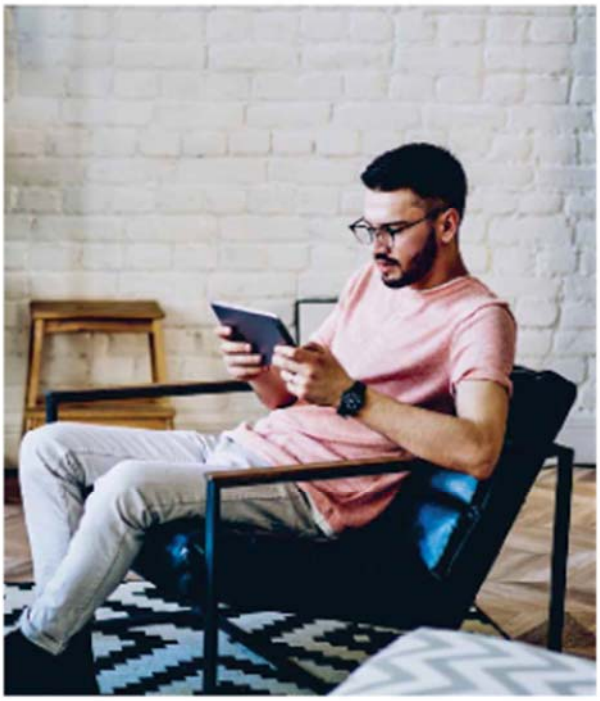
Virtual care visits are convenient and easy.
To schedule an appointment:

Access MDLIVE by logging into myCigna.com and clicking on "Talk to a doctor." You can also call MDLIVE at 888.726.3171. (No phone calls for virtual dermatology.)

Select the type of care you need: medical care or counseling; cost will be displayed on both myCigna.com and MDLIVE

Follow the prompts for an on-demand urgent care visit, to make an appointment for primary or behavioral care, or to upload photos for dermatology care

Appointments are available via video or phone, whenever it's most convenient for you. Virtual dermatology does not require an appointment.



Visit myCigna.com to make an appointment for virtual care today.

Together, all the way.*

Cigna.

1. Cigna provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs. Virtual primary care through MDLIVE is only available for Cigna medical members aged 18 and older.
2. For customers who have a non-zero preventive care benefit, MDLIVE virtual wellness screenings will not cost $0 and will follow their preventive benefit.
3. Limited to labs contracted with MDLIVE for virtual wellness screenings.
4. Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days, but usually within 24 hours.

You're not alone

The Cigna Total Behavioral Health Program can help you move forward.

Studies show that behavioral problems, such as depression, can contribute to heart disease.[1] Many physical conditions can worsen with stress, substance use and other behavioral health issues. Our Cigna Total Behavioral Health® program can help.

Our whole-person approach

If you or a loved one has been diagnosed with a behavioral health condition, we are here for you. Our comprehensive program provides help with life events, dedicated support, lifestyle coaching, and online tools. **You can call us anytime, any day.** We're here 24/7 to assist you with your routine or urgent needs. We can also help you find a provider with confirmed appointment availability.

Virtual behavioral care

You can talk to a licensed psychiatrist or counselor by phone or video with MDLIVE[2,3] or our Behavioral Health network. With MDLIVE you can schedule phone and video appointments online. With our Behavioral Health network, you can find a provider and start video counseling by going to MyCigna.com, Find Care & Costs.

You can also access online therapy through Talkspace,[2] via private messaging or live video session. Refer to your plan documents for costs and details of coverage. We also include Ginger behavioral health coaching via text-based chats, self-guided learning activities and content, and, if needed, video-based therapy and psychiatry.[2,3]

myCigna.com guided navigation

Our digital portal includes guided navigation that provides you with personalized, convenient care options to help you along your journey. Care options include digital, coaching, virtual and in person options.

On-demand coaching and personalized learning with iPrevail offered through Cigna[2]

Learn how to boost your mood and improve mental health with on-demand coaching 24/7. After completing a brief assessment, you receive a program tailored to your needs that includes interactive lessons and tools. You get access to a peer coach who is matched based on your symptoms. You can also join support communities focused on stress, anxiety, depression and more. iPrevail also includes a caregiver support program designed to help you cope with stress, improve resilience and enhance your overall health and well-being.

Services to help manage life events

At no additional charge to you, you can receive face-to-face sessions[4] with a licensed mental health professional in our Employee Assistance Program network.[5] You also get online, on-demand seminars, as well as community resources and referrals on a range of topics, including:

- Child care
- Adoption
- Senior care
- Pet care
- Legal and financial consultation services[6]
- Identity theft support
- Summer camps
- Parenting
- Convenience services

Enhanced ways to access care

We offer provider search and match support, in-the-moment appointment scheduling, and new online scheduling options.[7]

Unlimited in-the-moment consultations

Our team will take time to talk through your issue and get you to the right resource or licensed clinician based on your needs.[7]

100% follow up

After your initial consult, we'll check in with you digitally or telephonically to see if your needs are being met or provide additional assistance if needed.[7]

Science-based activities and games for stress and worries, with Happify offered through Cigna[2]

Everyday stressors can impact your relationships, work, health and emotional well-being. But you can change your outlook — and the way you see the world — with Happify. Happify's activities and games are designed to help you overcome life's challenges and can be accessed at any time.

Behavioral Specialty Coaching & Support Services

Our coaches provide dedicated support for a broad range of conditions including:

- Autism spectrum disorder
- Eating disorders
- Intensive behavioral case management
- Opioid and pain management
- Substance use

We also provide coaching and support for parents and families, which empowers individuals to be effective advocates for their family member or their own mental health needs. Our team can help for as long as needed (you must stay covered under your plan to continue service).

They can help you:

- Understand a behavioral diagnosis
- Learn about treatment choices and how your choices can affect what you'll pay out of pocket
- Identify and manage triggers that affect your condition
- Find a health care professional or facility in our network geared to your needs. Our network includes a Centers of Excellence (COE) program.[8] COE facilities have earned a top ranking for quality and cost-effective care. With nationwide locations for adult mental health, child and adolescent mental health, eating disorder and substance use treatment, help is available and closer than you think.
- Find community resources and programs near you
- Get referrals to other wellness and lifestyle programs available to you

Our Coaching and Support services include a digital interface through Vela.[2] Your Coach will help you acquire the app which features secure two-way messaging, ability to share resources, as well as appointment tracking on a shared calendar.

Take control of your health with extra support.

Lifestyle management programs

Get help to reach your goals like losing weight, quitting tobacco or lowering your stress level. Each program offers support with phone and online coaching.

Behavioral awareness webinars

We offer free monthly seminars on autism, eating disorders, substance use and behavioral health awareness for children and families. The seminars are taught by industry experts and offer tips, tools and helpful information.

Enhanced online tools

Visit **myCigna.com** or use the myCigna® app to access on-demand support, including:

- Information about your benefits, in-network providers and treatment options
- Health and well-being articles
- Self-assessment, stress management and mindfulness podcasts and tools

Additional resources can be found on Cigna.com.

To learn more or access services:

To access services to help manage life events, visit **myCigna.com**, Coverage, Employee Assistance Program.

You can call **877.231.1492** for referrals or go online, search the provider directory and obtain an authorization.

For links to iPrevail and Happify, visit the Wellness page. You can also call the toll-free number on your ID card.

GET HELP WITH CHRONIC CONDITIONS

Your health coach provides the guidance and support you need.

Chronic health conditions don't have to keep you down. Cigna provides one-on-one dedicated health coaching to help you:

- **Manage a chronic health condition,** ranging from asthma and low back pain to depression and coronary artery disease, among many others
- **Make more educated decisions** about your health and treatment options
- **Obtain information and resources** about your condition
- **Save money** on your medically related expenses
- **Create a plan** to help improve your health, based on your personal goals
- **Understand medications** and doctor's orders
- **Identify the triggers** that affect your condition

Online tools help you take charge of your health

24/7 online support helps you better understand your condition and overcome barriers to better health.

- **Online programs** that can offer help with lifestyle issues such as weight management, stress and smoking, and chronic condition support for diabetes, asthma, heart failure and more
- **Tools** to help you understand your condition and make more informed treatment decisions
- **Articles and podcasts** for education on hundreds of important health topics

Together, we can help you take control and achieve your health goals

Take the first step toward taking control of your chronic conditions today. Call us at the number on your Cigna ID card.

Or, visit **myCigna.com** for information and self-help resources.

Cigna.

IdentityForce.
A TransUnion® Brand

OFFERED THROUGH cigna healthcare

Protecting What Matters Most

Identity theft can have serious repercussions. It can hurt your credit score, taint your medical records and drain your college funds and retirement accounts – everything you've worked so hard to build.

IdentityForce, a TransUnion® brand, has been helping people protect their identity and credit for over 40 years, and our Certified Resolution Specialists work diligently to keep you and your family safe.

Two ways to activate your account[1]

1. Visit https://cigna.identityforce.com/starthere
2. Call 833-580-2523

Questions?

Call Member Services at
1-833-580-2523

[1]Available to employees enrolled in a Cigna Healthcare℠ medical plan and their children in household up to age 18.

Offered by Cigna Health and Life Insurance Company

PLAN FEATURES

Identity Protection

Dark Web Monitoring
Compromised Credentials Alerts
Change of Address Monitoring (USPS)
Court Records Monitoring
Sex Offender Registry Notification
Smart SSN Tracker (SSN Monitoring)
Social Media Identity Monitoring
Medical ID Fraud Protection
Identity Vault and Secure Storage

Credit Health and Financial Account Protection

Bank and Credit Card Activity Alerts
401(k), HSA and Investment Account Activity Alerts
Any Financial Account Covered
Education Resource Center
Credit Score Simulator
Credit Score Tracker (monthly)
Credit Freeze and Lock Assistance (Adult and Child)
Credit Monitoring TransUnion (daily)
Credit Report and Score TransUnion (quarterly)

Restoration Services

24/7 Customer Support
Fully Managed Identity Restoration
Restoration for Pre-Existing Identity Theft
Deceased Member Fraud Remediation[2]
Stolen Funds Replacement
Lost Wallet Assistance
$1M Expense Reimbursement Insurance[3]

Mobile and PC Protection

Mobile App (iOS and Android)
Password Manager

[2]Deceased Household Member Fraud Remediation available for adults or eligible dependents enrolled in an active IdentityForce Family Plan at the time of their death

[3]The expense reimbursement insurance benefit for members is underwritten by certain Underwriters at Lloyd's, under a master group policy issued in the name of Cyberscout Limited, Sontiq Inc. and all subsidiaries for the benefit of members. A summary of the terms of coverage are set forth in your account dashboard under the "Support" tab. The complete policy is available from Sontiq on request. Claims will be reviewed by the insurer in accordance with the terms and conditions of the master group policy. Restoration services are provided by Sontiq, Inc.

The program and services are provided by **Sontiq, Inc. and not by Cigna Healthcare or its affiliates.** Program and services are subject to all applicable program terms and conditions. Product availability may vary by location and plan type and is subject to change. References to third-party organizations or companies, and/or their products, processes or services, does not constitute an endorsement or warranty thereof. Your use of such products, processes or services are at your sole risk. Product may be updated or modified prior to availability.

The Apple logo is a trademark of Apple Inc., registered in the U.S. and other countries. App Store is a registered service mark of Apple Inc. Android and Google Play are trademarks of Google LLC. App/online store terms and mobile phone carrier/data charges apply.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company (Bloomfield, CT), or its affiliates. In Utah, all products and services are provided by Cigna Health and Life Insurance Company (Bloomfield, CT). Policy forms: OK – HP-APP-1 et al., OR – HP-POL38 02-13, TN – HP-POL43/HC-CERIV1 et al. (CHLIC); GSA-COVER, et al. (CHC-TN).

964869 © 2023 Cigna Healthcare.

GET THE MYSONTIQ APP: Download on the App Store | GET IT ON Google Play

ABOUT IDENTITYFORCE

IdentityForce, a TransUnion brand, offers proven identity, privacy and credit security solutions. We combine advanced detection technology, timely alerts, identity recovery and 24/7 support with over 40 years of experience to get the job done. We are trusted by millions of people, global 1000 organizations and the U.S. government to protect what matters most.

Thank you for being a valued customer. We're here to help make sure you're getting care and services that fit your current needs.

Cigna Medicare Concierge Services are provided by licensed benefit advisors who help you sort through your Medicare options. Here's what you can expect:

- Facts about what Medicare does and doesn't cover
- A look into money-saving programs
- Answers to your Medicare questions
- Information about special enrollment periods

Get help to review your Medicare options with a licensed benefit advisor.

1-866-317-4116 (TTY 711)

Monday – Friday,
7:30 a.m. – 7:30 p.m. CT

You may also find answers you need online, 24/7.

CignaMedicare.com

Together, all the way.®

Cigna.

Summary Plan Description

Wayne County Medical Benefit Plan

Table of Contents

Important Notice

The Wayne County medical benefits plan (Plan) described in this Summary Plan Description (SPD) is a benefit plan of the Employer. These benefits are not insured with Cigna or any of its affiliates, but will be paid from the Employer's funds. Cigna and its affiliates will provide certain administrative services under the Cigna medical benefits plan.

Cigna agrees with the Employer to provide administrative services in accordance with the conditions, rights, and privileges as set forth in this SPD. The Employer selects the products and benefit levels under the Cigna medical benefits plan.

The SPD describes your rights and obligations, what the Cigna medical benefits plan covers, and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this SPD. This SPD includes the Schedule of Benefits and any amendments.

This SPD replaces and supersedes all SPD's describing coverage for the medical benefits plan described in this SPD that you may previously have received. The plan sponsor reserves the right to interpret, amend and/or terminate this plan, in whole or in part, at any time and for any reason.

Employer ..... ***Wayne County***
Contract Number ***3345930***
Plan Network ..... ***Open Access Plus***
Plan Coverage Start Date ..... ***January 1, 2024***

Coverage for You and Your Dependents

Health Expense Coverage

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is "incurred" on the day you receive a health care service or supply. It is your responsibility to notify us if you or your dependents are no longer eligible for coverage under any of the Plans. Employees are responsible to reimburse the Plans for any administrative or claim expenses incurred by the Plan for coverage provided for ineligible members on or after the coverage period has ended.

Coverage under this plan is non-occupational. Only Non-Occupational Injuries and Non-Occupational Illnesses are covered.
Refer to the What the Plan Covers section of the SPD for more information about your coverage.

Treatment Outcomes of Covered Services

Wayne County and Cigna are not providers of health care services and therefore are not responsible for and do not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for CVS Caremark, providers of health care services, including Hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of Cigna or its affiliates.

When Your Coverage Begins

Who Can Be Covered, How and When to Enroll, When Your Coverage Begins

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, "you" means the employee.

Who Can Be Covered

Elected Officials/Employees

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

- ☐ You must be *actively employed* (defined as actively working, using any form of paid leave, or on approved FMLA); and
- ☐ You will need to be in an eligible class, as defined below; and
- ☐ You will need to meet the Eligibility Date criteria described below.
- ☐ You will need to enroll and be accepted for coverage.

Determining if You Are in an Eligible Class

You are in an eligible class if:

- ☐ You are an Elected Official or regular full-time employee, as defined by your employer (for purposes of this SPD, full-time is defined as being expected or determined to be a permanent employee working on average 30 or more hours per week).
- ☐ You do not meet the regulations above, but you meet the regulations to be eligible for insurance under Affordable Care Act (ACA) rules.

Determining When You Become Eligible

You become eligible for the plan on your Eligibility Date, which is determined as follows:

On the Plan Coverage Start Date

If you are in an eligible class and are currently enrolled on the plan coverage start date, then your coverage Eligibility Date is the same as the plan coverage start date and there is no waiting period.

After the Plan Coverage Start Date

If you are hired or enter an eligible class after the plan coverage start date, your Eligibility Date is as follows:

- The first of the month that occurs 1 calendar month *after* the month in which you are hired (this is considered your Administrative Period).
- Example: If your hire date is between January 1 and January 31, 2017, you will start on the Health Plan on March 1, 2017.

Obtaining Coverage for Dependents

Qualified dependents can be covered under this Plan. You may enroll the following dependents:

- ☐ Your Spouse.
- ☐ Your children.

Cigna will rely upon the Plan Administrator to determine whether or not a person meets the definition of a dependent for coverage under this Plan. This determination will be conclusive and binding upon all persons for the purposes of this Plan.

Coverage for Spouses

To be eligible, a Spouse must meet the following definition:

- The marriage is recognized by the State of Ohio as being a legal marriage; and
- You are married and living together as a married couple; or
- You are married and living apart, but not legally separated under a decree of divorce, separate maintenance or legal separation document; or
- You are separated under an interlocutory (not final) decree of divorce.

Married employees cannot be members on separate county insurance plans (unless one of the employees is employed by a noncounty agency that does not allow Spouses on their plan).

Coverage for Eligible Children

To be eligible, a child must be under 26 years of age and qualify as identified below under "An Eligible Child".

An Eligible Child includes:

- Your biological children;
- Your Stepchildren, as long as their parent is included on the insurance plan as a Spouse;
- Your legally adopted children or children placed with you for adoption;
- Any children for whom you (our employee) are responsible under court order.

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

Important Notice: In the case of Stepchildren, whether or not the custodial parent is a member on the plan, they should have access to their covered child's medical card with the ability to communicate that information to the child's doctor.

Important Reminder: Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

Please note that you will need to provide proof of your dependent(s)' eligibility (such as a Marriage or Birth Certificate and any court orders) when you originally enroll your dependent(s) and whenever an eligibility audit is conducted.

How and When to Enroll

Initial Enrollment in the Plan

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

You will need to enroll within 31 days of your Eligibility Date. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify for a Life Event enrollment, as described below.

Late Enrollment

If you do not enroll for coverage when you first become eligible, but wish to do so later, you may request information from your employer on when and how you can enroll.

Annual Enrollment/Open Enrollment

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. Annual enrollment typically occurs from mid-October to mid-November. The choices you make during this annual enrollment period will become effective on January 1 of the following year.

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

Life Event Enrollment

You are not permitted to terminate, add or make changes to a plan or the dependent(s) on a plan at any time other than Open Enrollment, unless you qualify for a Life Event as defined below. You may make changes to your insurance, including your dependent(s) and/or plan options, for a Life Event if you:

- ☐ Are an Eligible Employee in an Eligible Class at the time of the Life Event; and
- ☐ You, or one of your dependents that are on or will be added to/removed from the plan, experience a qualifying Life Event; and
- ☐ You notify your employer and complete an enrollment within 31 days of the event.

Enrollment instructions will be provided by your employer upon request.

The following will be considered as qualifying Life Events and proof may be required as a condition of eligibility and must be supplied upon request:

- ☐ *Marriage.* This plan will allow for the addition or termination of insurance for a marriage, involving you or your child that will be terminating from your plan, that is recognized by the State of Ohio as being a legal marriage and with submission of a certified marriage certificate.

- ☐ *Divorce, Legal Separation or Annulment.* This plan will allow for the addition or termination of insurance for a divorce, legal separation or annulment involving you or your child that will be joining or terminating from your plan and with submission of an applicable certified court certificate.
- ☐ *Death of Spouse or Child*.
- ☐ *Birth, Adoption, or Placement for Adoption.* New children must fit the definition of an Eligible Child and will require submission of a certified birth certificate unless:
    - Birth by a dependent currently covered on the plan is being used as a reason for that dependent to terminate from the Employee's plan; or
    - A new child is placed in your care for adoption and you have taken on the legal obligation for total or partial support of the child and a certified birth certificate is not available and you are able to provide another acceptable form of proof of placement.
- ☐ *Termination of the Employment of Spouse or Child.*
- ☐ *Start of New Employment of Spouse or Child*
- ☐ *Change in Employment Status (between part-time and full-time) by the Employee, Spouse or Child.*
- ☐ *A Strike or Lockout Reducing Hours of Employment of Employee, Spouse or Child*
- ☐ *Start or Return from Unpaid Leave of Absence from Employment by Employee, Spouse or Child*
- ☐ *Significant Change in Health Coverage of Employee, Spouse or Child*
- ☐ *A Change in the Place of Residence or Work of Employee, Spouse or Child, Which Changes that Individual's Plan Service Area*
- ☐ *Child of Employee Becoming Ineligible for Coverage.* This includes a child becoming ineligible due to age limits.
- ☐ *Entitlement to Medicare or Medicaid of Employee, Spouse or Child*
- ☐ *Issuance of a Judgement, Decree or Order That Requires Health Coverage for Employee's Child.* In the case of dependent care benefits under Article VIII, such other events that the Plan Administrator may determine will permit a change or revocation of an election in accordance with the rulings and regulations under Code Section 125. Such events will be triggered by the receipt of a National Medical Support Notice (NMSN) that has been issued by a court or a state child support enforcement agency authorized to issue Child Support Orders that provides for the medical support of a child. This plan will provide coverage for a child who is identified on a NMSN, if:
    - The child meets the plan's definition of an eligible dependent; and
    - A state child support enforcement agency issues a NMSN that the group health plan determines to be qualified; and
    - The issuing state child support enforcement agency does not issue a Notice to Employer/Health Plan Administrator of Expiration or Terminations of Withholding Requirements Under the NMSN.

  Coverage for the dependent will become effective on the date of issuance of the medical Child Support Order if received within 31 days of issuance, or as required by the NMSN.
- ☐ *Enrollment of Employee, Spouse or Child in a State or Federal Healthcare Exchange*

Important Notices:

- If you do not report your Life Event and submit all required documentation and your

enrollment is not received within 31 days of the date the Life Event took place, then you will not qualify to make changes to your insurance plan and will need to wait to make changes during the next annual enrollment period.

- You must pay any increase in premiums in full or coverage will not be effective.
- For child(ren) under a NMSN, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims may be paid to the custodial parent.
- All current requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) outlined in the Special Enrollment Notice (behind Tab 10) are covered by the Plan.

When Your Coverage Begins under Life Events

Your Effective Date of Coverage

If you met the requirement of a Life Event and completed all requirements for enrollment within the defined time, then your Effective Date of coverage will take place as follows:

- ☐ On the date that the Life Event took place, if you added insurance or made a change to your plan due to the Life Event.
- ☐ On the last day of the month, if you terminated insurance due to a Life Event.
- ☐ There was no change to your Effective Date of coverage, if you
  - ■ Are only adding or terminating dependent(s) from your plan; and
  - ■ You were previously and will continue to be enrolled on the same plan

Your Dependent's Effective Date of Coverage

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan.

How Your Medical Plan Works

Common Terms, Assessing Providers, Precertification

It is important that you have the information and useful resources to help you get the most out of your medical plan. This SPD is not all inclusive, but explains:

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

Important Notices:

- Unless otherwise indicated, "you" refers to you and your covered dependents.
- Your health plan pays benefits only for services and supplies described in this SPD as Covered Expenses that are Medically Necessary.
- This SPD applies to coverage only and does not restrict your ability to receive health care services that are not or might not be covered benefits under this health plan.
- Store this SPD in a safe place for future reference.

Common Terms

Many terms throughout this SPD are defined in the Glossary section at the back of this document. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

About Your Medical Plan

This medical plan provides coverage for a wide range of medical expenses for the treatment of Illness or Injury. It does not provide benefits for all medical care. The plan also provides coverage for certain preventive and wellness benefits. With your plan, you can directly access any Physician, Hospital or other health care provider (in-network or out-of-network) for covered services and supplies under the plan. The plan pays benefits differently for services and supplies obtained through In-Network Providers versus Out-of-Network Providers.

The plan will pay for Covered Expenses up to the maximum benefits shown in this SPD. Coverage is subject to all the terms, policies and procedures outlined in this SPD. Not all medical expenses are covered under the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the What the Plan Covers, Exclusions, Limitations and Schedule of Benefits sections to determine if medical services are covered, excluded or limited.

This plan provides access to covered benefits through a network of health care providers and facilities. These In-Network Providers have contracted with Cigna, an affiliate or third-party vendor to provide health care services and supplies to plan members at a reduced fee called the Negotiated Charge. This plan is designed to lower your out-of-pocket costs when you use In-Network Providers

for Covered Expenses. Your Deductibles, Copayments, and Payment Percentage will generally be lower when you use participating In-Network Providers and facilities.

You also have the choice to access licensed providers, Hospitals and facilities outside the network for covered benefits. Your deductibles, Copayments, and Payment Percentage are usually higher when you utilize Out-of-Network Providers. Also, out-of-network providers have not agreed to accept the Negotiated Charge and may balance bill you for charges over the amount Cigna pays under the plan.

Some services and supplies may only be covered through In-Network Providers. Refer to the What the Plan Covers section and your Schedule of Benefits to determine if any services are limited to in-network coverage only.

Your out-of-pocket costs may vary between in-network and out-of-network benefits. Read your Schedule of Benefits carefully to understand the cost sharing charges applicable to you.

Availability of Providers

Cigna, as the network provider, cannot guarantee the availability or continued participation of a particular provider. Either Cigna or any In-Network Provider may terminate the provider contract or limit the number of patients accepted in a practice. If the provider you select is not available for new patients, then Cigna has a list of In-Network Providers and services which can be accessed by logging into your Cigna account.

Ongoing Reviews

Cigna conducts ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are covered benefits under this SPD. If Cigna determines that the recommended services or supplies are not covered benefits, you should be notified. You may appeal such determinations by contacting Cigna to seek a review of the determination. Please refer to the Reporting of Claims and the Claims and Appeals sections of this SPD.

To better understand the choices that you have with your Cigna Open Access Plus plan, please carefully review the following information.

How Your Medical Plan Works

The Primary Care Physician

To access in-network benefits, you are encouraged to select a Primary Care Physician (PCP) from Cigna's network of providers at the time of enrollment. Each covered family member may select his or her own PCP. If your covered dependent is a minor, or otherwise incapable of selecting a PCP, you should select a PCP on their behalf. By choosing a PCP, you will have one medical professional helping you navigate all of your healthcare needs. A PCP coordinates your medical care, as appropriate either by providing treatment or may direct you to other In-Network Providers for other covered services and supplies. The PCP can also order lab tests and x-rays, prescribe medicines or therapies, and arrange Hospitalization. Selection of a PCP is not required by this plan, but this option is available to you.

Selection of a Primary Care Physician

You can choose a provider based on geographic location, group practice, medical specialty, language spoken, or Hospital affiliation. See below on how to access the provider Directory online. Cigna's list of providers is updated several times a week. You may also call the toll-free number on your ID card or reach out to the Employee Health Clinic for help finding a provider.

Specialists and Other In-Network Providers

You may directly access Specialists and other health care professionals in the network for covered services and supplies under this SPD. Refer to the Cigna In-Network Provider Directory to locate in-network Specialists, providers and Hospitals in your area. Refer to the Schedule of Benefits section for benefit limitations and out-of-pocket costs applicable to your plan.

> **Important Notice:** You will receive an ID card which identifies you as a member when you receive services from health care providers. If you have not received your ID card or if your card is lost or stolen, you can:
>
> - Log into your Cigna account on a computer or mobile device to access a digital copy;
> - Request a copy through your Cigna account;
> - Contact the Benefits Specialist.

Accessing In-Network Providers and Benefits

- ☐ You may select an in-network provider from the In-Network Provider Directory or by logging on to Cigna's website at www.Cigna.com. You can search Cigna's online Directory for names and locations of Physicians and other health care providers and facilities.
- ☐ If a service you need is covered under the plan but not available from an in-network provider or Hospital in your area, please contact Member Services at the toll-free number on your ID card for assistance. If Member Services is not able to provide help, you may contact the Employee Health Clinic.
- ☐ Certain health care services such as Hospitalization, outpatient surgery and certain other outpatient services require Precertification with Cigna to verify coverage for these services. In-network providers will be responsible for obtaining necessary Precertification for you. Since Precertification is the provider's responsibility, there are no additional out-of-pocket costs to you as a result of an In-Network Provider's failure to Precertify services. Refer to the Understanding Precertification section for more information on the Precertification process and what to do if your request for Precertification is denied.
- ☐ You will not have to submit medical claims for treatment received from in-network health care professionals and facilities. Your In-Network Provider will take care of claim submission. Cigna will directly pay the In-Network Provider or facility less any cost sharing required by you. You will be responsible for Deductibles, Payment Percentage and Copayments, if any.

You will receive notification of what the plan has paid toward your Covered Expenses. This is called an Explanation of Benefits (EOB). EOBs can be accessed by logging into your Cigna account. It will indicate any amounts you owe towards your Deductible, Copayments, or Payment Percentage or other non-Covered Expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call Member Services if you have questions regarding your statement. If Member Services is unable to help, you may contact the Employee Health Clinic.

Cost Sharing for In-Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits section.

- ☐ You will need to satisfy any applicable Deductibles before the plan will begin to pay benefits.
- ☐ For certain types of services and supplies, you will be responsible for any Copayments shown in the Schedule of Benefits section.
- ☐ After you satisfy any applicable Deductible, you will be responsible for any applicable Payment Percentage for Covered Expenses that you incur. Your Payment Percentage is based on the Negotiated Charge. You will not have to pay any balance bills above the Negotiated Charge for that covered service or supply. You will be responsible for your Payment Percentage up to the Maximum Out-of-Pocket Limit applicable to your plan.
- ☐ Once you satisfy any applicable Maximum Out-of-Pocket Limit, the plan will pay 100% of the Covered Expenses that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the Maximum Out-of-Pocket Limit. Refer to the Schedule of Benefits section for information on what expenses do not apply and for the specific Maximum Out-of-Pocket Limit amounts that apply to your plan.
- ☐ The plan will pay for Covered Expenses, up to the maximums shown in the What the Plan Covers or Schedule of Benefits sections. You are responsible for any expenses incurred over the maximum limits outlined in the What the Plan Covers or Schedule of Benefits sections.
- ☐ You may be billed for any Deductible, Copayment, or Payment Percentage amounts, or any non-Covered Expenses that you incur.
- ☐ It is your responsibility to know if your provider is in, or out, of network. Your doctor is not responsible to only refer you to in-network providers, so please verify with each provider if they are in, or out, of network before you have your appointment

Cost Sharing for Out-of-Network Benefits

You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits section.

- ☐ You will need to satisfy any applicable Deductibles before the plan will begin to pay benefits.
- ☐ For certain types of services and supplies, you will be responsible for any Copayments shown in the Schedule of Benefits section. After you satisfy any applicable Deductible, you will be responsible for any applicable Payment Percentage for Covered Expenses that you incur. You will be responsible for your Payment Percentage up to the Maximum Out-of-Pocket Limit applicable to your plan.
- ☐ Your Payment Percentage will be based on the Recognized Charge. If the health care provider you select charges more than the Recognized Charge, you will be responsible for any expenses above the Recognized Charge, even if you have met the annual maximum out of pocket.
- ☐ Once you satisfy any applicable Maximum Out-of-Pocket Limit, the plan will pay 100% of the Covered Expenses that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the Maximum Out-of-Pocket Limit. Refer to the Schedule of Benefits section for information on what expenses do not apply and for the specific Maximum Out-of-Pocket Limit amounts that apply to your plan.
- ☐ The plan will pay for Covered Expenses, up to the maximums shown in the What the Plan Covers or Schedule of Benefits sections. You are responsible for any expenses incurred over

the maximum limits outlined in the What the Plan Covers or Schedule of Benefits sections.

Understanding Precertification

Precertification

Certain services, such as inpatient Stays, certain tests, procedures and outpatient surgery require Precertification by Cigna. Precertification is a process that helps you and your Physician determine whether the services being recommended are Covered Expenses under the plan. It also allows Cigna to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

In-network providers will be responsible for obtaining necessary Precertification for you. It is your responsibility to make sure that the In-Network Provider has performed Precertification before the services take place. Since Precertification is the provider's responsibility, there is no additional out-of-pocket cost to you as a result of an In-Network Provider's failure to Precertify services.

When you go to an Out-of-Network Provider, it is your responsibility to obtain Precertification from Cigna for any applicable services or supplies. If you do not Precertify, your benefits may be reduced, or the plan may not pay any benefits. The list of services requiring Precertification is below.

> **Important Notice:** If you sign a paper that says you will be financially responsible if insurance doesn't cover a service, then you can be held responsible for the full amount of that service.

The Precertification Process

Prior to being Hospitalized or receiving certain other medical services or supplies there are certain Precertification procedures that must be followed.

You or a member of your family, a Hospital staff member, or the attending Physician, must notify Cigna to Precertify the admission or medical services and expenses prior to receiving any of the services or supplies that require Precertification pursuant to this SPD in accordance with the following timelines.

Precertification should be secured within the timeframes specified below. To obtain Precertification, call Cigna at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your Physician or the facility will need to call and request Precertification at least 14 days before the date you are scheduled to be admitted.
For an emergency outpatient medical condition:	You or your Physician should call prior to the outpatient care, treatment or procedure if possible; or as soon as reasonably possible.

For an emergency admission:	You, your Physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
For an Urgent Admission:	You, your Physician or the facility will need to call before you are scheduled to be admitted. An Urgent Admission is a Hospital admission by a Physician due to the onset of or change in an Illness; the diagnosis of an Illness; or an Injury.
For outpatient non-emergency medical services requiring Precertification:	You or your Physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

Cigna will notify you and your Physician of the Precertification decision. If your Precertified expenses are approved the approval is good for 60 days as long as you remain enrolled in the plan.

When you have an inpatient admission to a facility, Cigna will notify you, your Physician and the facility about your Precertified length of Stay. If your Physician recommends that your Stay be extended, additional days will need to be certified. You, your Physician, or the facility will need to call Cigna at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. Cigna will review and process the request for an extended Stay. You and your Physician will receive a notification of an approval or denial.

If Precertification determines that the Stay or services and supplies are not Covered Expenses, the notification will explain why and how Cigna's decision can be appealed. You or your provider may request a review of the Precertification decision pursuant to the Claims and Appeals section included with this SPD.

Services and Supplies Which Require Precertification

It is your responsibility to verify if Precertification is required for your service or supplies and to make sure that the In-Network Provider has performed Precertification before the services take place. If the service is out-of-network, it is also your responsibility to obtain Precertification from Cigna for any applicable services or supplies.

How Failure to Precertify Affects Your Benefits

A Precertification benefit reduction may be applied to the benefits paid if you fail to obtain a required Precertification prior to incurring medical expenses. This means Cigna may reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

You are responsible for obtaining the necessary Precertification from Cigna prior to receiving services from an Out-of-Network Provider. Your provider may Precertify your treatment for you; however, you should verify with Cigna prior to the procedure, that the provider has obtained Precertification from Cigna. If your treatment is not Precertified by you or your provider, the benefit payable may be significantly reduced or your expenses may not be covered.

How Your Benefits are Affected

The chart below illustrates the effect on your benefits if necessary Precertification is not obtained.

If Precertification is:	then the expenses are:
■ requested and approved by Cigna.	■ covered per the Schedule of Benefits
■ requested and denied.	■ not covered, may be appealed.
■ not requested, but would have been covered if requested.	■ covered per the Schedule of Benefits after a Precertification benefit reduction is applied.*
■ not requested, would not have been covered if requested.	■ not covered, may be appealed.

It is important to remember that any additional out-of-pocket expenses incurred because your Precertification requirement was not met will not count toward your Deductible or Payment Percentage or Maximum Out-of-Pocket Limit.

*Refer to the Schedule of Benefits section for the amount of Precertification benefit reduction that applies to your plan.

Emergency and Urgent Care

You have coverage 24 hours a day, 7 days a week, anywhere inside or outside the plan's Service Area, for:

- ☐ An Emergency Medical Condition; or
- ☐ An Urgent Condition.

In Case of a Medical Emergency

When Emergency Care is necessary, please follow the guidelines below:

- ☐ Go to the nearest emergency room, or dial 911 or your local emergency response service for medical and Ambulance help. If possible, call your Physician provided a delay would not be detrimental to your health.
- ☐ After assessing and stabilizing your condition, the emergency room should contact your Physician to obtain your medical history to assist the emergency Physician in your treatment.
- ☐ If you are admitted to an inpatient facility, notify your Physician as soon as reasonably possible.
- ☐ **If you seek care in an emergency room for a non-emergency condition, the plan may not cover the expenses you incur. Please refer to the Schedule of Benefits section for specific details about the plan. No other plan benefits will pay for non-Emergency Care in the emergency room unless otherwise specified under the plan.**

Coverage for Emergency Medical Conditions

Refer to Coverage for Emergency Medical Conditions in the What the Plan Covers section.

In Case of an Urgent Condition

Call your Physician if you think you need urgent care. If it is not feasible to contact your Physician, please do so as soon as possible after urgent care is provided. If you need help finding an Urgent Care

Provider you may call Member Services at the toll-free number on your I.D. card, or you may access Cigna's online provider Directory at www.Cigna.com.

Coverage for an Urgent Condition
Refer to Coverage for Urgent Medical Conditions in the What the Plan Covers section.

Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition
Follow-up care is not considered an emergency or Urgent Condition and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your Physician for any necessary follow-up care.

For coverage purposes, follow-up care is treated as any other expense for Illness or Injury. If you access a Hospital emergency room for follow-up care, your expenses will not be covered and you will be responsible for the entire cost of your treatment. Refer to the Schedule of Benefits section for cost sharing information applicable to your plan.

To keep your out-of-pocket costs lower, your follow-up care should be provided by a Physician.

You may use an Out-of-Network Provider for your follow-up care. You will be subject to the Deductible and Payment Percentage that apply to out-of-network expenses, which may result in higher out-of-pocket costs to you.

> **Important Notice:** Follow up care, which includes (but is not limited to) suture removal, cast removal and radiological tests such as x-rays, should not be provided by an emergency room facility.

Requirements For Coverage

To be covered by the plan, services and supplies must meet all of the following requirements:

1. The service or supply must be covered by the plan. For a service or supply to be covered, it must:
    - Be included as a covered expense in this SPD;
    - Not be an excluded expense under this SPD. Refer to the Exclusions sections of this SPD for a list of services and supplies that are excluded;
    - Not exceed the maximums and limitations outlined in this SPD. Refer to the What the Plan Covers and the Schedule of Benefits sections for information about certain expense and visit/day limits; and
    - Be obtained in accordance with all the terms, policies and procedures outlined in this SPD.
2. The service or supply must be provided while coverage is in effect. See the Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends and Continuation of Coverage sections for details on when coverage begins and ends.
3. The service or supply must be Medically Necessary. To meet this requirement, the medical services or supply must be provided by a Physician, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms. The provision of the service or supply must be:
    - In accordance with generally accepted standards of medical practice;
    - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
    - Not primarily for the convenience of the patient, Physician or other health care provider;
    - And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, or disease.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with Physician specialty society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

> **Important Note:** Not every service or supply that fits the definition for Medical Necessity is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example, some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the What the Plan Covers and the Schedule of Benefits sections for the plan limits and maximums.

What The Plan Covers

Wellness, Physician Services, Hospital Expenses, Other Medical Expenses

Many preventive and routine medical expenses as well as expenses incurred for a serious Illness or Injury are covered. This section describes which expenses are Covered Expenses. Only expenses incurred for the services and supplies shown in this section are Covered Expenses. Limitations and exclusions apply.

Alcoholism, Substance Abuse and Mental Disorders Treatment

Covered Expenses include charges made for the treatment of alcoholism, Substance Abuse and Mental Disorders by Behavioral Health Providers.

Alcoholism and Substance Abuse

Covered Expenses include charges made for the treatment of alcoholism and Substance Abuse by Behavioral Health Providers. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

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

The Schedule of Benefits section shows the benefits payable and applicable benefit maximums for the treatment of alcoholism and Substance Abuse.

Inpatient Treatment for Alcoholism and Substance Abuse

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

Coverage includes:

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

Outpatient Treatment for Alcoholism and Substance Abuse

The plan covers outpatient treatment of alcoholism or Substance Abuse.

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

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

The Partial Confinement Treatment will only be covered if you would need a Hospital Stay if you were not admitted to this type of facility.

Treatment of Mental Disorders
Covered Expenses include charges made for the treatment of other Mental Disorders by Behavioral Health Providers. In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

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

The Schedule of Benefits section shows the benefits payable and applicable benefit maximums for the treatment of Mental Disorders.

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

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

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

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

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

Limitations:

- Inpatient visits for Alcoholism and Substance Abuse have a lifetime maximum of 2 courses of treatment. Refer to the Schedule of Benefits section.

- Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See the Health Plan Exclusions and Limits section for more information.

Important Reminders:

- Wayne County also provides a separate mental health benefit under our Employee Assistance Program (EAP) which is not a part of this Medical Plan. Please see the section for our EAP benefits for more details.
- Inpatient care must be Precertified by Cigna. Refer to the How the Plan Works section for more information about Precertification.

Alternatives to Hospital Stays

Home Health Care

Covered Expenses include charges made by a Home Health Care Agency for home health care, and the care:

- ☐ Is given under a Home Health Care Plan;
- ☐ Is given to you in your home while you are Homebound.

Home health care expenses include charges for:

- ☐ Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available.
- ☐ Part-time or intermittent home health aide services provided in conjunction with and in direct support of care by an R.N. or an L.P.N.
- ☐ Physical, occupational, and speech therapy.
- ☐ Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an R.N. or an L.P.N.
- ☐ Medical supplies, prescription drugs and lab services by or for a Home Health Care Agency to the extent they would have been covered under this plan if you had continued your Hospital Stay.

Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse or therapist is one visit. In figuring the Calendar Year Maximum Visits, each visit of up to 4 hours is one visit.

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

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

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

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or Custodial Care service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be

provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

Limitations:

Unless specified above, not covered under this benefit are charges for:

- Services or supplies that are not a part of the Home Health Care Plan.
- Services of a person who usually lives with you, or who is a member of your or your Spouse's family.
- Services of a certified or licensed social worker.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are Custodial Care.

Important Reminders:

- The plan does not cover Custodial Care, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.
- Home health care needs to be Precertified by Cigna. Refer to the How the Plan Works section for details about Precertification.

Refer to the Schedule of Benefits section for details about any applicable home health care visit maximums.

Hospice Care

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

Facility Expenses

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

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

Outpatient Hospice Expenses

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

- Part-time or intermittent nursing care by a R.N. or L.P.N. for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day.
- Medical social services under the direction of a Physician. These include but are not limited to:
    - Assessment of your social, emotional and medical needs, and your home and family situation;
    - Identification of available community resources; and
    - Assistance provided to you to obtain resources to meet your assessed needs.

- Physical and occupational therapy; and
- Consultation or case management services by a Physician;
- Medical supplies.
- Prescription drugs;
- Dietary counseling; and
- Psychological counseling.

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

- A Physician for a consultation or case management;
- A physical or occupational therapist;
- A Home Health Care Agency for:
    - Physical and occupational therapy;
    - Part time or intermittent home health aide services for your care up to eight hours a day;
    - Medical supplies;
    - Prescription drugs;
    - Psychological counseling; and
    - Dietary counseling.

Limitations

Unless specified above, not covered under this benefit are charges for:

- Daily Room and Board charges over the Semi-Private Room Rate.
- Bereavement counseling.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.
- Respite care. This is care furnished during a period of time when your family or usual caretaker cannot attend to your needs.

Important Reminders:

- Refer to the Schedule of Benefits section for details about any applicable Hospice Care maximums.
- Inpatient Hospice Care and home health care must be Precertified by Cigna. Refer to the How the Plan Works section for details about Precertification.

Outpatient Surgery and Physician Surgical Services

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

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

The surgery must meet the following requirements:

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

The following outpatient surgery expenses are covered:

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

Limitations

Not covered under this plan are charges made for:

- The services of a Physician or other health care provider who renders technical assistance to the operating Physician.
- A Stay in a Hospital.
- Facility charges for office-based surgery.

Important Notice: Benefits for surgery services performed in a Physician's or Dentist's office are described under Physician Services benefits in the previous section.

Skilled Nursing Facility

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

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

Limitations

Unless specified above, not covered under this benefit are charges for:

- The treatment of:
  - Drug addiction;
  - Alcoholism;
  - Senility;

- Mental retardation; or
- Any other mental Illness; and

- Daily Room and Board over the semi-private rate.

Important Reminders:

- Refer to the Schedule of Benefits section for details about any applicable Skilled Nursing Facility maximums.
- Admissions to a Skilled Nursing Facility must be Precertified by Cigna. Refer to Using Your Medical Plan for details about Precertification.

Ambulance Service

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

Air or Water Ambulance

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

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

Ground Ambulance

Covered Expenses include charges for transportation:

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

Limitations

Not covered under this benefit are charges incurred to transport you:

- If an Ambulance service is not required by your physical condition; or
- If the type of Ambulance service provided is not required for your physical condition; or
- By any form of transportation other than a professional Ambulance service; or
- In non-emergency situations, Precertified transportation to a Hospital by a licensed Ambulance from home to Hospital if an Ambulance is the only safe way to transport is limited to 100-500 miles.

Autism Spectrum Disorder

Autism Spectrum Disorder is defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association. Eligible health services include the services and supplies provided by a Physician or Behavioral Health Provider for the diagnosis and treatment of Autism Spectrum Disorder. This treatment will only be covered if a Physician or Behavioral Health Provider orders it as part of a treatment plan.

Contraception

The Plan covers Contraceptives as currently required under the Affordable Care Act under the prescription benefit.

Diagnostic and Preoperative Testing

Diagnostic Complex Imaging Expenses

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

- ☐ C.A.T. scans;
- ☐ Magnetic Resonance Imaging (MRI);
- ☐ Positron Emission Tomography (PET) Scans; and
- ☐ Any other outpatient diagnostic imaging service costing over $500.

Complex Imaging Expenses for preoperative testing will be payable under this benefit.

Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

Outpatient Diagnostic Lab Work

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

Important Reminder: Refer to the Schedule of Benefits section for details about any Deductible, Payment Percentage and maximum that may apply to outpatient diagnostic testing, and lab services.

Outpatient Diagnostic Radiological Services

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

Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

Important Reminder: Refer to the Schedule of Benefits section for details about any Deductible, Payment Percentage and maximum that may apply to outpatient diagnostic radiological services.

Outpatient Preoperative Testing

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

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

Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan. If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will not be covered.

Important Reminder: Complex Imaging testing for preoperative testing is covered under the complex imaging section. Separate cost sharing may apply. Refer to the Schedule of Benefits section for information on cost sharing amounts for complex imaging.

Durable Medical and Surgical Equipment (DME)

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

- ☐ The initial purchase of DME if:
  - ■ Long term care is planned; and
  - ■ The equipment cannot be rented or is likely to cost less to purchase then to rent.
- ☐ Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered.
- ☐ Replacement of purchased equipment if:
  - ■ The replacement is needed because of a change in your physical condition; and
  - ■ It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

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

Covered Durable Medical Equipment includes those items covered by Medicare unless excluded in

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

> **Important Reminder:** Refer to the Schedule of Benefits section for details about Durable Medical and Surgical Equipment Deductible, Payment Percentage and benefit maximums. Also refer to the Exclusions section for information about Home and Mobility exclusions. DME is only covered through In-Network Providers.

Experimental or Investigational Treatment

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

- ☐ You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- ☐ Standard therapies have not been effective or are inappropriate;
- ☐ Cigna determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- ☐ There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
  - The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
  - The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
  - The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
  - The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI-designated cancer center; and
  - You are treated in accordance with protocol.

Gene-based, Cellular and Other Innovative Therapies (GCIT)

Covered services include GCIT provided by a Physician, Hospital or other provider.

Key Terms

Here are some key terms we use in this section. These will help you better understand GCIT.

- ☐ Gene: A gene is a unit of heredity which is transferred from a parent to child and is thought to determine some feature of the child.
- ☐ Molecular: Molecular means relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest vital unit of a chemical compound that can take part in a chemical reaction.
- ☐ Therapeutic: Therapeutic means a treatment, therapy, or drug meant to have a good effect on the body or mind; adding to a sense of well-being.

GCIT are defined as any services that are:

- ☐ Gene-based
- ☐ Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not covered under the Institutes of Excellence™ (IOE) programs. We call these "GCIT services."

GCIT covered services include:

- ☐ Cellular immunotherapies.
- ☐ Genetically modified oncolytic viral therapy.
- ☐ Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions.
- ☐ All human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. The following two therapies are the only two gene therapies covered by this plan.
    - ■ Luxturna® (Voretigene neparvovec)
    - ■ Spinraza® (Nusinersen)
- ☐ Products derived from gene editing technologies, including CRISPR-Cas9.
- ☐ Oligonucleotide-based therapies. Examples include:
    - ■ Antisense. An example is Spinraza.
    - ■ siRNA.
    - ■ mRNA.
    - ■ microRNA therapies.

Facilities/provider for gene-based, cellular and other innovative therapies
We designate facilities to provide GCIT services or procedures. GCIT Physicians, Hospitals and other providers are GCIT-designated facilities/providers for Cigna and CVS Caremark.

Exceptions:
The following are not covered services unless you receive prior written approval from us:

- GCIT services received at a facility or with a provider that is not a GCIT-designated facility/provider.
- All associated services when GCIT services are not covered. Examples include:
    - Infusion
    - Lab
    - Radiology
    - Anesthesia
    - Nursing services
    - Zolgensma® (Onasemnogene abeparvovec-xioi)

Important Note: You must get GCIT covered services from the GCIT-designated facility/provider. If there are no GCIT-designated facilities/providers assigned in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you do not get your GCIT services at the facility/provider we designate, they will not be covered services.

Hearing Related Services

See Schedule of Benefits section for more coverage details. Our coverage for Hearing Related Services is limited to $2,000 of services every 3 years per member. This allowance will apply to testing and treatment of hearing related Injury, Illness and disease including the provision of hearing aids and hearing related devices. This includes:

- ☐ Bone anchored hearing aids;
- ☐ Cochlear implants;
- ☐ Any device meant to restore, enhance, or replace your hearing.

This does not include:

- ☐ Any hearing service that does not meet professionally accepted standards;
- ☐ Hearing exams given during a Stay in a Hospital or other facility.

Hospital Expenses

Covered medical expenses include services and supplies provided by a Hospital during your Stay.

Coverage for Emergency Medical Conditions

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

The Emergency Care benefit covers:

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

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

> **Important Reminder:** With the exception of Urgent Care described below, if you visit a Hospital emergency room for a non-emergency condition, the plan will not cover your expenses, as shown in the Schedule of Benefits section. No other plan benefits may pay for non-Emergency Care in the emergency room.

Coverage for Urgent Conditions

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

Your coverage includes:

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

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

Other Hospital Services and Supplies
Covered Expenses include charges made by a Hospital for services and supplies furnished to you in connection with your Stay.

Covered Expenses include Hospital charges for other services and supplies provided, such as:

- ☐ Ambulance services.
- ☐ Physicians and surgeons.
- ☐ Operating and recovery rooms.
- ☐ Intensive or special care facilities.
- ☐ Administration of blood and blood products, but not the cost of the blood or blood products.
- ☐ Radiation therapy.
- ☐ Speech therapy, physical therapy and occupational therapy.
- ☐ Oxygen and oxygen therapy.
- ☐ Radiological services, laboratory testing and diagnostic services.
- ☐ Medications.
- ☐ Intravenous (IV) preparations.
- ☐ Discharge planning.

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

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

Room and Board charges also include:

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

Important Reminders:

- The plan will only pay for nursing services provided by the Hospital as part of its charge. The plan does not cover private duty nursing services as part of an inpatient Hospital Stay.
- If a Hospital or other health care facility does not itemize specific Room and Board charges and other charges, Cigna will assume that 40 percent of the total is for Room and Board charge, and 60 percent is for other charges.
- Hospital admissions need to be Precertified by Cigna. Refer to the How the Plan Works section for details about Precertification.
- In addition to charges made by the Hospital, certain Physicians and other providers may bill you separately during your Stay.

- Refer to the Schedule of Benefits section for any applicable Deductible, Copay and Payment Percentage and maximum benefit limits.

Jaw Joint Disorder Treatment

The plan covers charges made by a Physician, Hospital or Surgery Center for the diagnosis and surgical treatment of Jaw Joint Disorder. A Jaw Joint Disorder is defined as a painful condition:

- ☐ Of the jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome; or
- ☐ Involving the relationship between the jaw joint and related muscles and nerves such as myofacial pain dysfunction (MPD).

Unless specified above, not covered under this benefit are charges for non-surgical treatment of a Jaw Joint Disorder. This does not apply to in-mouth appliances needed for the treatment of a Jaw Joint Disorder.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

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

- ☐ Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- ☐ Treat a fracture, dislocation, or wound.
- ☐ Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
- ☐ Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
- ☐ Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

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

Dental work, surgery and Orthodontic Treatment needed to remove, repair, restore or reposition:

- ☐ Natural teeth damaged, lost, or removed; or
- ☐ Other body tissues of the mouth fractured or cut due to Injury.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the Injury.

The treatment must be completed in the Calendar Year of the Accident or in the next Calendar Year.

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

- ☐ The first denture or fixed bridgework to replace lost teeth;
- ☐ The first crown needed to repair each damaged tooth; and

- ☐ An in-mouth appliance used in the first course of Orthodontic Treatment after the Injury.

Physician Services

Alternatives to Physician Office Visits

Walk-in Clinic Visits

Covered Expenses include charges made by Walk-in Clinics for:

- ■ Unscheduled, non-emergency Illnesses and injuries; and the administration of certain immunizations administered within the scope of the clinic's license.

Anesthetics

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

Physician Visits

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

- ☐ Immunizations for infectious disease, but not if solely for your employment;
- ☐ Allergy testing, treatment and injections; and
- ☐ Charges made by the Physician for supplies, radiological services, x-rays, and tests provided by the Physician.

Surgery

Covered Expenses include charges made by a Physician for:

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

Important Reminder: Certain procedures need to be Precertified by Cigna. Refer to the How the Plan Works section for more information about Precertification.

Pregnancy Related Expenses

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

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

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

Covered Expenses also include charges made by a birthing center as described under Alternatives

to Hospital Care.

Covered Expenses also include services and supplies provided for circumcision of the newborn during the Stay.

> Important Notice: All current requirements outlined in the Newborns' and Mothers' Health Protection Act of 1996 are covered by the Plan.
>
> Important Reminder: Charges specific to the newborn child may be billed under the child as a dependent, and therefore, may require the family Deductible and out-of-pocket maximum to be met.

Preventive Care

This section on Preventive Care describes the Covered Expenses for services and supplies provided when you are well.

Hearing Exam

Covered Expenses include charges for an audiometric hearing exam if the exam is performed by:

- ☐ A Physician certified as an otolaryngologist or otologist; or
- ☐ An audiologist who:
  - ■ Is legally qualified in audiology; or
  - ■ Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
  - ■ Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

The plan will not cover expenses for charges for more than one hearing exam for any 24-month period.

All Covered Expenses for the hearing exam are subject to any applicable Deductible, Copay and Payment Percentage shown in the Schedule of Benefits section.

Routine Cancer Screenings

Covered Expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

- ☐ mammograms;
- ☐ pap smears;
- ☐ gynecological exams;
- ☐ fecal occult blood tests;
- ☐ digital rectal exams;
- ☐ prostate specific antigen (PSA) tests;
- ☐ sigmoidoscopies;
- ☐ double contrast barium enemas (DCBE); and
- ☐ colonoscopies.

These benefits will be subject to any age; family history; and frequency guidelines as set forth in the

most current:

- ☐ Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and
- ☐ The comprehensive guidelines supported by the Health Resources and Services Administration.

Unless specified above, not covered under this benefit are charges incurred for:

- ☐ Services which are covered to any extent under any other part of this Plan.

Important Notices:

- Refer to the Schedule of Benefits section for details about cost sharing and benefit maximums that apply to Preventive Care.
- For details on the frequency and age limits that apply to Routine Physical Exams and Routine Cancer Screenings, contact your Physician, log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.

Routine Physical Exams

Covered Expenses include charges made by your Physician for routine physical exams, including routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a Physician for a reason other than to diagnose or treat a suspected or identified Illness or Injury, and also includes:

- ☐ Radiological services, x-rays, lab and other tests given in connection with the exam;
- ☐ Immunizations for infectious diseases and the materials for administration of immunizations that have, in effect, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- ☐ Testing for Tuberculosis;
- ☐ For covered newborns, an initial Hospital checkup;
- ☐ Well visits (including routine oral screenings), for covered persons in accordance with the evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- ☐ The frequency of routine exams for newborns is as follows: 7 visits the first 12 months of life; 3 visits the second 12 months of life; 3 visits the third 12 months of life; and 1 visit per each 12-month period thereafter.

Limitations

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services which are for diagnosis or treatment of a suspected or identified Illness or Injury;
- Exams given during your Stay for medical care;
- Services not given by a Physician or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams.

Prosthetic Devices

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

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

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

Covered Expenses also include replacement of a prosthetic device if:

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

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

- ☐ An artificial arm, leg, hip, knee or eye;
- ☐ Eye lens;
- ☐ An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- ☐ A breast implant after a mastectomy;
- ☐ Ostomy supplies, urinary catheters and external urinary collection devices;
- ☐ Speech generating device;
- ☐ A cardiac pacemaker and pacemaker defibrillators;
- ☐ Orthopedic shoes, therapeutic shoes, foot orthotics or other devices to support the feet. Coverage for these types of shoes, orthotics or devices is limited to a maximum of two (2) pairs in a calendar year period; and
- ☐ A durable brace that is custom made for and fitted for you.

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

- ☐ Trusses, corsets, and other support items;
- ☐ There is no coverage for hearing aids or any hearing related services and surgeries under the prosthetic section of this Plan;
- ☐ Any item listed in the Exclusions section.

Reconstructive or Cosmetic Surgery and Supplies

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

- ☐ Surgery needed to improve a significant functional impairment of a body part except this plan will not pay any benefit for the replacement of any hearing loss or defect.
- ☐ Surgery to correct the result of an Accidental Injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original Injury. For a covered child, the time period for coverage may be extended through age 18.

- ☐ Surgery to correct the result of an Injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original Injury.
- ☐ Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an Illness or Injury) when:
    - The defect results in severe facial disfigurement; or
    - The defect results in significant functional impairment and the surgery is needed to improve function.

    Note: Injuries that occur as a result of a medical (i.e., non-surgical) treatment are not considered Accidental injuries, even if unplanned or unexpected.

Reconstructive Breast Surgery

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

The Plan provides coverage for:

- ☐ All stages of reconstruction of the breast on which the mastectomy has been performed;
- ☐ Surgery and reconstruction of the other breast to product a symmetrical appearance; and
- ☐ Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

Important Notices:

- A benefit maximum may apply to reconstructive or Cosmetic surgery services. Please refer to the Schedule of Benefits section.
- All current requirements outlined in the Woman's Health and Cancer Rights Act of 1998 are covered by the Plan.

Sexual Dysfunction/Enhancement

The Plan covers sexual dysfunction and enhancement as currently required under the Affordable Care Act under the prescription benefit.

Short-Term Rehabilitation Therapy Services

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

- ☐ A licensed or certified physical, occupational or speech therapist;
- ☐ A Hospital, Skilled Nursing Facility, or Hospice Facility; or
- ☐ A Physician.

Charges for the following short-term rehabilitation expenses are covered:

Cardiac and Pulmonary Rehabilitation Benefits

- ☐ Cardiac rehabilitation benefits are available as part of an inpatient Hospital Stay. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a Physician. This course of treatment is limited to a maximum of 36 sessions in a 12-week period.
- ☐ Pulmonary rehabilitation benefits are available as part of an inpatient Hospital Stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a 6-week period.

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

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

- ☐ Physical therapy is covered for non-chronic conditions and acute Illnesses and injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute Illness, Injury or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- ☐ Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute Illnesses and injuries, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute Illness, Injury or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- ☐ Speech therapy is covered for non-chronic conditions and acute Illnesses and injuries and expected to restore the speech function or correct a speech impairment resulting from Illness or Injury; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- ☐ Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

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

The therapy should follow a specific treatment plan that:

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

Important Reminder: Refer to the Schedule of Benefits section for details about the short-term rehabilitation therapy maximum benefit.

Unless specifically covered above, not covered under this benefit are charges for:

- ☐ Therapies for the treatment of delays in development, unless resulting from acute Illness or Injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down's Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature;
- ☐ Any services which are Covered Expenses in whole or in part under any other group plan sponsored by an employer;
- ☐ Any services unless provided in accordance with a specific treatment plan;
- ☐ Services provided during a Stay in a Hospital, Skilled Nursing Facility, or Hospice Facility except as stated above;
- ☐ Services not performed by a Physician or under the direct supervision of a Physician;
- ☐ Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section;
- ☐ Services provided by a Physician or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your Spouse's family;
- ☐ Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

Specialized Care

Chemotherapy

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

Outpatient Infusion Therapy Benefits

Covered Expenses include charges made on an outpatient basis for infusion therapy by:

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

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

- ☐ The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- ☐ Professional services;
- ☐ Total parenteral nutrition (TPN);
- ☐ Chemotherapy;
- ☐ Drug therapy (includes antibiotic and antivirals);

- ☐ Pain management (narcotics); and
- ☐ Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this infusion therapy benefit are charges incurred for:

- ☐ Enteral nutrition;
- ☐ Blood transfusions and blood products;
- ☐ Dialysis; and
- ☐ Insulin.

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

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

Benefits payable for infusion therapy will not count toward any applicable Home Health Care maximums.

Radiation Therapy Benefits

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

> **Important Reminder:** Refer to the Schedule of Benefits section for details on any applicable Deductible, Payment Percentage and maximum benefit limits.

Spinal Manipulation Treatment

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

Your benefits are subject to the maximum shown in the Schedule of Benefits section. However, this maximum does not apply to expenses incurred:

- ☐ During your Hospital Stay; or
- ☐ For surgery. This includes pre- and post-surgical care provided or ordered by the operating Physician.

Transplant Services

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

- ☐ Solid Organ (i.e. heart, lung, simultaneous pancreas kidney (SPK), pancreas, kidney, liver, intestine);
- ☐ Any other single organ transplant, unless otherwise excluded under the plan.
- ☐ Bone Marrow;
- ☐ Hematopoietic Stem Cell;
- ☐ CAR-T and T cell receptor therapy for FDA-approved treatments;

- ☐ Thymus tissue for FDA-approved treatments;
- ☐ Multiple organs replaced during one transplant surgery;
- ☐ Tandem transplants (Stem Cell);
- ☐ Sequential transplants;
- ☐ Re-transplant of same organ type within 180 days of the first transplant;

The following will be considered to be more than one Transplant Occurrence:

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

The in-network level of benefits is paid only for a treatment received at a facility designated by the plan as an Institute of Excellence™ (IOE) for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants.

Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as Out-of-Network Services and Supplies, even if the facility is a in-network facility or IOE for other types of services.

The plan covers:

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

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

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

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

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

If you are a participant in the IOE program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any Covered Expenses you incur from an IOE facility will be considered in-network care expenses.

Limitations

Unless specified above, not covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant Occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant Occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing Illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing Illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Cigna.

Important Reminders:

- To ensure coverage, all transplant procedures need to be Precertified by Cigna. Refer to the How the Plan Works section for details about Precertification.
- Refer to the Schedule of Benefits section for details about transplant expense maximums, if applicable.

Network of Transplant Specialist Facilities

Through the IOE network, you will have access to a provider network that specializes in

transplants. Benefits may vary if an IOE facility or non-IOE or Out-of-Network Provider is used. In addition, some expenses are payable only within the IOE network. The IOE facility must be specifically approved and designated by Cigna to perform the procedure you require. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

Treatment of Infertility

Basic Infertility Expenses

Covered Expenses include charges made by a Physician to diagnose and to surgically treat the underlying medical cause of Infertility.

Medical Plan Exclusions

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your Physician or Dentist. The plan covers only those services and supplies that are Medically Necessary and included in the What the Plan Covers section. Charges made for the following are not covered except to the extent listed under the What The Plan Covers section or by amendment attached to this SPD.

Acupuncture and related therapies
Acupuncture, acupressure and acupuncture therapy, except as provided in the What the Plan Covers section.

Allergy
Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.

Behavioral Analysis Programs
Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs.

Behavioral Health Services
- ☐ Alcoholism or Substance Abuse rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for Detoxification or treatment of alcoholism or Substance Abuse is specifically provided in the What the Plan Covers section.
- ☐ Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.
- ☐ Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- ☐ Treatment of antisocial personality disorder.
- ☐ Treatment in wilderness programs or other similar programs.
- ☐ Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in the What the Plan Covers section of this SPD.

Blood Products
Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.

Charges
Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this SPD.

Charges for a service or supply furnished by an In-Network Provider in excess of the Negotiated Charge, or an Out-of-Network Provider in excess of the Recognized Charge.

Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.

Charges submitted for services by an unlicensed Hospital, Physician or other provider or not within the scope of the provider's license.

Contraception
Contraception, except as specifically described in the What the Plan Covers section.

Cosmetic Services and Plastic Surgery
Any treatment, surgery (Cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:

- ☐ Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, Cosmetic eyelid surgery and other surgical procedures;
- ☐ Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- ☐ Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- ☐ Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when Medically Necessary;
- ☐ Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
- ☐ Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- ☐ Surgery to correct Gynecomastia;
- ☐ Breast augmentation;
- ☐ Otoplasty.

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

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

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

- ☐ services of Dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, treatment

of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;

- ☐ dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- ☐ non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors and orthodontogenic cysts.

Disposable Outpatient Supplies

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

Drugs, Medications and Supplies

- ☐ Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins;
- ☐ Any services related to the dispensing, injection or application of a drug;
- ☐ Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- ☐ Immunizations related to work;
- ☐ Needles, syringes and other injectable aids;
- ☐ Drugs related to the treatment of non-Covered Expenses;
- ☐ Performance enhancing steroids;
- ☐ Injectable drugs if an alternative oral drug is available;
- ☐ Outpatient prescription drugs;
- ☐ Self-injectable prescription drugs and medications;
- ☐ Any prescription drugs, injectables, or medications or supplies provided by the customer or through a third-party vendor contract with the customer; and
- ☐ Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy except those specifically described in the What the Plan Covers section.

Educational Services

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

Examinations
Any health examinations required:

- ☐ by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
- ☐ by any law of a government;
- ☐ for securing insurance, school admissions or professional or other licenses;
- ☐ to travel;
- ☐ to attend a school, camp, or sporting event or participate in a sport or other recreational activity; and

Any special medical reports not directly related to treatment except when provided as part of a covered service.

Experimental or Investigational
Experimental or Investigational drugs, devices, treatments or procedures, except as described in the What the Plan Covers section.

Facility Charges (Custodial Care)
Facility charges for care services or supplies provided in:

- ☐ rest homes;
- ☐ assisted living facilities;
- ☐ similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
- ☐ health resorts;
- ☐ spas, sanitariums; or
- ☐ infirmaries at schools, colleges, or camps.

Food Items
Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

Foot Care
Except as specifically covered for diabetics, any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

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

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

Hair Loss
Expenses for hair loss or hair transplants will not be considered eligible.

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

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

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

Illegal Acts
Expenses for treatment, services and supplies resulting from Injury or Illness which is incurred while the Covered Person is taking part in, or attempting to take part in, an illegal act, even if the proximate cause of the Illness or Injury is not the illegal act itself. It is not necessary for an arrest to occur, charges to be filed, or a conviction to occur for this exclusion to apply. Notwithstanding the foregoing, any conviction or acquittal on any filed charges shall be conclusory. This exclusion does not apply to an Injury resulting from being a victim of an act of domestic violence or resulting from a documented and verified medical condition (including both physical and mental health conditions).

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

- ☐ Drugs related to the treatment of non-covered benefits;
- ☐ Injectable Infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- ☐ Artificial Insemination;
- ☐ Any advanced reproductive technology ("ART") procedures or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); Artificial Insemination for covered females attempting to become pregnant who are not Infertile as defined by the plan;
- ☐ Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- ☐ Procedures, services and supplies to reverse voluntary sterilization;
- ☐ Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- ☐ The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- ☐ Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, Hospital, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- ☐ Home ovulation prediction kits or home pregnancy tests;
- ☐ Any charges associated with care required to obtain ART Services (e.g., office, Hospital, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and
- ☐ Ovulation induction and intrauterine insemination services if you are not Infertile.

Marijuana

Marijuana family of products; medical marijuana may be legal in Ohio, but it is not covered under this medical or prescription plan.

Medical Error

Treatment or services for unintended Injury or Illness resulting from an adverse consequence of care that could reasonably have been prevented, including foreign object left in body after surgery, surgery performed on wrong body part, air embolism, blood incompatibility, etc.

Medicare

Payment for that portion of the charge for which Medicare or another party is the primary payer.

Miscellaneous Charges

Miscellaneous charges for services or supplies including:

- ☐ Annual or other charges to be in a Physician's practice;
- ☐ Charges to have preferred access to a Physician's services such as boutique or concierge Physician practices;
- ☐ Cancelled or missed appointment charges or charges to complete claim forms;

- ☐ Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service;
  - Care while in the custody of a governmental authority;
  - Any care a public Hospital or other facility is required to provide; or
  - Any care in a Hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

Maintenance Care
Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

Non-Medically Necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not Medically Necessary, as determined by Cigna, for the diagnosis and treatment of Illness, Injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your Physician or Dentist.

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

Private duty nursing during your Stay in a Hospital, and outpatient private duty nursing services, except as specifically described in the Private Duty Nursing provision of the What the Plan Covers section.

Non-Emergency Services outside the US
Any non-emergency charges incurred outside of the United States:
- ☐ if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this SPD, or
- ☐ such drugs or supplies are unavailable or illegal in the United States, or
- ☐ the purchase of such prescription drugs or supplies outside the United States is considered illegal.

Riot/Revolt
Expenses resulting from a Covered Person's participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

Services
Services provided by a Spouse, domestic partner, parent, child, stepchild, brother, sister, in-law or

any household member.

Services of a resident Physician or intern rendered in that capacity.

Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.

Services, including those related to pregnancy, rendered before your Effective Date or after the termination of your coverage, unless coverage is continued under the Continuation of Coverage section of this SPD.

Services that are not covered under this SPD.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Sexual Dysfunction/Enhancement

Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire except those specifically described in the What the Plan Covers section, including:

- ☐ Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
- ☐ Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

Speech Therapy

Speech therapy for treatment of delays in speech development, except as specifically provided in the What the Plan Covers section. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.

Spinal Disorder

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

Strength and Performance Enhancement

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

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

Surrogate
Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan and for any Covered Person other than the Employee and Spouse will not be considered eligible, including pre-pregnancy, conception, prenatal, childbirth and postnatal expenses. This exclusion does not apply to Preventive Services for any Covered Person as described under the What the Plan Covers section of the Plan.

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

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

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

Tobacco Use
Any treatment, service, supply or non-preventative drug to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum except as specifically provided in the What the Plan Covers section.

Transplant
Transplant coverage does not include charges for:

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

Transportation, Travel and Lodging
Transportation costs, including Ambulance services for routine transportation to receive outpatient or inpatient services except as described in the What the Plan Covers section.

Expenses for travel and lodging will not be considered eligible, except as specified under the What the Plan Covers section or the Centers of Excellence Program.

Unauthorized Services
Unauthorized services, including any service obtained by or on behalf of a covered person without Precertification by Cigna when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.

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

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

Voluntary Termination of Pregnancy
Voluntary termination of pregnancy, including related services.

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

- ☐ Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including Morbid Obesity;
- ☐ Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- ☐ Counseling, coaching, training, hypnosis or other forms of therapy; and
- ☐ Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

Work Related

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

Workers' Compensation

Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Workers' Compensation Law or occupational disease law or similar legislation will not be considered eligible.

Expenses for Injuries or Illness which were eligible for payment under Workers' Compensation or similar law and have reached the maximum reimbursement paid under Workers' Compensation or similar law will not be eligible for payment under this Plan.

When Coverage Ends

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

When Coverage Ends for Employees

Your health benefits coverage will end at the end of the month in which the following occurs if:

- ☐ The health benefits plan is discontinued;
- ☐ You voluntarily stop your coverage;
- ☐ You are no longer eligible for coverage;
- ☐ You do not make any required contributions;
- ☐ You become covered under another plan offered by your employer;
- ☐ Your employer notifies Cigna that your employment is ended;
- ☐ Your employment is terminated by your own choice;

If a covered employee dies, the coverage for the existing and covered dependents will continue until the end of the month, following the month of the employee's death.

It is your employer's responsibility to let Cigna know when your employment ends.

Inactive Pay Status

An employee who is not in an active pay status (vacation, comp/flex time, sick, paid/unpaid Family Medical Leave) is considered to be Inactive Pay Status and not eligible to be on the Plan. Please note that Workers' Comp is not considered active pay status.

- ☐ Please keep in mind that unpaid time off does not constitute active pay status for purposes of the Plan At the point that they are **not** in an active pay status, their insurance eligibility is over and they are terminated from the Plan on the last day of the month in which they were active. (for instance, an employee who is terminated from the Plan on May 9 would Stay on the Plan through May 31);
- ☐ Employees who return to active pay status within 60 calendar days of the date they are terminated from the Plan (using May 31 from the above example) will be able to start back on the Plan effective on the date they return to active pay status. They will not have to wait to join the Health Plan like a new employee;
- ☐ Employees who return to active pay status 61 or more calendar days from the date they are terminated from the Plan will be treated as a new employee for purposes of their Effective Date on the Plan;
- ☐ Employees who elect COBRA and are on COBRA on the date of their return to active pay status will start on the Plan effective on the date of their return, no matter if their return is over or under 60 days. These employees never left the Plan, so they do not have to wait like a new employee.

Examples:

- An employee who is out on paid leave and runs out of paid leave on May 8, but returns to active pay status on July 15, would be eligible to rejoin the plan with an Effective Date of July 15 (insurance *always* terms on the last date of the month in which the termination happens, so in this example, since insurance wouldn't have termed until May 31, it has

been less than 60 days).

- An employee who is out on paid leave and runs out of paid leave on May 8, but returns to active pay status on August 15, would be treated as a new employee with regard to the start date on the Plan, unless they elected COBRA and were carried by COBRA when they returned (because it has been over 60 days of not being on the Plan).

When Coverage Ends for Dependents

Coverage for your dependents will end if:

- ☐ You are no longer eligible for dependents' coverage;
- ☐ You do not make the required contribution toward the cost of dependents' coverage;
- ☐ Your own coverage ends for any of the reasons listed under When Coverage Ends for Employees; if a covered employee dies, the coverage for the existing and covered dependents will continue until the end of the month, following the month of the employee's death.
- ☐ Your dependent is no longer eligible for coverage. In this case, coverage ends at the end of the calendar month when your dependent no longer meets the plan's definition of a dependent (examples: divorce, child over 26 years of age, etc.); or
- ☐ As permitted under applicable federal and state law, your dependent becomes eligible for comparable benefits under this or any other group plan offered by your employer.
- ☐ *PLEASE NOTE that failure to notify Wayne County of a dependent termination, due to not meeting the plan's definition of a dependent, will result in the employee being responsible for 100 percent of any and all claims paid for that dependent after the date which they should have been terminated.*

COBRA benefits may apply to existing and covered dependents. Please refer to Section 7 of the Wayne County Employee Benefit Manual for more information.

Coverage for handicapped dependents may continue after your dependent reaches any Limiting Age. See Continuation of Coverage for more information.

Continuation of Coverage

COBRA

You and/or your dependents may be given the opportunity to continue health coverage under the Plan when you experience a loss of coverage under the Plan.

See Section 7 of the Wayne County Employee Benefit Manual for information regarding COBRA & USERRA continuation rights, including how long these benefits are available to you and how to elect and pay for these benefits.

Handicapped Dependent Children

Health Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- ☐ he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- ☐ he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to Cigna no later than 31 days after the date your child reaches the maximum age under your plan.
Coverage will cease on the first to occur of:

- ☐ Cessation of the handicap.
- ☐ Failure to give proof that the handicap continues.
- ☐ Failure to have any required exam.
- ☐ Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

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

Coordination of Benefits – What Happens When There is More Than One Health Plan

Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a Coordination of Benefits provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to account for payments made by "other plans".

When this and another health coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
   A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended. In such cases, Medicare rules will apply. See the When you have Medicare Coverage section. The benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:
   - ☐ Covers the person as other than a dependent; and
   - ☐ Is secondary to Medicare.
2. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.
3. If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
4. In the case of a dependent child whose parents are divorced or separated:
   - ☐ If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.
   - ☐ If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.
   - ☐ If there is not such a court decree:

- If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
- If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:
   - ☐ The benefits of a plan which covers the person on whose expenses claim is based as a:
     - Laid-off or retired employee; or
     - The dependent of such person.
   - ☐ Shall be determined after the benefits of any other plan which covers such person as:
     - An employee who is not laid-off or retired; or
     - Dependent of such person.
   - ☐ If the other plan does not have a provision:
     - regarding laid-off or retired employees; and
     - as a result, each plan determines its benefits after the other;

     then the above paragraph will not apply.
   - ☐ The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.
   - ☐ If the other plan does not have a provision:
     - regarding right of continuation pursuant to federal or state law; and
     - as a result, each plan determines its benefits after the other;

     then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses processed during a single "processed claim transaction" will be reduced by the total benefits payable under all "other plans" for the same expenses. An exception to this rule is that when the coordination of benefits rules of this Plan and any "other plan" both agree that this Plan is primary, the benefits of the other plan will be ignored in applying this rule. As used in this paragraph, a "processed claim transaction" is a group of actual or prospective charges submitted to Cigna for consideration, that have been grouped together for administrative purposes as a "claim transaction" in accordance with Cigna's then current rules. If the contract includes both medical and dental coverage, those coverages will be considered separate plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy plans. In turn, the dental coverage will be coordinated with other dental plans.

In order to administer this provision, Cigna can release or obtain data. Cigna can also make or recover payments.

Other Plan
This means any other plan of health expense coverage under:

- ☐ Group insurance.
- ☐ Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- ☐ No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

When You Have Medicare Coverage

This section explains how the benefits under the Plan interact with benefits available under Medicare including Which Plan Pays First and How Coordination with Medicare Works.

Medicare, when used in this SPD, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare

You are eligible for Medicare if you are:

- ☐ Covered under it by reason of age, disability, or
- ☐ End Stage Renal Disease
- ☐ Not covered under it because you:
    - ■ Refused it;
    - ■ Dropped it; or
    - ■ Failed to make a proper request for it.

Which Plan Pays First
If you are eligible for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, the plan is the primary payor, which means that the plan pays benefits before Medicare pays benefits. Under other circumstances, the plan is the secondary payor, and pays benefits after Medicare. To determine whether the Plan is primary or secondary, please visit https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance or call 1-877-319-0729.

How Coordination with Medicare Works

When the Plan is Primary
The plan pays benefits first when it is the primary payor. You may then submit your claim to Medicare for consideration.

When Medicare is Primary
Your health care expense must be considered for payment by Medicare first. You may then submit the expense to Cigna for consideration.

Cigna will calculate the benefits the plan would pay in the absence of Medicare:

The amount will be reduced so that when combined with the amount paid by Medicare, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense.

This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B Deductible under Medicare will be applied under the plan in the order received by Cigna. Cigna will apply the largest charge first when two or more charges are received at the same time.

Cigna will apply any rule for coordinating health care benefits after determining the benefits payable.

Right to Receive and Release Required Information
Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under This Plan and other plans. Cigna has the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.

General Provisions

Additional Provisions

The following additional provisions apply to your coverage:

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

Assignments

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

Claims, Appeals and External Review

Claims and Appeals

Filing Health Claims under the Plan

Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to "you" in this Claims and Appeals section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

Reporting of Claims

A claim must be submitted to Cigna showing proof of the nature and extent of the loss.

Claims must be submitted for payment to Cigna within one year of the date of service in order to be considered for payment. If a claim is submitted after one year from the date of service it will be denied.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Cigna. The notice will explain the reason for the denial and the appeal procedures available under the Plan.

Urgent Care Claims

An "Urgent Care Claim" is any claim for medical care or treatment for which the application of the

time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if Cigna or your Physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside Cigna's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of Cigna's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to an Cigna representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to Cigna and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves

urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Health Claims – Standard Appeals

As an individual enrolled in the Plan, you have the right to file an appeal from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the Plan.

An "Adverse Benefit Determination" is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- ☐ Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- ☐ Coverage determinations, including plan limitations or exclusions;
- ☐ The results of any Utilization Review activities;
- ☐ A decision that the service or supply is Experimental or Investigational; or
- ☐ A decision that the service or supply is not Medically Necessary.

A "Final Internal Adverse Benefit Determination" is defined as an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (Cigna) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Exhaustion of Internal Appeals Process

Generally, you are required to complete all appeal processes of the Plan before being able to bring an action in litigation. However, if Cigna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") and may pursue any available remedies under state law, as applicable.

Full and Fair Review of Claim Determinations and Appeals

Cigna will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Cigna (or at the direction of Cigna), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to Cigna at the address provided in this SPD, or, if your appeal is of an urgent nature, you may call Cigna's Member Services Unit at the toll-free phone number on your ID card. Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

An Cigna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to Cigna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that Cigna provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to Cigna's Member Services. Cigna's Member Services telephone number is on your Identification Card. You or your Authorized Representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your Authorized Representative and Cigna by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.
If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Cigna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Cigna within 60 days of receipt of the level one appeal decision. Cigna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

External Review
Cigna may deny a claim because it determines that the care is not appropriate or a service or treatment is Experimental or Investigational in nature. In either of these situations, you may request an external review if you or your provider disagrees with Cigna’s decision. An external review is a review by an independent clinical reviewer, selected by an External Review Organization, who has expertise in the problem or question involved.
To request an external review, the following requirements must be met:

- ☐ You have received notice of the denial of a claim by Cigna; and
- ☐ Your claim was denied because Cigna determined that the care was not necessary or was Experimental or Investigational; and
- ☐ The cost of the service or treatment in question for which you are responsible exceeds $500; and
- ☐ You have exhausted the applicable internal appeal processes.

The claim denial letter you receive from Cigna will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Cigna within 60 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

Cigna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent clinical reviewer with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Cigna's contractual documents and plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 30 calendar days of Cigna's receipt of your request form and all necessary information. A quicker review is possible if your Physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after Cigna receives the request.

Cigna, the Company and the Health Plan will abide by the decision of the External Review Organization, except where Cigna can show conflict of interest, bias or fraud.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Cigna. Cigna is responsible for the cost of sending this information to the External Review Organization and for the cost of the external review.

For more information about Cigna's External Review process, call the toll-free Customer Services telephone number shown on your ID card.

Appeal to the Plan Sponsor

If you choose to appeal to the Plan sponsor following an adverse determination by External Review where applicable or an adverse determination at the final level of standard appeals, you must do so in writing, and you should send the following information:

- ☐ The specific reason(s) for the appeal;
- ☐ Copies of all past correspondence with your Health Plan (including any EOBs); and
- ☐ Any applicable information that you have not yet sent to your Health Plan.

If you file a voluntary appeal, you will be deemed to authorize the Company to obtain information from your Health Plan relevant to your claim.

Mail your written appeal directly to:

Company Name:	**Wayne County HR Benefits Specialist**
Company Address:	**428 West Liberty Street**
	Wooster, Ohio 44691

The Company will review your appeal. The Company reviewer will evaluate your claim within 60 days after you file your appeal and make a decision. If the reviewer needs more time, the reviewer may take an additional 60-day period. The reviewer will notify you in advance of this extension.

The Company reviewer will follow relevant internal rules maintained by the applicable Health Plan to the extent they do not conflict with its own internal guidelines.

The Company reviewer will notify you of the final decision on your appeal electronically or in writing. The written notice will give you the reason for the decision and what Plan provisions apply.

All decisions by the Company with respect to your claim shall be final and binding.

Contacting Cigna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to Cigna, you may contact Cigna using their toll-free Member Services phone number on your ID card or visit Cigna's web site at www.Cigna.com.

Discount Programs

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

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

Failure to Provide Required Documentation

Dependents could be terminated from your plan or denied coverage if you fail to submit required birth and/or marriage certificates either at the time of enrollment or as the result of an eligibility audit.

Governing Laws

This Plan is a governmental sponsored plan and as such it is exempt from the requirement of the Employee Retirement Income Security Act of 1974 (ERISA), which is a Federal law regulating Employee welfare and pension plans. The Covered Person's rights in the Plan are governed by the plan documents and applicable Ohio law and regulations.

Health Savings Account Benefits

If you have chosen the High-Deductible Plan, you will need to set up a Health Savings Account (HSA) at your choice of banks. An HSA is an account that allows you to save money to help pay for qualified medical expenses; this money is never taxed if it is spent on qualifying medical expenses.

It is your responsibility to:

- ☐ Make sure all earned, given and personal contributions do not exceed IRS maximum limits.

- ☐ Make sure your HSA is only used to pay for eligible healthcare costs. We recommend saving all receipts which are paid from your HSA to prove those payments/costs were for eligible purposes, in case your account is audited by the IRS.
- ☐ Make sure an additional form is completed at tax time, IRS Form #8889; please communicate this with your tax return preparer.
- ☐ Refer to IRS Publication 969 and IRS Publication 502 for more information and a list of eligible purposes.
- ☐ Make sure you are eligible for an HSA. You are not eligible if:
    - You (or any of your enrolled dependents) are enrolled in Medicare or Medicaid.
    - You (or any of your enrolled dependents) are enrolled in Veterans medical services.
    - You (or any of your enrolled dependents) are on a low Deductible plan elsewhere.
    - You (or any of your enrolled dependents) are claimed as a dependent on someone else's return.

In the event that you are eligible for an HSA and you do not establish your HSA, submit your HSA banking information, and have it approved on or before the last day of February in any given year, then the Plan is not required to make any contributions to your HSA for the previous calendar year.

Legal Action

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Misstatements

Failure to implement or insist upon compliance with any provision of this Cigna medical benefits plan at any given time or times, shall not constitute a waiver of the Plan's right to implement or insist upon compliance with that provision at any other time or times.

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

Payment of Benefits

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

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

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

When a PCP provides care for you or a covered dependent, or care is provided by an In-Network Provider (In-Network Services or supplies), the In-Network Provider will take care of filing claims. However, when you seek care on your own (Out-of-Network Services and Supplies), you may be

responsible for filing your own claims.

Physical Examinations

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

Subrogation and Right of Recovery Provision

Definitions

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

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

For purposes of this provision, a Covered Person includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan member or person entitled to receive any benefits from the plan.

Subrogation

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

Reimbursement

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

Constructive Trust

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

Lien Rights

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

First Priority Claim

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

Applicability to All Settlements and Judgments

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

Cooperation

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

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

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

Interpretation

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

Jurisdiction

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

Records of Expenses

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

Very important are:

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

Recovery of Overpayments

Health Coverage

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

- ☐ To require the return of the overpayment; or
- ☐ To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan.

Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's third-party administrator – Cigna. Under this process, Cigna reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the Plan that overpaid the provider. Payments to providers under this Plan are

subject to this same process when Cigna recovers overpayments for other plans administered by Cigna.

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

Workers' Compensation

If benefits are paid under the Plan and the Plan determines you received Workers' Compensation benefits for the same incident, the Plan has the right to recover as described under the "Subrogation and Right of Reimbursement" provision. Cigna, on behalf of the Plan, will exercise its right to recover against you.

The Recovery Rights will be applied even though:

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

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

If benefits are paid under the Plan, and you or your covered dependent recover from a responsible party by settlement, judgment or otherwise, the Plan has a right to recover from you or your covered dependent an amount equal to the amount the Plan paid.

Type of Coverage

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

Glossary

This section only provides definitions and does not indicate coverage, or lack of coverage for any item. To determine what is and is not covered, you must carefully read this entire SPD and the appropriate Schedule of Benefits sections.

A

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

Cigna
Cigna HealthCare, an affiliate, or a third party vendor under contract with Cigna.

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

B

Behavioral Health Provider/Practitioner
A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

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

C

Child Support Order
As defined in Ohio Revised Code 3119.01.

Copay or Copayment
The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various Copayments, and these Copayment amounts or percentages are specified in the Schedule of Benefits section.

Cosmetic
Services or supplies that alter, improve or enhance appearance.

Covered Expenses
Medical, dental, vision or hearing services and supplies shown as covered under this SPD.

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

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

D

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

Deductible
The part of your Covered Expenses you pay before the plan starts to pay benefits. Additional information regarding Deductibles and Deductible amounts can be found in the Schedule of Benefits section.

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

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

metabolic or other means, the:

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

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

Directory
A listing of all In-Network Providers serving the class of employees to which you belong. In-Network Provider information is also available through Cigna's online provider Directory.

Durable Medical and Surgical Equipment (DME)
Equipment, and the accessories needed to operate it, that is:

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

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

Updated 1/1/19

E

Effective Date
The date that a member's plan becomes effective. If you do not elect coverage, then you will not have an Effective Date.

Eligibility Date
The date you become eligible for benefits (not including any waiting period).

Emergency Care
This means the treatment given in a Hospital's emergency room to evaluate and treat an Emergency Medical Condition.

Emergency Medical Condition
A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, Illness, or Injury is of such a nature that failure to get immediate medical care could result in:

- ☐ Placing your health in serious jeopardy; or
- ☐ Serious impairment to bodily function; or
- ☐ Serious dysfunction of a body part or organ; or

- ☐ In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental or Investigational
A drug, a device, a procedure, or treatment will be determined to be Experimental or Investigational if:

- ☐ There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the Illness or Injury involved; or
- ☐ Approval required by the FDA has not been granted for marketing; or
- ☐ A recognized national medical or dental society or regulatory agency has determined, in writing, that it is Experimental or Investigational, or for research purposes; or
- ☐ It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- ☐ The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is Experimental or Investigational, or for research purposes.

H

Homebound
This means that you are confined to your place of residence:

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

Situations where you would not be considered Homebound include (but are not limited to) the following:

- ☐ You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- ☐ You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Care Agency
An agency that meets all of the following requirements.

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

Home Health Care Plan
This is a plan that provides for continued care and treatment of an Illness or Injury. The care and

treatment must be:

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

Hospice Care

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

Hospice Care Agency

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

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

Hospice Care Program

This is a written plan of Hospice Care, which:

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

to be given to meet those needs.

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

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

Hospital
An institution that:

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

In no event does Hospital include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, Skilled Nursing Facility, hospice, rehabilitative Hospital or facility primarily for rehabilitative or custodial services.

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

I

Illness
A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Infertile or Infertility
The condition of a presumably healthy covered person who is unable to conceive or produce conception after:

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

Injury
An Accidental bodily Injury that is the sole and direct result of:
- ☐ An unexpected or reasonably unforeseen Occurrence or event; or
- ☐ The reasonable unforeseeable consequences of a voluntary act by the person.
- ☐ An act or event must be definite as to time and place.

In-Network Provider
A health care provider who has contracted to furnish services or supplies for this plan; but only if the provider is, with Cigna's consent, included in the Directory as an In-Network Provider for:
- ☐ The service or supply involved; and
- ☐ The class of employees to which you belong.

In-Network Service(s) or Supply(ies)
Health care service or supply that is:
- ☐ Furnished by an In-Network Provider; or
- ☐ Furnished or arranged by your PCP.

Institute of Excellence (IOE)
A Hospital or other facility that has contracted with Cigna to furnish services or supplies to an IOE patient in connection with specific transplants at a Negotiated Charge. A facility is an IOE facility only for those types of transplants for which it has signed a contract.

J

Jaw Joint Disorder
This is:
- ☐ A Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint; or
- ☐ A Myofacial Pain Dysfunction (MPD); or
- ☐ Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

L

Life Event
An event that qualifies eligible employees to make changes to their insurance plan. Life Events include the same considerations that are made for Special Enrollment Periods as defined by the IRS.

Limiting Age
Under Federal Law, Eligible Children over the age of 26 are no longer eligible for coverage.

L.P.N.
A licensed practical or vocational nurse.

M

Maintenance Care
Care made up of services and supplies that:

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

Maximum Out-of-Pocket Limit
Your plan has a Maximum Out-of-Pocket Limit. Your Deductibles, Copays, Payment Percentage and other eligible out-of-pocket expense apply to the Maximum Out-of-Pocket Limit. Once you satisfy the maximum amount the plan will pay 100% of Covered Expenses that apply toward the limit for the rest of the calendar year. There are separate Maximum Out-of-Pocket Limits that apply to both in-network and out-of-network out-of-pocket expenses.

Medically Necessary or Medical Necessity
Health care or dental services, and supplies or prescription drugs that a Physician, other health care provider or dental provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that provision of the service, supply or prescription drug is:

- ☐ In accordance with generally accepted standards of medical or dental practice;
- ☐ Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease; and
- ☐ Not primarily for the convenience of the patient, Physician, other health care or dental provider; and
- ☐ Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, or disease.

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with Physician or dental specialty society recommendations and the views of Physicians or Dentists practicing in relevant clinical areas and any other relevant factors.

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

- ☐ Alcoholism and Substance Abuse.

- ☐ Bipolar disorder.
- ☐ Major depressive disorder.
- ☐ Obsessive compulsive disorder.
- ☐ Panic disorder.
- ☐ Pervasive Mental Developmental Disorder (Autism).
- ☐ Psychotic depression.
- ☐ Schizophrenia.

For the purposes of benefits under this plan, Mental Disorder will include alcoholism and Substance Abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and Substance Abuse.

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

N

Negotiated Charge
The maximum charge an In-Network Provider has agreed to make as to any service or supply for the purpose of the benefits under this plan.

Night Care Treatment
A Partial Confinement Treatment program provided when you need to be confined during the night. A room charge is made by the Hospital, Psychiatric Hospital or Residential Treatment Facility. Such treatment must be available at least:
- ☐ 8 hours in a row a night; and
- ☐ 5 nights a week.

Non-Occupational Illness
An Illness that does not:
- ☐ Arise out of (or in the course of) any work for pay or profit; or
- ☐ Result in any way from an Illness that does.

An Illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person:
- ☐ Is covered under any type of workers' compensation law; and
- ☐ Is not covered for that Illness under such law.

Non-Occupational Injury
An Accidental bodily Injury that does not:
- ☐ Arise out of (or in the course of) any work for pay or profit; or
- ☐ Result in any way from an Injury which does.

Non-Specialist
A Physician who is not a Specialist.

O

Occupational Injury or Occupational Illness
An Injury or Illness that:

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

Occurrence
This means a period of disease or Injury. An Occurrence ends when 60 consecutive days have passed during which the covered person:

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

Orthodontic Treatment
This is any:

- ☐ Medical service or supply; or
- ☐ Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- ☐ Of the teeth; or
- ☐ Of the bite; or
- ☐ Of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

The following are not considered Orthodontic Treatment:

- ☐ The installation of a space maintainer; or
- ☐ A surgical procedure to correct malocclusion.

Out-of-Network Service(s) and Supply(ies)
Health care service or supply that is:

- ☐ Furnished by an Out-of-Network Provider; or
- ☐ Not furnished or arranged by your PCP.

Out-of-Network Provider
A health care provider who has not contracted with Cigna, an affiliate, or a third-party vendor, to furnish services or supplies for this plan.

P

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

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

Payment Percentage
This is both the percentage of Covered Expenses that the plan pays, and the percentage of Covered Expenses that you pay. Once applicable Deductibles have been met, your plan will pay a percentage of the Covered Expenses, and you will be responsible for the rest of the costs. The percentage that the plan pays may vary by the type of expense. The percentage that you pay is also known as "Co-Insurance". Please refer to the Schedule of Benefits section for specific information on Payment Percentage amounts for each covered benefit.

Physician
A duly licensed member of a medical profession who:

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

This also includes a health professional who:

- ☐ Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- ☐ Provides medical services which are within the scope of his or her license or certificate;
- ☐ Under applicable insurance law is considered a "Physician" for purposes of this coverage;
- ☐ Has the medical training and clinical expertise suitable to treat your condition;
- ☐ Specializes in psychiatry, if your Illness or Injury is caused, to any extent, by alcohol abuse, Substance Abuse or a Mental Disorder; and
- ☐ A Physician is not you or related to you.

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

Primary Care Physician (PCP)
This is the In-Network Provider who:

- ☐ Is selected by a person from the list of Primary Care Physicians in the Directory;

- ☐ Supervises, coordinates and provides initial care and basic medical services to a person as a general or family care practitioner, or in some cases, as an internist or a pediatrician; and
- ☐ Is shown on Cigna's records as the person's PCP.

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

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

Psychiatric Physician
This is a Physician who:

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

R

Recognized Charge
The covered expense is only that part of a charge which is the Recognized Charge.

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

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

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

Cigna may also reduce the Recognized Charge by applying Cigna Reimbursement Policies. Cigna

Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- ☐ The duration and complexity of a service;
- ☐ Whether multiple procedures are billed at the same time, but no additional overhead is required;
- ☐ Whether an assistant surgeon is involved and necessary for the service;
- ☐ If follow up care is included;
- ☐ Whether there are any other characteristics that may modify or make a particular service unique; and
- ☐ When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Cigna Reimbursement Policies are based on Cigna's review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with Physician or dental specialty society recommendations; and the views of Physicians and Dentists practicing in the relevant clinical areas. Cigna uses a commercial software package to administer some of these policies.
As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- ☐ Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- ☐ Prevailing Charge Rates: These are rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. Cigna updates its systems with these changes within 180 days after receiving them from FAIR Health.

Important Note:
Cigna periodically updates its systems with changes made to the Prevailing Charge Rates.

What this means to you is that the Recognized Charge is based on the version of the rates that is in use by Cigna on the date that the service or supply was provided.

Additional Information:
Cigna's website www.Cigna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Cigna Member Website to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Cost Estimator" tools, or contact our Customer Service Department for assistance.

Residential Treatment Facility (Alcoholism and Substance Abuse)
This is an institution that meets all of the following requirements:

- ☐ On-site licensed Behavioral Health Provider 24 hours per day/7 days a week.
- ☐ Provides a comprehensive patient assessment (preferably before admission, but at least upon

admission).

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

Residential Treatment Facility (Mental Disorders)

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

- ☐ On-site licensed Behavioral Health Provider 24 hours per day/7 days a week.
- ☐ Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- ☐ Is admitted by a Physician.
- ☐ Has access to necessary medical services 24 hours per day/7 days a week.
- ☐ Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- ☐ Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- ☐ Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- ☐ Provides access to at least weekly sessions with a Psychiatrist or psychologist for individual

psychotherapy.

- ☐ Has peer-oriented activities.
- ☐ Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the Cigna credentialing criteria as an individual Behavioral Health Practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- ☐ Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- ☐ Provides a level of skilled intervention consistent with patient risk.
- ☐ Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- ☐ Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

R.N.
A registered nurse.

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

S

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

Service Area
This is the geographic area, as determined by Cigna, in which In-Network Providers for this plan are located.

Skilled Nursing Facility
An institution that meets all of the following requirements:

- ☐ It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from Illness or Injury:
  - ■ Professional nursing care by an R.N., or by a L.P.N. directed by a full-time R.N.; and
  - ■ Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- ☐ Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- ☐ Is supervised full-time by a Physician or an R.N.
- ☐ Keeps a complete medical record on each patient.
- ☐ Has a utilization review plan.
- ☐ Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of Mental Disorders.

- ☐ Charges patients for its services.
- ☐ An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- ☐ Qualifies as a Skilled Nursing Facility under Medicare or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of Hospitals of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation Hospitals (all levels of care, e.g. acute) and portions of a Hospital designated for skilled or rehabilitation services.

Skilled Nursing Facility does not include:

- ☐ Institutions which provide only:
  - Minimal care;
  - Custodial Care services;
  - Ambulatory; or
  - Part-time care services.
- ☐ Institutions which primarily provide for the care and treatment of alcoholism, Substance Abuse or Mental Disorders.

Skilled Nursing Services

Services that meet all of the following requirements:

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

Specialist

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

Spouse

Spouse must meet the definition as defined on Page 6, under *Coverage for Spouses*, in this Summary Plan Description.

Stay

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

Stepchild(ren)

Stepchildren are natural or adopted children of your Spouse who have not met any of the termination requirements listed under Ohio Revised Code section 3119.88.

Substance Abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent

(These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a Mental Disorder that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

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

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

Must have all of the following:

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

T

Terminally Ill (Hospice Care)
Terminally Ill means a medical prognosis of 6 months or less to live.

U

Urgent Admission
A Hospital admission by a Physician due to:

- ☐ The onset of or change in a Illness; or
- ☐ The diagnosis of a Illness; or
- ☐ An Injury.
- ☐ The condition, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a Hospital within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider
This is:

- ☐ A freestanding medical facility that meets all of the following requirements.
  - ■ Provides unscheduled medical services to treat an Urgent Condition if the person's Physician is not reasonably available.
  - ■ Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - ■ Makes charges.
  - ■ Is licensed and certified as required by any state or federal law or regulation.
  - ■ Keeps a medical record on each patient.
  - ■ Provides an ongoing quality assurance program. This includes reviews by Physicians other than those who own or direct the facility.
  - ■ Is run by a staff of Physicians. At least one Physician must be on call at all times.
  - ■ Has a full-time administrator who is a licensed Physician.
- ☐ A Physician's office, but only one that:
  - ■ Has contracted with Cigna to provide urgent care; and
  - ■ Is, with Cigna's consent, included in the Directory as an in-network Urgent Care Provider.
- ☐ It is not the emergency room or outpatient department of a Hospital.

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

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

W

Walk-in Clinic

Walk-in Clinics are free-standing health care facilities. They are an alternative to a Physician's office visit for treatment of unscheduled, non-emergency Illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a Physician. Neither an emergency room, nor the outpatient department of a Hospital, shall be considered a Walk-in Clinic.

IMPORTANT HEALTH CARE REFORM NOTICES

CHOICE OF PROVIDER

If your Cigna plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, Cigna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Employer or, if you are a current member, your Cigna contact number on the back of your ID card.

If your Cigna plan allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider.

If your Cigna plan provides coverage for obstetric or gynecological care and requires the designation of a primary care provider, then you do not need prior authorization from Cigna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Employer or, if you are a current member, your Cigna contact number on the back of your ID card. ***Our plan does not require, but does allow you to select a PCP.***

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of Stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter Stay if the attending provider (e.g., your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) Stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the Stay.

In addition, a plan or issuer may not, under federal law, require that you, your Physician, or other health care provider obtain authorization for prescribing a length of Stay of up to 48 hours (or 96 hours). However, you may be required to obtain Precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on Precertification, contact your plan administrator.

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- ☐ All stages of reconstruction of the breast on which a mastectomy has been performed;
- ☐ Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- ☐ Prostheses; and
- ☐ Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending Physician and the patient, and will be provided in accordance with the plan design, limitations, Copays, Deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, http://www.cms.gov/HealthInsReformforConsume/, and this U.S. Department of Labor website, http://www.dol.gov/ebsa/consumer_info_health.html.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply with Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA).

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Health Expense Benefits for you and your eligible dependents.

At the time you request the leave, you must agree to make any contributions required by your Employer to continue coverage.

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- ☐ The date you are required to make any contribution and you fail to do so.
- ☐ The date your Employer determines your approved FMLA leave is terminated.
- ☐ The date the coverage involved discontinues as to your eligible class. However, coverage for health expenses may be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Health Expense Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation Under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on

such date. If this Plan provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under this Plan will be in force as though you had continued in active employment rather than going on an approved FMLA leave.

If any coverage being continued terminates because your Employer determines the approved FMLA leave is terminated, any Conversion Privilege will be available on the same terms as though your employment had terminated on the date your Employer determines the approved FMLA leave is terminated.

Recognized Charge with Surprise Billing

The amount of an Out-of-Network Provider's charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

Through the National Advantage Program (NAP), the Recognized Charge is determined as follows:

- ☐ If your service was received from a NAP provider, a pre-Negotiated Charge will be paid. NAP providers are Out-of-Network Providers that have contracts with Cigna, directly or through third-party vendors, that include a pre-Negotiated Charge for services. NAP providers are not network providers.
- ☐ If your service was not received from a NAP provider, a claim specific rate or discount may be negotiated by Cigna or a third-party vendor.

If your claim is not paid as outlined above, the Recognized Charge for specific services or supplies will be the out-of-network plan rate, calculated in accordance with the following:

Service or Supply	Out-of-Network Plan Rate
Professional services	An amount determined by Cigna, or its third-party vendors, based on data resources selected by Cigna, reflecting typical costs, competitive charges and/or payments for a service, adjusted for the geographic area in which the service was provided.

Inpatient and outpatient charges of Hospitals	An amount determined by Cigna (such as FCR), or its third-party vendors, based on data resources selected by Cigna, reflecting typical costs, competitive charges and/or payments for a service, adjusted for the geographic area in which the service was provided.
Inpatient and outpatient charges of facilities other than Hospitals	Facility Charge Review
Prescription drugs	110% of the average wholesale price (AWP)

Important note: If the provider bills less than the amount calculated using the out-of-network plan rate described above, the Recognized Charge is what the provider bills.

In the event you receive a balance bill from a provider for your Out-of-Network Service, Patient Advocacy Services may be available to assist you in certain circumstances.

The out-of-network plan rate does not apply to involuntary services. Involuntary services are services or supplies that are one of the following:

- ☐ Performed at an in-network facility by certain Out-of-Network Providers
- ☐ Not available from an In-Network Provider
- ☐ Emergency services

We will calculate your cost share for involuntary services in the same way as we would if you received the services from an In-Network Provider. If you receive a surprise bill, your cost share will be calculated at the median contracted rate.

Important Note:
In the case of a surprise bill from an Out-of-Network Provider, where you had no control of their participation in your covered services, you will pay the same cost share you would have if the covered services were received from an In-Network Provider. The cost share will be based on the median contracted rate. Contact us immediately if you receive such a bill.

Special terms used:

- ☐ Average wholesale price (AWP) is the current average wholesale price of a prescription drug listed in the Facts and Comparisons, Medi-span weekly price updates (or any other similar publication chosen by Cigna).
- ☐ Facility charge review (FCR) rate is an amount that we determine is enough to cover the facility provider's estimated costs for the service and leave the facility provider with a reasonable profit. For Hospitals and other facilities that report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on what the facilities report to CMS. For facilities that do not report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on statewide averages of the facilities that do report to CMS. We may adjust the formula as needed to maintain the reasonableness of the Recognized Charge. For example, we may make an adjustment if we determine that in a particular state the charges of ambulatory Surgery Centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to-charge ratios) to CMS.
- ☐ Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.

Our reimbursement policies
We reserve the right to apply our reimbursement policies to all Out-of-Network Services including involuntary services. Our reimbursement policies may affect the Recognized Charge.

These policies consider:

- ☐ The duration and complexity of a service
- ☐ When multiple procedures are billed at the same time, whether additional overhead is required
- ☐ Whether an assistant surgeon is necessary for the service
- ☐ If follow-up care is included
- ☐ Whether other characteristics modify or make a particular service unique
- ☐ When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- ☐ The educational level, licensure or length of training of the provider

Our reimbursement policies may consider:

- ☐ The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- ☐ Generally accepted standards of medical and dental practice
- ☐ The views of **Physicians** and Dentists practicing in the relevant clinical areas
- ☐ Cigna's own data and/or databases and methodologies maintained by third parties.

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

Get the most value out of your benefits
We have online tools to help you decide where to get care. Use the "Estimate the Cost of Care" tool on Cigna member website. Cigna's secure member website at www.Cigna.com may contain additional information that can help you determine the cost of a service or supply. Log on to Cigna member website to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Cost Estimator" tools.

Emergency services important note:

- ☐ Out-of-Network Providers do not have a contract with us. The provider may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by the plan. If the provider bills you for an amount above your cost share, you are not responsible for payment of that amount. You should send the bill to the address on your ID card and we will resolve any payment issue with the provider. Make sure the member ID is on the bill.
- ☐ In the case of a surprise bill from an Out-of-Network Provider, where you had no control of their participation in your covered services, you will pay the same cost share you would have if the covered services were received from an In-Network Provider. The cost share will be based on the median contracted rate. Contact us immediately if you receive such a bill.
- ☐ If you are admitted to the Hospital for an inpatient Stay right after you visit the emergency room, you will not pay your emergency room cost share if you have one. You will pay the inpatient Hospital cost share, if any.

Emergency services
When you experience an Emergency Medical Condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and Ambulance help.

Your coverage for emergency services will continue until your condition is stabilized and:

- ☐ Your attending Physician determines that you are medically able to travel or to be transported, by non-medical or non-emergency medical transportation, to another provider if you need more care
- ☐ You are in a condition to be able to receive from the Out-of-Network Provider delivering services the notice and consent criteria with respect to the services
- ☐ Your Out-of-Network Provider delivering the services meets the notice and consent criteria with respect to the services

If your Physician decides you need to Stay in the Hospital (emergency admission) or receive follow-up care, these are not emergency services. Different benefits and requirements apply. Please refer to the *How your plan works – Medical Necessity and Precertification requirements* section and the *Coverage and exclusions* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact us or your in-network Physician or Primary Care Physician (PCP).

Non-Emergency Services
If you go to an emergency room for what is not an Emergency Medical Condition, the plan may not cover your expenses. See the Schedule of Benefits section for more information.

Schedule of Benefits

	LOW -DED +INCENTIVE		LOW -DED NON- INCENTIVE		HIGH DEDUCTIBLE	
Plan Features	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Calendar Year Deductible*						
Individual Deductible*	$500	$1,000	$1,000	$1,500	$1,800	$1,800
Family Deductible*	$1,000	$2,000	$2,000	$3,000	$3,600 (*with $3,200 individual Deductible*)	$3,600 (*with $3,200 individual Deductible*)
Lifetime Maximum Benefit per person	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited

Unless otherwise indicated, any applicable **Deductible must be met before benefits are paid.*

Plan Maximum Out of Pocket Limit includes plan **Deductible**.

	LOW -DED +INCENTIVE		LOW -DED NON- INCENTIVE		HIGH DEDUCTIBLE	
Plan Features	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Individual Maximum Out of Pocket Limit	For in-network expenses: $1,500	For out-of-network expenses: $3,000	For in-network expenses: $3,000	For out-of-network expenses: $4,500	For in-network expenses: $5,000	For out-of-network expenses: $10,000
Family Maximum Out of Pocket Limit	For in-network expenses: $3,000	For out-of-network expenses: $6,000	For in-network expenses: $6,000	For out-of-network expenses: $9,000	For in-network expenses: $10,000	For out-of-network expenses: $20,000

Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any Deductibles and the remaining Payment Percentage. You are responsible for full payment of any non-Covered Expenses you incur.

All Covered Expenses are subject to the Calendar Year Deductible unless otherwise noted in the Schedule below.

Maximums for specific Covered Expenses, including visit, day and dollar maximums are combined maximums between in-network and out-of-network, unless specifically stated otherwise.

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
PREVENTIVE CARE BENEFITS						
Routine Physical Exams Includes coverage for immunizations	100% per visit No Copay or Deductible applies	60% per visit after Calendar Year Deductible	100% per visit No Copay or Deductible applies	60% per visit after Calendar Year Deductible	100% per visit No Deductible applies	65% per visit after Calendar Year Deductible
Maximum Exams per 12 consecutive month period						
Adults age 18 and over	1 exam	1 exam	1 exam	1 exam	1 exam	1 exam
Well Child Exams Includes coverage for immunizations	100% per visit No Copay or Deductible applies	60% per visit after Calendar Year Deductible	100% per visit No Copay or Deductible applies	60% per visit after Calendar Year Deductible	100% per visit No Copay or Deductible applies	65% per visit after Calendar Year Deductible
Maximum Exams						
Under age 3						
first 12 months of life	7 exams	7 exams	7 exams	7 exams	7 exams	7 exams
13th-36th months of life	3 exams	3 exams	3 exams	3 exams	3 exams	3 exams
For age 3 to 18	1 exam	1 exam	1 exam	1 exam	1 exam	1 exam
Hearing Exam	$40 per exam Copay then the plan pays 100% - No Calendar Year Deductible applies	60% per exam after Calendar Year Deductible	$80 per exam Copay then the plan pays 100% - No Calendar Year Deductible applies	60% per exam after Calendar Year Deductible	85% per exam after Calendar Year Deductible	65% per exam after Calendar Year Deductible
Maximum exams per 24 month period	1 exam	1 exam	1 exam	1 exam	1 exam	1 exam
ROUTINE CANCER SCREENINGS						
Routine Gynecological Exam (Includes Routine Pap Smears)	100% per exam No Calendar Year Deductible applies.	60% per exam after Calendar Year Deductible	100% per exam No Calendar Year Deductible applies.	60% per exam after Calendar Year Deductible	100% per exam No Calendar Year Deductible applies.	65% per exam after Calendar Year Deductible

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Maximum exams per Calendar Year	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your Physician, log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.*	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your Physician, log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.*	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your Physician, log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.*	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your Physician, log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.*	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your Physician, log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.*	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your Physician, log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.*
All Other Routine Exams and Screenings	100% per exam No Calendar Year Deductible applies.	60% per exam after Calendar Year Deductible	100% per exam No Calendar Year Deductible applies.	60% per exam after Calendar Year Deductible	100% per exam No Calendar Year Deductible applies.	65% per exam after Calendar Year Deductible
Maximum tests per Calendar Year	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
	For details, contact your Physician, [log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.]	*For details, contact your Physician, [log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.]*	*For details, contact your Physician, [log onto the Cigna website www.Cigna.com, or or call the number on the back of your ID card.]*	*For details, contact your Physician, [log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.]*	*For details, contact your Physician, [log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.]*	*For details, contact your Physician, [log onto the Cigna website www.Cigna.com, or call the number on the back of your ID card.]*
PHYSICIAN SERVICES						
Office Visits to Primary Care Physician Office visits (non-surgical) to Non-Specialist (including Chiropractic, up to 20 visits per year)	$20 visit Copay then the plan pays 100% No Calendar Year Deductible applies	60% per visit after Calendar Year Deductible	$40 visit Copay then the plan pays 100% No Calendar Year Deductible applies	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Telehealth with MDLIVE Primary Care Services	$10 visit Copay then the plan pays 100% No Calendar Year Deductible applies	Not covered	$20 visit Copay then the plan pays 100% No Calendar Year Deductible applies	Not covered	85% per visit after Calendar Year Deductible	Not covered
Specialist Office Visits	$40 visit Copay then the plan pays 100% No Calendar Year Deductible applies.	60% per visit after Calendar Year Deductible	$80 visit Copay then the plan pays 100% No Calendar Year Deductible applies.	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Telehealth with MDLIVE Specialty Care Services	$20 visit Copay then the plan pays 100% No Calendar Year Deductible applies	Not covered	$40 visit Copay then the plan pays 100% No Calendar Year Deductible applies	Not covered	85% per visit after Calendar Year Deductible	Not covered
Physician Office Visits-Surgery	80% per visit after Calendar Year Deductible	60% per visit after Calendar Year Deductible	70% per visit after Calendar Year Deductible	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Walk-in Clinics Non-Emergency Visit	$20 visit Copay then the plan pays 100%	60% per visit after Calendar Year Deductible	$40 visit Copay then the plan pays 100%	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
	No Calendar Year Deductible applies.		No Calendar Year Deductible applies.			
Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Calendar Year Deductible	60% per visit after Calendar Year Deductible	70% per visit after Calendar Year Deductible	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Administration of Anesthesia	80% per procedure after Calendar Year Deductible	60% per procedure after Calendar Year Deductible	70% per procedure after Calendar Year Deductible	60% per procedure after Calendar Year Deductible	85% per procedure after Calendar Year Deductible	65% per procedure after Calendar Year Deductible
Allergy Testing	$40 visit Copay then the plan pays 100% No Calendar Year Deductible applies.	60% per visit after Calendar Year Deductible	$80 visit Copay then the plan pays 100% No Calendar Year Deductible applies.	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Allergy Injections and Treatment	80% per visit No Calendar Year Deductible applies.	60% per visit No Calendar Year Deductible applies.	70% per visit No Calendar Year Deductible applies.	60% per visit No Calendar Year Deductible applies.	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Immunizations (when not part of the physical exam)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Prenatal Visits	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Hearing Related Services $2,000 limit every 3 years per member	80% per visit after Calendar Year Deductible	60% per visit after Calendar Year Deductible	70% per visit after Calendar Year Deductible	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible

LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
EMERGENCY MEDICAL SERVICES					
Hospital Emergency Facility and Physician	$150 Copay per visit then the plan pays 100% No Calendar Year Deductible applies.	$150 Deductible per visit then the plan pays 100% No Calendar Year Deductible applies.	$300 Copay per visit then the plan pays 100% No Calendar Year Deductible applies.	$300 Deductible per visit then the plan pays 100% No Calendar Year Deductible applies.	85% per visit after the Calendar year Deductible	85% per visit after the Calendar year Deductible
Important Note: Please note that some providers are not network providers and do not have a contract with Cigna, the provider may not accept payment of your cost share (your Deductible and Payment Percentage), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or Physician bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.					
Important Notice: A separate Hospital emergency room Deductible or Copay applies for each visit to an emergency room for Emergency Care. If you are admitted to a Hospital as an inpatient immediately following a visit to an emergency room, your Copay is waived but you will be subject to any inpatient Deductibles and Payment Percentages for your inpatient Stay. (This notice does not apply to the High Deductible Plan.)					
URGENT CARE SERVICES					
Urgent Medical Care *(at a non-Hospital free standing facility)*	$20 Copay per visit then the plan pays 100% No Calendar Year Deductible applies	60% per visit after Calendar Year Deductible	$40 Copay per visit then the plan pays 100% No Calendar Year Deductible applies	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Urgent Medical Care *(from other than a non-Hospital free standing facility)*	Refer to *Emergency Medical Services* and *Physician Services* above	Refer to *Emergency Medical Services* and *Physician Services* above	Refer to *Emergency Medical Services* and *Physician Services* above	Refer to *Emergency Medical Services* and *Physician Services* above	Refer to *Emergency Medical Services* and *Physician Services* above	Refer to *Emergency Medical Services* and *Physician Services* above
Telehealth with MDLIVE Urgent Virtual Care Services	Plan pays 100%	Not covered	Plan pays 100%	Not covered	Plan pays 85% after Calendar Year Deductible	Not covered
OUTPATIENT DIAGNOSTIC AND PREOPERATIVE TESTING						
Complex Imaging	80% per procedure after Calendar Year Deductible	60% per procedure after Calendar Year Deductible	70% per procedure after Calendar Year Deductible	60% per procedure after Calendar Year Deductible	85% per procedure after Calendar Year Deductible	65% per procedure after Calendar Year Deductible
Diagnostic Laboratory Testing	$40 per visit Copay per procedure then the plan pays 100%	60% per procedure after Calendar Year Deductible	$80 per visit Copay per procedure then the plan pays 100%	60% per procedure after Calendar Year Deductible	85% per procedure after Calendar Year Deductible	65% per procedure after Calendar Year Deductible

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
	No Calendar Year Deductible applies.		No Calendar Year Deductible applies.			
Important Note: If you have your lab work done by the Wayne County Wellness Nurse, you may not be subject to the Copay (and for the High Deductible Plan, you may be able to save money). Contact the Wellness Nurse for more details and/or to see if your lab work will qualify for the waived Copay!						
Diagnostic X-Rays (except complex imaging services)	80% per procedure after Calendar Year Deductible	60% per procedure after Calendar Year Deductible	70% per procedure after Calendar Year Deductible	60% per procedure after Calendar Year Deductible	85% per procedure after Calendar Year Deductible	65% per procedure after Calendar Year Deductible
OUTPATIENT SURGERY						
Outpatient Surgery	80% per visit/surgical procedure after Calendar Year Deductible	60% per visit/surgical procedure after Calendar Year Deductible	70% per visit/surgical procedure after Calendar Year Deductible	60% per visit/surgical procedure after Calendar Year Deductible	85% per visit/surgical procedure after Calendar Year Deductible	65% per visit/surgical procedure after Calendar Year Deductible
INPATIENT FACILITY EXPENSES						
Hospital Facility Expenses Room and Board (including maternity)	80% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	70% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	85% per admission after Calendar Year Deductible	65% per admission after Calendar Year Deductible
Other than Room and Board	80% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	70% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	85% per admission after Calendar Year Deductible	65% per admission after Calendar Year Deductible
Skilled Nursing Inpatient Facility	80% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	70% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	85% per admission after Calendar Year Deductible	65% per admission after Calendar Year Deductible
Maximum Days per Calendar Year	180 days	180 days	180 days	180 days	180 days	180 days
SPECIALTY BENEFITS						
Home Health Care (Outpatient)	80% per visit after the Calendar Year Deductible	60% per visit after the Calendar Year Deductible	70% per visit after the Calendar Year Deductible	60% per visit after the Calendar Year Deductible	85% per visit after the Calendar Year Deductible	65% per visit after the Calendar Year Deductible
Maximum Visits per Calendar Year	30 visits	30 visits	30 visits	30 visits	30 visits	30 visits

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
HOSPICE BENEFITS						
Hospice Care - Facility Expenses (Room & Board)	100% per admission No Calendar Year Deductible applies	100% per admission No Calendar Year Deductible applies	100% per admission No Calendar Year Deductible applies	100% per admission No Calendar Year Deductible applies	85% per admission after the Calendar Year Deductible	65% per admission after the Calendar Year Deductible
Hospice Care - Other Expenses during a Stay	100% per admission No Calendar Year Deductible applies	100% per admission No Calendar Year Deductible applies	100% per admission No Calendar Year Deductible applies	100% per admission No Calendar Year Deductible applies	85% per admission after the Calendar Year Deductible	65% per admission after the Calendar Year Deductible
Maximum Benefit per lifetime*	360 days	360 days	360 days	360 days	360 days	360 days
**Lifetime maximum is a combined maximum for inpatient and outpatient services.*						
Hospice Outpatient Visits	100% per visit No Calendar Year Deductible applies	100% per visit No Calendar Year Deductible applies	100% per visit No Calendar Year Deductible applies	100% per visit No Calendar Year Deductible applies	85% per visit after the Calendar Year Deductible	65% per visit after the Calendar Year Deductible

INFERTILITY TREATMENT						
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the under-lying medical condition causing the Infertility only	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

MENTAL DISORDERS						
Office Visits (non-surgical)	$20 visit Copay then the plan pays 100%; No Calendar Year Deductible applies	60% per visit after Calendar Year Deductible	$40 visit Copay then the plan pays 100%; No Calendar Year Deductible applies	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Inpatient Treatment	80% per admission after the Calendar Year Deductible	60% per admission after the Calendar Year Deductible	70% per admission after the Calendar Year Deductible	60% per admission after the Calendar Year Deductible	85% per admission after the Calendar Year Deductible	65% per admission after the Calendar Year Deductible

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Maximum Benefit per Calendar Year	30 days	10 days	30 days	10 days	30 days	10 days
Outpatient Treatment	80% per admission after the Calendar Year Deductible	60% per admission after the Calendar Year Deductible	70% per admission after the Calendar Year Deductible	60% per admission after the Calendar Year Deductible	85% per admission after the Calendar Year Deductible	65% per admission after the Calendar Year Deductible
Maximum Visits per Calendar Year	50 visits	20 visits	50 visits	20 visits	50 visits	20 visits

Updated 1/1/19

ALCOHOLISM AND SUBSTANCE ABUSE						
Office Visits (non-surgical)	$20 visit Copay then the plan pays 100%; No Calendar Year Deductible applies	60% per visit after Calendar Year Deductible	$40 visit Copay then the plan pays 100%; No Calendar Year Deductible applies	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Inpatient Treatment	80% per admission after the Calendar Year Deductible	60% per admission after the Calendar Year Deductible	70% per admission after the Calendar Year Deductible	60% per admission after the Calendar Year Deductible	85% per admission after the Calendar Year Deductible	65% per admission after the Calendar Year Deductible
Maximum Days per Calendar Year	30 days	10 days	30 days	10 days	30 days	10 days
Lifetime Maximum	2 courses of treatment		2 courses of treatment		2 courses of treatment	
Outpatient Treatment	80% per admission after the Calendar Year Deductible	60% per admission after the Calendar Year Deductible	70% per admission after the Calendar Year Deductible	60% per admission after the Calendar Year Deductible	85% per admission after the Calendar Year Deductible	65% per admission after the Calendar Year Deductible
Maximum Visits per Calendar Year	50 visits	20 visits	50 visits	20 visits	50 visits	20 visits
Important Notice: Both in-network and out-of-network alcoholism and Substance Abuse and mental Illness treatment visit limits accumulate toward any maximum shown above for alcoholism and Substance Abuse and mental Illness treatment visit limits.						

Updated 1/1/19

TRANSPLANT SERVICES FACILITY AND NON-FACILITY EXPENSES									
	Network (IOE Facility)	**Network (Non-IOE Facility)**	**Out-of-Network**	**Network (IOE Facility)**	**Network (Non-IOE Facility)**	**Out-of-Network**	**Network (IOE Facility)**	**Network (Non-IOE Facility)**	**Out-of-Network**
Transplant Facility Expenses	100% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	100% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	60% per admission after Calendar Year Deductible	85% per admission after Calendar Year Deductible	65% per admission after Calendar Year Deductible	65% per admission after Calendar Year Deductible

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided
OTHER COVERED HEALTH EXPENSES						
Ground, Air or Water Ambulance	80% after Calendar Year Deductible	80% after Calendar Year Deductible	70% after Calendar Year Deductible	70% after Calendar Year Deductible	85% after Calendar Year Deductible	85% after Calendar Year Deductible
Durable Medical and/or Surgical Equipment	80% per item after the Calendar Year Deductible	Not covered	70% per item after the Calendar Year Deductible	Not covered	85% per item after the Calendar Year Deductible	Not covered
Gene-based Cellular and Other Innovative Therapies (GCIT)	$100 Copay per visit; Plan pays 80% after Deductible	Not covered outside of approved clinic.	$100 Copay per visit; Plan pays 80% after Deductible	Not covered outside of approved clinic.		
Jaw Joint Disorder Treatment	80% per visit after Calendar Year Deductible* *if not part of an office visit	60% per visit after Calendar Year Deductible	70% per visit after Calendar Year Deductible* *if not part of an office visit	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided
Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
OUTPATIENT THERAPIES						
Chemo-therapy	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided
Infusion Therapy	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided
Radiation Therapy	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided
Renal Replacement Therapy (RRT) / Dialysis	Covered same as plan's Outpatient Facility Services benefit	Covered same as plan's Outpatient Facility Services benefit	Covered same as plan's Outpatient Facility Services benefit	Covered same as plan's Outpatient Facility Services benefit	Covered same as plan's Outpatient Facility Services benefit	Covered same as plan's Outpatient Facility Services benefit
SHORT TERM OUTPATIENT REHABILITATION THERAPIES						
Outpatient Physical and Occupational Therapy only	$40 per day Copay then the plan pays 100% No Calendar Year Deductible applies	60% per day after Calendar Year Deductible	$80 per day Copay then the plan pays 100% No Calendar Year Deductible applies	60% per day after Calendar Year Deductible	85% per day after Calendar Year Deductible	65% per day after Calendar Year Deductible
Physical Therapy Maximum visits per Calendar Year	30 visits	30 visits	30 visits	30 visits	30 visits	30 visits
Occupational Therapy Maximum visits per Calendar Year	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits
Speech Therapy only	$40 per day Copay then the plan pays 100%	60% per day after Calendar Year Deductible	$80 per day Copay then the plan pays 100%	60% per day after Calendar Year Deductible	85% per day after Calendar Year Deductible	65% per day after Calendar Year Deductible

	LOW-DED +INCENTIVE		LOW-DED NON-INCENTIVE		HIGH DEDUCTIBLE	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
	No Calendar Year Deductible applies		No Calendar Year Deductible applies			
Speech Therapy Maximum visits per Calendar Year	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits

SPINAL MANIPULATION						
Spinal Manipulation only	$40 per visit Copay then the plan pays 100% No Calendar Year Deductible applies.	60% per visit after Calendar Year Deductible	$80 per visit Copay then the plan pays 100% No Calendar Year Deductible applies.	60% per visit after Calendar Year Deductible	85% per visit after Calendar Year Deductible	65% per visit after Calendar Year Deductible
Spinal Manipulation Maximum visits per Calendar Year	20 visits	20 visits	20 visits	20 visits	20 visits	20 visits
Important Notice: Both **in-network** and **out-of-network** Short Term Outpatient Rehabilitation Therapies visit limits accumulate toward any maximum shown above for Short Term Outpatient Rehabilitation Therapies visit limits.						
Updated 10/7/2022						

Expense Provisions

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this Schedule of Benefits.

This Schedule of Benefits replaces any Schedule of Benefits previously in effect under your plan of health benefits.

Deductible Provisions

In-Network Calendar Year Deductible

This is an amount of in-network Covered Expenses incurred each Calendar Year for which no benefits will be paid. The in-network Calendar Year Deductible applies separately to you and each of your covered dependents. After Covered Expenses reach the in-network Calendar Year Deductible, the plan will begin to pay benefits for Covered Expenses for the rest of the Calendar Year.

Out-of-Network Calendar Year Deductible

This is an amount of out-of-network Covered Expenses incurred each Calendar Year for which no benefits will be paid. The out-of-network Calendar Year Deductible applies separately to you and each of your covered dependents. After Covered Expenses reach the out-of-network Calendar Year Deductible, the plan will begin to pay benefits for Covered Expenses for the rest of the Calendar Year.

Covered Expenses applied to the out-of-network Deductible will not be applied to satisfy the in-network Deductible and Covered Expenses applied to the in-network Deductible will not be applied to satisfy the out-of-network Deductible.

In-Network Family Deductible Limit

When you incur in-network Covered Expenses that apply toward the in-network Calendar Year Deductibles for you and each of your covered dependents, these expenses will also count toward the in-network Calendar Year family Deductible limit. Your in-network family Deductible limit will be considered to be met for the rest of the Calendar Year once the combined Covered Expenses reach the in-network family Deductible limit in a Calendar Year.

Out-of-Network Family Deductible Limit

When you incur out-of-network Covered Expenses that apply toward the out-of-network Calendar Year Deductibles for you and each of your covered dependents, these expenses will also count toward the out-of-network Calendar Year family Deductible limit. Your out-of-network family Deductible limit will be considered to be met for the rest of the Calendar Year once the combined Covered Expenses reach the out-of-network family Deductible limit in a Calendar Year.

Covered Expenses applied to the out-of-network Deductible will not be applied to satisfy the in-network Deductible and Covered Expenses applied to the in-network Deductible will not be applied to satisfy the out-of-network Deductible.

Copayments and Benefit Deductible Provisions (does not apply to High Deductible Plan)

This is a specified dollar amount or percentage of the Negotiated Charge required to be paid by you at the time you receive a covered service from an In-Network Provider. It represents a portion of the applicable expense.

Payment Percentage

This is both the percentage of Covered Expenses that the plan pays, and the percentage of Covered Expenses that you pay. Once applicable Deductibles have been met, your plan will pay a percentage of the Covered Expenses, and you will be responsible for the rest of the costs. The percentage that the plan pays may vary by the type of expense. The percentage that you pay is also known as “Co-Insurance”. Please refer to this Schedule of Benefits section for specific information on Payment Percentage amounts for each covered benefit.

Maximum Out-of-Pocket Limit

The Maximum Out-of-Pocket Limit is the maximum amount you are responsible to pay for Covered Expenses during the Calendar Year. Once you satisfy the Maximum Out-of-Pocket Limit, the plan will pay 100% of the Covered Expenses that apply toward the limit for the rest of the Calendar Year. The Maximum Out-of-Pocket Limit applies to both in-network and out-of-network benefits.

This plan has an Individual Maximum Out-of-Pocket Limit. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the individual Maximum Out-of-Pocket Limit, the plan will pay 100% of Covered Expenses for the remainder of the Calendar Year for that person.

There is also a Family Maximum Out-of-Pocket Limit. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets two times the individual Maximum Out-of-Pocket Limit, the plan will pay 100% of Covered Expenses for the remainder of the Calendar Year for all covered family members.

The Maximum Out-of-Pocket Limit applies to both in-network and out-of-network benefits. You have separate Maximum Out-of-Pocket Limits for in-network and out-of-network benefits. Maximum Out-of-Pocket Limit amounts paid by you for in-network and out-of-network Covered Expenses apply to each limit separately and may not be combined and applied toward one limit.

Expenses That Do Not Apply to Your Out-of-Pocket Limit

Certain Covered Expenses do not apply toward your plan out-of-pocket limit. These include:

- ☐ Charges over the Recognized Charge;
- ☐ Expenses incurred for outpatient prescription drugs (this bullet does not apply to High Deductible Plan);
- ☐ Non-Covered Expenses;
- ☐ Expenses that are not paid, or Precertification benefit reductions because a required Precertification for the service(s) or supply was not obtained from Cigna.

Calendar Year Maximum Benefit

The most the plan will pay for Covered Expenses incurred by any one covered person in a Calendar Year is called the Calendar Year maximum benefit. The Calendar Year maximum benefit applies to in-network care and out-of-network care expenses combined.

Precertification Benefit Reduction

The SPD contains a complete description of the Precertification program. Refer to the Understanding Precertification section for a list of services and supplies that require Precertification. Failure to Precertify your Covered Expenses when required will result in a benefits reduction as follows:

- ☐ A $500 benefit reduction will be applied separately to each type of expense.

Time Frame to Turn in Claims

All claims must be turned into Cigna for processing within 12 months of the service date. Claims turned in after 12 months from the date of service will not be paid nor considered covered services.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your SPD and should be kept with your SPD.

Important Notices:

- Review the Summary of Benefit Coverage behind tab 10 of this binder for a recap of the Wayne County Plan design and coverage examples.
- Read more about the Wellness Program in the Notice Regarding Wellness Program behind tab 10 and in the Wellness Program section of this binder

Prescriptions

- CVS Caremark Member Website
- Coverage At A Glance
- Making The Most Of Your Prescription Benefit
- CVS Caremark Mail
- Generics
- Summary Plan Description
- Forms

Wayne County Commissioners

CVS Caremark Member Website

www.caremark.com

You can easily access the CVS Caremark member website at www.caremark.com through a computer, mobile web browser or mobile app. Once logged in, you can view prescription and benefit information that is specific to your plan. Explore all of the member tools available to help you handle all your prescription needs.

Access Prescription information

- View Order Status
- View/Refill All Prescriptions
- Manage Prescriptions
- Financial Summary
- Start RX Delivery by Mail

Access Plan & Benefits information

- Plan Summary
- Check Drug Cost & Coverage
- Pharmacy Locator
- Print Member ID Card (we recommend using your combined Medical/RX card)
- Drug Savings Opportunities
- Covered Drug Lists
- Reimbursement Claims

Learn about Health Resources

- Drug Reference & Interactions
- Health Information Center
- About Generics
- Email a Pharmacist
- Pharmacist FAQs
- Drug Safety Alerts

How to Register For the First Time:

Step 1 – Navigate to the Website

- Go to www.caremark.com
- Click "Sign In" in the top left corner
- Click "Create an account at the bottom of the page

Step 2 – Create an Account

- Choose to create an account using either your Member ID or Personal information.
- Complete all fields
- Click "Continue"

Step 2 – Create Credentials

- Create a user name
- Create a password
- Continue with remaining fields
- Click "Continue"

Step 3 – Terms and Conditions

- Read the Terms and Conditions
- Click "I Agree and Continue"

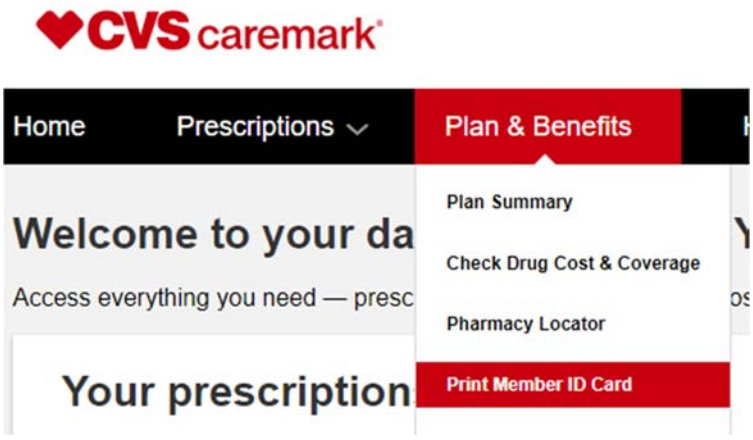
Step 4 – Profile

- Verify that all the information from your registration is correct.
- Explore your new account.

How to Print an ID card:

We recommend using your combined Medical/RX card from Cigna. The back side of this card will show your prescription coverage. You can also log into your CVS Caremark account and print a copy of your prescription insurance card (not combined).

- Click on "Plan & Benefits" and then choose Print Member ID Card from the dropdown menu.
- A copy of your prescription card is displayed on the screen. Click the red button that says "Print Member ID Card"



Coverage at a Glance

Prescription Plan

	RETAIL PHARMACY *For Immediate Medicine Needs or Short-Term Medicine*	**MAIL SERVICE PHARMACY (OR PICK UP AT CVS)** *For Maintenance or Long-Term Medicine*	**SPECIALTY PHARMACY** *For Drugs in the Specialty Category*
Annual Maximum Out-Of-Pocket on Low-Ded *without* incentive: $3,000 per Individual/$6,000 per Family Annual Maximum Out-Of-Pocket on Low-Ded *with* incentive: $2,000 per Individual/$4,000 per Family Annual Maximum Out-Of-Pocket on High-Deductible is combined with Medical Plan.			
You Will Pay	12% for all generic prescription 30% for each brand name* prescription on the primary drug list 50% for each brand name* prescription <u>not</u> on the primary drug list	15% up to a $20 maximum for each generic prescription 30% up to a $120 maximum for each brand name* prescription on the formulary drug list 50% up to a $180 maximum for each brand name* prescription <u>not</u> on the formulary drug list** 50% for Over The Counter (OTC) medicine in the Proton Pump Inhibitor (PPI) Classification (NOTE! Must be filled at a CVS Pharmacy!)	Under Prudent Rx Program, $0 co pay for eligible specialty prescriptions If you opt out of the program, 30% co-insurance charge up to your Maximum Out of Pocket for eligible specialty prescriptions.
Day Supply Limit.....	30-day supply	90-day supply (except specialty pharmacy drug list)	
Refill.....	One initial fill, plus one (1) refill	Must be filled by CVS Caremark	Must be filled by CVS Caremark
This is a short recap of your prescription benefits, not your Summary Plan Description. Please see the Summary Plan Description for additional details and terms of your actual coverage. Details about drug prices, options, and the Formulary Drug List can be found at www.caremark.com.			
Updated 1/1/24			

**When a generic is available but the pharmacy dispenses the brand name medicine for any reason, you will pay the difference between the brand name medicine and the generic, plus the brand co-insurance/co-pay.*

***Note that this maximum amount does not include any Dispense as Written penalty for filling a Non-Preferred brand that has a Generic available*

High-Deductible Plan Exception

On the high-deductible Plan, prescriptions that are not for Maintenance Medication, as determined by the IRS, (columns 2 and 4) will need to be paid by employees at 100% until the medical deductible is met. Once the deductible is met, the above schedule will apply. Maintenance medications are not subject to the deductible and will be paid per the above schedule. After the deductible is met, all rules will apply until an employee hits their medical out-of-pocket maximum.

Prescriptions that qualify as IRS Maintenance Medications will be subject to the Coverage at a Glance rules and not your Medical Plan deductibles. If you want to know if your medication qualifies as a Maintenance Medication under IRS guidelines, contact CVS Caremark at the number on the back of your card.

Maintenance Medication

Wayne County and CVS Caremark have implemented various step therapy protocols which may require you to use certain drugs before others are covered. If you feel you need a different drug that is denied due to this step therapy process, you will be given information on how to appeal the decision reached by CVS Caremark.

Avoid Paying Extra

Medications that are required to be provided free of charge per the Affordable Care Act will still require a prescription for coverage, and they must be purchased at a network pharmacy. Where allowed, CVS Caremark has restricted access to only generic or over-the-counter options.

Prescriptions filled at any pharmacy outside the CVS Caremark pharmacy network will not be covered! Remember to use your CVS Caremark card when getting prescriptions filled at retail stores! Maintenance medications can be filled via the CVS Caremark Mail Service Pharmacy or at your local CVS Pharmacy (some are located inside Target Stores).

When an employee uses a coupon for part of their co-pay, that coupon amount will not accumulate towards their deductible or maximum out of pocket.

Some drug companies have developed copay card programs for specific drugs. If you choose to participate in these programs, please know that any co-pays or co-insurance paid through these programs will not be applied to your annual maximum out-of-pocket.

Updated 1/1/24

Making The Most Of Your Prescription Benefit

Save Money

Your prescription benefit is designed to make your drugs more affordable. Through the Estimate Drug Costs tool, available online at www.caremark.com, you can check drug costs based on your specific plan to compare retail to mail and brand-name drugs to generics. You can also determine your copay or coinsurance amount.

CVS Caremark Will Help Support Your Safety and Health

- By filling your mail service prescriptions accurately.
- By making sure that the medicines you receive are high quality, safe and what your doctor prescribed.
- By reviewing your prescription history with every prescription, they fill to identify and prevent any potential problems such as unintended drug interactions.

There Are Two Easy And Convenient Ways To Fill Your Prescriptions:

At Your Local Pharmacy

Simply present your prescription and your benefit ID card at any participating retail pharmacy (your card is accepted at most major pharmacy chains and many independent pharmacies across the country). To find a participating pharmacy near you, visit at www.caremark.com.

Through CVS Caremark Mail Service Pharmacy

If your doctor has prescribed a maintenance drug for you to take regularly to treat chronic conditions like arthritis, diabetes or heart disease, mail order may be right for you. You may be able to have a 90-day supply delivered directly to your home or location of choice from the CVS Caremark Mail Service Pharmacy.

When it's time to get a refill, you can order online or by phone anytime, day or night. This option will not only save you money on your prescriptions, but will also save you a trip to your local pharmacy. And *regular* delivery is at no additional cost. For more information about home delivery, please refer to the following section titled "CVS Caremark Mail Service Pharmacy".

Updated 1/1/2020

CVS Caremark Mail Service Pharmacy

Every year, more people with chronic or genetic conditions are being prescribed *specialty* or *biotech* medicines. People taking these drugs often have complex health conditions such as multiple sclerosis, hemophilia, Crohn's disease or Hepatitis C. CVS Caremark Mail Service Pharmacy offers home delivery of specialty drugs and supplies and provides personalized therapy-specific clinical support to help individuals successfully manage their condition.

CVS Caremark's dedicated team of pharmacists, nurses and pharmacy customer service representatives can address all therapy support needs through CVS Caremark's toll-free number. Regular business hours are Monday through Friday, 8 a.m. to 8 p.m. ET. CVS Caremark's clinical representatives remain available for member education and support 24 hours a day, 7 days a week.

Talk to your Wellness Nurse or HR Director for a list of covered services, visit www.caremark.com or call the toll-free Customer Service number on your CVS Caremark ID card to learn more about CVS Caremark Mail Service Pharmacy.

CVS Caremark Mail Service Pharmacy is staffed by registered pharmacists who perform the same safety checks as your local pharmacist, including a review of your prescription history.

Getting Started with CVS Caremark Mail Service Pharmacy

It's quick and easy! Your prescription benefit offers you the convenient option to get 90-day supplies of your long-term medications delivered to you by mail – at no extra cost. Home Delivery is available for prescriptions used to treat conditions such as high cholesterol, asthma, arthritis, diabetes, heart disease and high blood pressure.

Through CVS Caremark Mail Service Pharmacy, members benefit from:

- **Convenience** – Quick, confidential shipping of maintenance drugs direct to their home, place of work or any other location they choose.
- **Ease of Use** – CVS Caremark's simple, two-step process makes ordering maintenance drugs easy.
- **Quality of Service** – Registered pharmacists check orders for accuracy and are available 24 hours a day, 7 days a week in case of an emergency.
- **Cost Savings** – Depending on the benefit plan, members can save money by using CVS Caremark Mail Service Pharmacy. In addition, standard shipping is always free.

Updated 1/1/2020

Generics

Manage Your Health and Money with Generics!

How can you save money?

To save money on your prescriptions, ask for Generics:

- Ask your doctor to prescribe generics and allow generic substitution at your local pharmacy.
- Say "yes" if your pharmacist asks whether you would like the generic equivalent of the brand-name medicine your doctor prescribed.
- If there is no generic equivalent for a brand-name medicine you are prescribed, ask your doctor if there's a generic alternative available to treat your condition and if it would be right for you.

Why do generic medicines cost less?

Research and development are already complete. Generics cost less because their manufacturers do not have to spend the hundreds of millions of dollars it takes to complete research and development on the new original medicine. The brand manufacturer makes that investment, along with the millions of dollars needed to market and advertise the new medicine. Therefore, it costs the generic manufacturer less to develop the same medicine. The savings are passed on to you! Visit www.caremark.com to view the formulary list and the generic drugs available which treat common conditions.

What is the difference between generic and brand-name medicines?

All the money you save. Each time you fill a prescription, you could save money by asking for a generic medicine. That could add up to big savings in just a short time. Research shows that you can save an average of 30 to 80 percent when you fill your prescriptions with a generic drug instead of a brand-name drug. To see if a generic is available for a drug you are currently taking or considering, visit www.caremark.com to view the formulary list, or you can visit the Check Drug Cost tool, available online at , where you can check drug costs to find out how much you can save.

Are there any other differences between generic and brand-name medicines?

Yes, the name and how they look are different, not how they work. When the patent of a brand-name medication expires, other drug manufacturers can make and sell the same medicine. This medicine is sold under its chemical name, which is why it is called a "generic". Like their brand-name counterparts, all generic medicines are tested and approved by the U.S. Food and Drug Administration (FDA) before they can be sold to consumers.

FDA-approved generic medicines are as safe and effective as brand-name medicines. In the United States, trademark laws do not allow a generic medicine to look exactly like its brand-name counterpart. Therefore, you can expect a generic medicine to be a different color or a different shape than its brand-name counterpart. However, the way it looks has no effect on how the medicine works. In fact, generics are often made by the same company manufacturing the brand-name drug.

Are generics safe and effective?

Yes, the FDA makes sure of it. The FDA puts each generic medicine through a rigorous quality control review process to ensure that generics are as safe and effective as the original brand-name medicine. Both brand-name and generic drug facilities must meet the same standards of good manufacturing practices. The FDA inspects more than 3,500 pharmaceutical manufacturing facilities each year to monitor how the medicines are made, processed, tested, packaged and labeled. To gain FDA approval, generic medicines must prove they are exactly like their brand-name equivalents in:

- Safety
- Identical Active Ingredients
- Performance (how it works in the body)
- Strength (e.g., 10 mg, 20 mg)
- Dosage Form (pill, liquid, cream, etc.)

Summary Plan Description

Wayne County Prescription Benefit Plan

Table of Contents

Contact Information

CVS Caremark Member Services:
1-844-345-2778
24/7 customer service
www.caremark.com

Paper Claim Reimbursement Information:
CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

Mail Service Order Information:
CVS Caremark PBM & Mail Order Pharmacy
www.caremark.com (login not required)
1-800-552-8159

Wayne County HR Director:
Wayne County Commissioners
428 West Liberty Street
Wooster, OH 44691
(330) 287-5409

Wayne County Wellness Nurse:
Wayne County Commissioners
428 West Liberty Street
Wooster, OH 44691
(330) 287-5487

Summary Plan Description

Effective Date: January 2024

This document replaces and supersedes any previous prescription Summary Plan Description

This document summarizes the main provisions of the prescription drug section of the Wayne County pharmacy Benefit Plan (Plan) and serves as the Summary Plan Description (SPD) for these benefits. It describes the prescription drug benefits as they apply to eligible employees. Nothing in the Plan or in this document is intended to provide employees, former employees or dependents with a vested right to any benefits and/or any rights for continued employment. This document replaces and supersedes any previous pharmacy Summary Plan Description.

We encourage you to read this SPD carefully and share it with your family members covered under the Plan. If you have any questions about your benefits, please contact CVS Caremark, the Wellness Nurse, or your HR Director. Contact information is on the first page of this section.

Please note that this SPD is only a summary. Complete details of the prescription drug plan are contained in the legal plan document. If there is any difference between the information in this SPD and in the legal plan document, the legal plan document will govern.

The plan sponsor reserves the right to interpret, amend and/or terminate this plan, in whole or in part, at any time and for any reason.

Eligibility

You do not enroll specifically for Prescription Coverage. Your eligibility for this benefit will be determined by your eligibility for the Medical Plan. If you are accepted for coverage under the Medical Plan, then you are automatically enrolled in Prescription Coverage.

You can add and/or remove dependents based on the ability to add and/or remove dependents under the Medical Plan.

If you lose eligibility for, or drop, your Medical Insurance, your coverage under this program will end on the same date. If you leave the Plan, and are eligible for and elect COBRA coverage, then you will only receive Prescription Coverage if you also are eligible for, and elect to receive and pay for COBRA for your Medical Coverage.

Employees who enroll dependents are responsible for any payments made on behalf of their dependents. If your dependent is not eligible for benefits, you will be responsible to reimburse the Plan for any payments made on their behalf.

Coverage Effective Date

Your prescription coverage will have the same effective dates as your Medical Coverage.

Plan Coverage and Cost

Depending on the rules adopted by your employer, the following may apply to you. If you are not sure if this section applies to you, please check with your employer. This section will apply to all employees of Wayne County.

This plan is self-funded with contributions from both the employer and eligible employees. The plan also is part of the County's Section 125 Flexible Benefit Plan that allows you to elect health care coverage and pay your contributions on a pre-tax basis. This tax savings advantage allows you to have a portion of your compensation deducted from your paycheck before your taxes are calculated. Because of this, you pay for your coverage with pre-tax dollars, you pay fewer taxes and you take home more pay. CVS Caremark administers the prescription drug benefit described in this document.

> **Important Notice:** See the Important Notice from Wayne County Employee Benefit Plan About Your Prescription Drug Coverage and Medicare behind Tab 10 if you are considering joining a Medicare drug plan.

Coverage at a Glance

SHORT-TERM RETAIL (up to a 30-day supply)	**MEMBER RESPONSIBILITY**
Generic Cost Share	12% For all Generic prescriptions
Formulary/Primary Drug List Cost Share	30% for each Brand Name* prescription on the formulary list
Brand Cost Share	50% for each Brand Name* prescription not on the formulary list
LONG-TERM MAIL SERVICE (up to a 90-day supply)	**MEMBER RESPONSIBILITY**
You can receive these medications:	**Through the mail, or at a CVS retail location**
Generic Cost Share	15% up to a $20 maximum for each Generic Prescription
Formulary Cost Share	30% up to a $120 maximum for each Brand Name* prescription on the Formulary list
Brand Cost Share	50% up to a $180 maximum for each Brand Name* prescription not on the Formulary list *(Note that this maximum amount does not include any DAW (Dispense as Written) penalty for filling a Non-Preferred brand that has a Generic available)*
Prudent Rx Program	$0 copay for eligible specialty prescriptions. If you opt out of the program, 30% co-insurance charge up to your Maximum Out of Pocket for eligible specialty prescriptions,
PPI Class (Proton Pump Inhibitor)	**MEMBER RESPONSIBILITY**
Over The Counter (OTC)	50% for OTC

Updated 10/7/2022

Medications that are required to be provided free of charge per the Affordable Care Act will still require a prescription for coverage, and they must be purchased at a network pharmacy. Where allowed, CVS Caremark has restricted access to only generic or over-the-counter options.

***If you or your doctor chooses for you to receive the brand name drug when a generic drug is available, you will be responsible for paying the difference between the brand name drug cost and the available generic drug cost. You will also be responsible for paying the appropriate cost share for the drug that the doctor prescribes.**

The Low-Ded plan has a separate Annual Maximum Out-of-Pocket from the Medical Benefit. For the Prescription Plan, the maximum out-of-pocket you pay in a calendar year for eligible prescriptions is as follows:

- ☐ $3,000 per Covered Person, not to exceed $6,000 for all Covered Persons in a family, per calendar year on the Low-Ded Non-incentive Plan.
- ☐ $2,000 per Covered Person, not to exceed $4,000 for all Covered Persons in a family, per calendar year on the Low-Ded +Incentive Plan.

Prudent Rx

If you require certain eligible drugs in the specialty pharmacy, you will automatically be enrolled in your Plan's co-payment assistance program administered by PrudentRx (but you can choose to opt-out by contacting PrudentRx). The PrudentRx Copay Program will assist you by helping you to enroll in these drug manufacturer copay assistance programs. If you or a covered family member are taking one or more medications included in the PrudentRx Copay Program drug list, PrudentRx will contact you with specific information about the program as it relates to your medication and will let you know if you are required to enroll in copay assistance for any medication that you take. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications – in that case, you must speak to someone at PrudentRx to provide any additional information needed to enroll in the copay program.

With copayment assistance for covered specialty prescription drugs, you will pay no cost share. If you choose to not use the program, or don't complete any participation requirements of the program, then you will pay a cost share of 30%, until your *prescription* maximum out-of-pocket is met (Low-Ded plan members have separate out-of-pocket maximums for medical and prescription).

If you are taking a specialty prescription drug, included in the program, we'll contact you. If there are participation requirements, we'll let you know and provide any additional information needed to participate.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Co-Pay Program.

Quantity Limitations

Any quantity limitations are indicated in the Coverage at a Glance chart above.

Coordination of Benefits

There is no coordination of benefits on this plan.

Classification of Medication

All prescriptions are classified into 4 groups: Generics, Preferred Brand, Non-Preferred Brands and Specialty Drugs. A general description of each of these types is as follows:

- ☐ ***Generic –*** A generic drug is a drug product that is comparable to brand/reference listed drug product in dosage form, strength, route of administration, quality and performance

characteristics, and intended use. We only cover A rated generic drugs, and all generic drugs have to receive approval from the FDA before they can be dispensed.

- ***Preferred Brand*** **–** These are generally brands which CVS Caremark has negotiated better rates with the manufacturers. Because these drugs are purchased at better pricing, we reduce your cost to purchase these drugs. This is also referred to as a preferred brand drug.
- ***Non-Preferred Brand*** **–** These are generally brands which CVS Caremark has determined are either costly or clinically non-effective and are considered non-preferred and covered at the highest copay.
  - A brand name drug is a drug that has a trade name and is protected by a patent. When a generic is available, but the pharmacy dispenses the brand name medicine for any reason you will pay the difference between the brand name medicine and the generic plus the brand co-insurance or co-payment.
- ***Over The Counter (OTC)*** **–** These are drugs that are normally available at retail drug stores. For the purposes of this plan, the only OTC drugs that are covered by this plan are those in the Proton Pump Inhibitor (PPI) family of drugs. PPI drugs are commonly used to treat symptoms for ulcers and acid reflux. You will still need a prescription from your doctor to purchase these drugs OTC and have part of the cost covered by your plan.
- ***Specialty*** **–** Specialty drugs generally are high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of the patient's drug therapy. These drugs are only available through CVS Caremark's Specialty Pharmacy Program.

Prior Authorization

CVS Caremark's prior authorization program supports you and your physician as you make decisions about your care and the use of prescription medications. The program aims to improve the quality of your drug therapy by:

- Promoting the appropriate and cost-effective use of your medications.
- Checking the appropriate length of your drug therapy.

How the program works

When filling your prescription, your prescription drug therapy is checked to see if it meets recommended guidelines:

- If the drug meets these guidelines, your prescription is filled without interruption.
- If the drug does not meet the guidelines, your prescription will not be filled until it has been reviewed.

Review process

You or your pharmacy can notify your physician that a prior authorization is needed for your medication. Your physician can request a prior authorization override through fax, telephone or online through CVS Caremark's secure password protected health care professional website. Forms are also available to your doctor for download through this website.

Once CVS Caremark Pharmacy Management receives your physician's information, its review process will take one to three business days. The decision is communicated to your physician by telephone, fax or e-mail (depending on how the request was received). If the request is denied, CVS Caremark

will fax or mail a follow-up letter to you and your physician within two business days (or as otherwise required by state law). This letter states the reason for denial and explains the appeal procedure. Once entered into the system, the information is immediately available to your pharmacies and your prescription can be filled.

Please refer to the Formulary list at www.caremark.com to see if your medication is subject to prior authorization.

Dispensed As Written Penalty

If you or your doctor chooses for you to receive the brand name drug when a generic drug is available, you will be responsible for paying the difference in cost between the generic and brand drug. You also will be responsible for paying the appropriate cost share for the drug that the doctor prescribes.

Care outside the United States

Prescription drugs purchased outside the United States are not covered under the Plan. However, if you are overseas and need to purchase prescription drugs due to an emergency, eligible prescription drugs that are purchased may be covered.

You will need to purchase the drug, obtain a receipt (be sure the receipt is translated into English) and submit a paper Claim reimbursement form to CVS Caremark for reimbursement. CVS Caremark will determine the appropriate currency exchange rate to use. Their decision on the exchange rate will be final.

Contraception

The Plan covers Contraceptives as currently required under the Affordable Care Act.

Diabetic Insulin and Supplies

You and your eligible dependents can receive free generic and preferred brand name diabetic insulin and supplies as prescribed by your doctor from CVS Caremark's prescription program; however non-preferred brand name diabetic insulin and supplies will be covered at the normal benefit level. Please check the formulary to determine which drugs are considered free with your plan. If you have questions about this program, please call CVS Caremark or the Wayne County Clinic Manager at the numbers listed at the front of this document. CVS Caremark reserves the right to change from time to time what products or manufacturers are covered under this free program. This program is designed to make complying with your medication and testing needs as easy as possible.

Sexual Dysfunction/Enhancement

The Plan covers dysfunction and enhancement as currently required under the Affordable Care Act.

Tobacco Use

Preventative drugs are covered under the Plan as part of the Employee Health Clinic's Tobacco Cessation program.

Clinical Solutions

Generic Alerts

Generic Launch Letters are announcements that are mailed to you regarding significant new generic launches. If you are taking a brand-name drug that will be available as a generic, you will receive a personalized letter educating you on the lower-cost alternative.

Specialty Pharmacy Guidelines

CVS Caremark requires precertification for specialty drugs. CVS Caremark uses Pharmacy Clinical Policy Bulletins (CPBs) as guides for prescribing physicians and detail criteria for medical exceptions and precertification. CVS Caremark bases criteria on peer-reviewed medical literature and other recognized resources of clinical information. CVS Caremark develops these criteria in consultation with physicians specializing in a particular field of practice and marries them with their medical CPBs.

The NPL is the National Precertification List. This list includes specialty drugs that require advance authorization before dispensing. Drugs included on the NPL are considered "specialty" drugs and are mostly injectable products either self-administered by the patient or administered by a health care professional, and may be covered under either the pharmacy or medical benefit.

Additional details regarding the NPL, including specific drugs and therapeutic classes, is located on www.caremark.com.

If You Have A New Prescription:

To find a network pharmacy near you, call the customer service number on the first page of this section, or go to www.caremark.com, click on the "Pharmacy" tab under "Find Care" and this will redirect you to *Find Care*, where you will add the following search filters:

1. Search for: Pharmacies
2. Type: Retail Pharmacy Locations
3. Search in: Please add your Zip Code and Distance
4. Select Plan: CVS Caremark Rx Managed Network

Short-Term/Retail Prescription Drugs

You can receive a prescription drug at any participating retail network pharmacy. Just give the pharmacist your CVS Caremark ID card along with your prescription. You will pay the applicable cost share listed in the Coverage at a Glance chart at the time of purchase. The Plan pays the remainder. If your charge of the retail drug is less than the minimum requirements, you pay the lesser of the two. If you do not have your CVS Caremark ID card, you will still have coverage. Simply pay the full amount of the prescription and save the original receipt, then complete a paper Claim reimbursement form and submit with your original receipt to the address on the first page of this section. You can receive a paper Claim reimbursement form by contacting Member Services at 1-844-345-2778 or by visiting www.caremark.com. CVS Caremark will then reimburse you for the portion that the plan would pay. CVS Caremark will not reimburse you for any prescriptions filled at any pharmacy that is not in the CVS Caremark retail pharmacy network.

Long-Term/Rx Home Delivery Prescription Drugs

To order a new prescription drug maintenance medication, ask your physician to write two separate prescriptions indicating that refills are allowed:

- ☐ One for a 30-day supply that you can fill right away at a local pharmacy.
- ☐ A second for a 90-day supply, the maximum supply allowed by the Plan, that you can mail to the CVS Caremark Mail Service Pharmacy (or take into a CVS pharmacy) within two weeks of your medicine running out.

You can only receive a maintenance medication for one initial 30-day (or less) prescription, plus one refill, at a participating retail pharmacy. After this, you must utilize the CVS Caremark Mail Service Pharmacy or CVS pick-up (some are located inside Target stores) to fill your maintenance medications.

> **Please Note:** CVS pharmacies are the only pharmacies in which you can receive your maintenance medications, outside of the initial fill.

Rx Home Delivery must be utilized for long-term maintenance medications after the first two fills. Mail order prescriptions cover up to a 90-day fill or refill of that prescription. Tell your prescribing physician that you have a mail order prescription program. That will inform them that you need a 90-day prescription for the medication you need to take.

You need to submit the new 90-day supply prescription(s) along with a completed Prescription delivery form and any applicable copayments or coinsurance for each prescription to the address on the order form in one of the following ways:

- ☐ Download and complete a CVS Caremark Mail Service Pharmacy Prescription mail-order delivery form at www.caremark.com and send it by mail.
- ☐ Have your physician submit the prescription by fax or e-prescription.

You will receive your prescriptions by mail in about two weeks, delivered in sealed, insulated (when necessary), and tamper-evident packaging. Since mail order delivery can take up to two weeks, be sure to have enough medication on hand in between orders.

> **Important Notice:** CVS Caremark Mail Service Pharmacy is staffed by registered pharmacists who perform the same safety checks as your local pharmacist, including a review of your prescription history.

What about Refills?

After the initial form has been submitted, you must refill your maintenance medication prescription by mail using the address on the order form, which can be accessed online at www.caremark.com, through your secured member website, by telephone or interactive voice response (IVR). CVS Caremark's toll-free number and website can be found on the bottle label of each prescription.

If there are no refills remaining, the pharmacy can request a new prescription from the physician, at your request.

Log in to www.caremark.com to learn more about your plan benefits and specific cost-savings opportunities through mail order and to initiate a mail order request via CVS Caremark Mail Service Pharmacy.

Please Note: You may switch from CVS Caremark Mail Service Pharmacy to store pick-up and vice-versa if one or the other is no longer desired, but you cannot constantly bounce back and forth between the two options. Long term maintenance drugs may only be dispensed at a CVS pharmacy.

Exclusions

New drugs are developed and introduced into the marketplace daily. As the FDA approves these new drugs for use in the United States, we, in conjunction with CVS Caremark, will assess the feasibility of covering the drug, as well as the application of any coverage restriction or limitation. The plan covers charges for drugs and medicines which, as required by law, may be dispensed only by a registered pharmacist on the written prescription of a physician.

Discretionary Authority

The plan administrator has discretionary authority to interpret and apply Plan terms and to make factual determinations in connection with its review of Claims under the Plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or Claim benefits under the Plan, the determination of whether a person is entitled to benefits under the Plan, and the computation of any and all benefit payments.

Plan Modification, Amendment and Termination

The employer, as Plan sponsor, reserves the right, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other Plan term or condition, and to terminate the whole Plan or any part of it. The procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated, is contained in the official legal plan document, which is available for inspection and copying from the Plan Administrator designated by the employer. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan will have no adverse effect on any benefits to be paid under the Plan for any covered prescription expenses incurred prior to the date the Plan terminates.

Termination of Coverage

Your prescription coverage will have the same end date as your Medical Coverage.

Updated 10/7/2022

Claims

In the previous section, we explained how you and the plan share responsibility for paying for your eligible health services.

When a Claim comes in, you will receive a decision on how you and the plan will split the expense. We also explain what you can do if you think it is wrong.

Claims are processed in the order in which they are received.

Claims Procedures

For Claims involving **out-of-network providers:**

Notice	Requirement	Deadline
Submit a Claim	• You should notify and request a Claim form from your employer. • The Claim form will provide instructions on how to complete and where to send the form(s).	• Within 15 working days of your request. • If the Claim form is not sent on time, CVS Caremark will accept a written description that is the basis of the Claim as proof of loss. It must detail the nature and extent of loss within 90 days of your loss.
Proof of loss (Claim)	• A completed Claim form and any additional information required by your employer.	• No later than 90 days after you have incurred expenses for covered benefits. • CVS Caremark will not void or reduce your Claim if you can't send them notice and proof of loss within the required time. But you must send them notice and proof as soon as reasonably possible. • Proof of loss may not be given later than 2 years after the time proof is otherwise required, except if you are legally unable to notify CVS Caremark.
Benefit payment	• Written proof must be provided for all benefits. • If any portion of a Claim is contested by CVS Caremark, the uncontested portion of the Claim will be paid promptly after the receipt of proof of loss.	• Benefits will be paid as soon as the necessary proof to support the Claim is received.

Types of Claims and Communicating CVS Caremark's Claim Decisions

You or your **provider** are required to send CVS Caremark a Claim in writing. You can request a Claim form from CVS Caremark. CVS Caremark will review that Claim for payment to the provider.

There are different types of Claims. The amount of time that CVS Caremark has to tell you about their decision on a Claim depends on the type of Claim. The section below will tell you about the different types of Claims.

Urgent Care Claim

An urgent Claim is one for which delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. Or it could be a situation in which you need care to avoid severe pain.

If you are pregnant, an urgent Claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-Service Claim
A Pre-Service Claim is a Claim that involves services you have not yet received and which CVS Caremark will pay for only if they pre-certify the Claim.

Post-Service Claim
A post service Claim is a Claim that involves health care services you have already received.

Concurrent care Claim extension
A concurrent care Claim extension occurs when you ask CVS Caremark to approve more services than they already have approved. Examples are extending a hospital stay or adding a number of visits to a provider.

Concurrent care Claim reduction or termination
A concurrent care Claim reduction or termination occurs when CVS Caremark decides to reduce or stop payment for an already approved course of treatment. CVS Caremark will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from CVS Caremark or an external review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as copayments/payment percentage and deductibles that apply to the service or supply. If CVS Caremark upholds their decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

The chart below shows a timetable view of the different types of Claims and how much time CVS Caremark has to tell you about their decision.

CVS Caremark may need to tell your physician about their decision on some types of Claims, such as a concurrent care Claim, or a Claim when you are already receiving the health care services or are in the hospital**.**

Type of notice	**Urgent Care Claim**	**Pre-Service Claim**	**Post-Service Claim**	**Concurrent Care Claim**
Initial determination (CVS Caremark)	72 hours	15 days	30 days	24 hours for urgent request* 15 calendar days for non-urgent request
Extensions	None	15 days	15 days	Not applicable
Additional information request (CVS Caremark)	72 hours	15 days	30 days	Not applicable
Response to additional information request (you)	48 hours	45 days	45 days	Not applicable

*CVS Caremark needs to receive the request at least 24 hours before the previously approved health

care services end.

Adverse Benefit Determinations

CVS Caremark pays many Claims at the full rate negotiated charge with a network provider and the recognized amount with an out-of-network provider, except for your share of the costs. But sometimes CVS Caremark pays only some of the Claim. And sometimes CVS Caremark denies payment entirely. Any time CVS Caremark denies even part of the Claim, that is an Adverse Benefit Determination or "adverse decision". It is also an Adverse Benefit Determination if CVS Caremark rescinds your coverage entirely.

If CVS Caremark makes an Adverse Benefit Determination, they will tell you in writing.

The Difference between a Complaint and an Appeal

A Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can call or write Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. CVS Caremark will review the information and provide you with a written response within 30 calendar days of receiving the complaint**.** They will let you know if they need more information to make a decision.

An Appeal

You can ask CVS Caremark to re-review an Adverse Benefit Determination. This is called an appeal. You can appeal to them verbally or in writing.

Appeals Process

Prior Authorization Review

CVS Caremark will implement the prescription drug cost containment programs requested by Wayne County by comparing your requests for certain medicines and/or other prescription benefits against pre-defined preferred drug lists or formularies before those prescriptions are filled.

If CVS Caremark determines that your request for prior authorization cannot be approved, that determination will constitute an Adverse Benefit Determination.

Appeals of Adverse Benefit Determinations

You can appeal CVS Caremark's Adverse Benefit Determination. CVS Caremark will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an Adverse Benefit Determination.

You can appeal by sending a written appeal to Member Services at the address on the notice of Adverse Benefit Determination. Or you can call Member Services at the number on your ID card. You need to include:

- Your name.
- The employer's name.
- A copy of the Adverse Benefit Determination.
- Your reasons for making the appeal.
- Any other information you would like CVS Caremark to consider.

Another person may submit an appeal for you, including a provider. That person is called an authorized representative. You need to tell CVS Caremark if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling CVS Caremark that you are allowing someone to appeal for you. You can get this form by contacting CVS Caremark. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision. All requirements for filing appeals will be provided in writing from CVS Caremark, you must comply with those rules in order to file an appropriate and timely appeal

Urgent care or Pre-Service Claim appeals

If your Claim is an urgent Claim or a Pre-Service Claim, your provider may appeal for you without having to fill out a form.

CVS Caremark will provide you with any new or additional information that they used or that was developed by them to review your Claim. They will provide this information at no cost to you before they give you a decision at your last available level of appeal. This decision is called the final Adverse Benefit Determination. You can respond to this information before they tell you what their final decision is.

Timeframes for Deciding Appeals

The amount of time that CVS Caremark has to tell you about their decision on an appeal Claim depends on the type of Claim. The chart below shows a timetable view of the different types of Claims and how much time they have to tell you about their decision.

Type of notice	Urgent Care Claim	Pre-Service Claim	Post-Service Claim	Concurrent Care Claim
Appeal determinations at each level (CVS Caremark)	36 hours	15 days	30 days	As appropriate to type of Claim
Extensions	None	None	None	

Exhaustion of the Appeals Process

In most situations you must complete the two levels of appeal with CVS Caremark before you can take these other actions:

- Appeal through an external review process.
- Pursue arbitration, litigation or other type of administrative proceeding.

But sometimes you do not have to complete the two levels of appeals process before you may take other actions. These situations are:

- You have an urgent Claim or a Claim that involves ongoing treatment. You can have your Claim reviewed internally and at the same time through the external review process.
- CVS Caremark did not follow all of the Claim determination and appeal requirements of the Federal Department of Health and Human Services. But, you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you.
  - The violation was for a good cause or beyond CVS Caremark's control.
  - The violation was part of an ongoing, good faith exchange between you and CVS Caremark.

External Review

External review is a review done by people in an organization outside of CVS Caremark. This is called an external review organization (ERO).

You have a right to external review only if:

- CVS Caremark's Claim decision involved medical judgment.
- CVS Caremark decided the service or supply is not Medically Necessary or not appropriate.
- CVS Caremark decided the service or supply is experimental or investigational.
- You have received an adverse determination.

If CVS Caremark's Claim decision is one for which you can seek external review, they will say that in the notice of Adverse Benefit Determination or final Adverse Benefit Determination they send you. That notice also will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:

- To CVS Caremark.
- Within 123 calendar days (four months) of the date you received the decision from CVS

Caremark.
- And you must include a copy of the notice from CVS Caremark and all other important information that supports your request.

CVS Caremark will:
- Contact the ERO that will conduct the review of your Claim.
- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review.
- Consider appropriate credible information that you sent.
- Follow their contractual documents and your plan of benefits.
- Send notification of the decision within 45 calendar days of the date they receive your request form and all the necessary information.

CVS Caremark will stand by the decision that the ERO makes, unless they can show conflict of interest, bias or fraud.

When an appeal is not eligible for ERO or when the appeal is upheld at the ERO level, CVS Caremark will inform the member of their right to appeal to the plan sponsor for voluntary level of review.

How long will it take to get an ERO decision?
CVS Caremark will tell you of the ERO decision not more than 45 calendar days after they receive your Notice of External Review Form with all the information you need to send in.

But sometimes you can get a faster external review decision. Your provider must call CVS Caremark or send them a Request for External Review Form.

There are two scenarios when you may be able to get a faster external review:

For initial adverse determinations:
Your provider tells CVS Caremark that a delay in your receiving health care services would:
- Jeopardize your life, health or ability to regain maximum function, or
- Be much less effective if not started right away (in the case of experimental or investigational treatment).

For final adverse determinations:
Your provider tells CVS Caremark that a delay in your receiving health care services would:
- Jeopardize your life, health or ability to regain maximum function;
- Be much less effective if not started right away (in the case of experimental or investigational treatment), or
- The final adverse determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 72 hours of CVS Caremark receiving your request.

Recordkeeping

CVS Caremark will keep the records of all complaints and appeals for at least 10 years.

Fees and Expenses

CVS Caremark does not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

Definitions

The following terms are used herein to describe the Claims and appeals review services provided by CVS Caremark:

Adverse Benefit Determination
A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a Plan benefit. An Adverse Benefit Determination includes a denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a Plan benefit based on the Application of a Utilization Review or on a determination of your eligibility to participate in the Plan. An Adverse Benefit Determination also includes a failure to cover a Plan benefit because use of the benefit is determined to be experimental, investigative or not Medically Necessary or appropriate.

Claim
A request for a Plan benefit that is made in accordance with the Plan's established procedures for filing benefit Claims.

Medically Necessary (Medical Necessity)
Medications, health care services or products are considered Medically Necessary if:

- ☐ Use of the medication, service or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;
- ☐ Use of the medication, service or product is based on recognized standards for the health care specialty involved;
- ☐ Use of the medication, service or product represents the most appropriate level of care for the member, based on the seriousness of the condition being treated, the frequency and duration of services and the place where services are performed; and
- ☐ Use of medication, service or product is not solely for the convenience of you, your family, or your provider.

Post-Service Claim
A Claim for a Plan benefit that is not a Pre-Service Claim.

Pre-Authorization
CVS Caremark's Pre-Service Review of your initial request for a particular medication. CVS Caremark will apply a set of pre-defined criteria (provided by the Plan sponsor) to determine whether there is need for the requested medication.

Pre-Service Claim
A Claim for a medication, service or product that is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining the requested medical care or service. Pre-Service Claims include member requests for Pre-Authorization.

Urgent Care Claim
A Claim for a medication, service or product where a delay in processing the Claim: (a) could seriously jeopardize your life or health and/or could result in your failure to regain maximum function, or (b) in the opinion of a physician with knowledge of your condition, would subject you

to severe pain that cannot be adequately managed without the requested medication, service or product.

Dental Insurance

- Delta Dental Website
- Coverage At A Glance
- Summary Plan Description
- Forms

Wayne County Commissioners

Delta Dental Website

Member Portal: www.memberportal.com

Website: www.deltadentaloh.com

You can find helpful information about your Delta Dental benefits plan 24 hours a day, 7 days a week.

Here's What You Will Find on the Member Portal:

- ☐ Find A Provider (Quickly and Easily!)
  - Create a customized list of providers based on preferences or look up a specific provider
  - Unique features include ability to create a short list of "favorite" providers for quick reference, plus get maps and directions to an office
  - Get your results printed, emailed or in .pdf format
- ☐ Estimate the Cost of Your Dental Care:
  - View estimates for cost of services prior to receiving the actual treatment
  - Look up coverage amounts, including deductibles and co-insurance amounts
  - View claims activity
- ☐ Print Dental Card and Claim Form:
  - Simply visit the web site listed above and click on "View & Print Member ID Card" or the "Claims" tab.
  - If you arrive at your doctor's appointment and forgot your card, it's no problem as you can simply tell them that Delta Dental is your insurance carrier and they will take care of it for you!
- ☐ Read About Oral Health
  - Click on the "Help" tab, then click "Health and Wellness" to learn about important health tips regarding oral cancer, fluoride, beverage choices, dental implants, tongue piercing and overall oral health!

How To Register For The First Time:

1. Go to **www.memberportal.com**
2. Click on "Sign Up!"
3. Follow the easy instructions!

How To Find a Provider:

1. Go To **www.deltadentaloh.com**
2. Click on "Find a Dentist"
3. Find *Delta Dental PPO and Delta Dental Premier* and click on "Search"
4. Choose the specialty you are searching for in the first dropdown list.
5. Choose either Delta Dental PPO or Delta Dental Premier. Both of these are in-network. However, Delta Dental Premier will pay a higher percentage towards your claim.
6. Click "Find Dentists"
7. *You may also customize your search by name, city, zip code or distance.*
8. Once you receive your results, you may print, email or .pdf your results. If you want to print, email or .pdf the results of only a few select dentists, simply check the box "Add to my list" next to each dentist, then click on "My List" at the top of the screen (right-hand side) and choose either print, email or .pdf.

Things To Remember:

- ☐ It is strongly recommended that you obtain a pre-treatment estimate for any major medical service. Please ask your doctor to submit this request to Delta Dental. Pre-treatment estimates come directly from Delta Dental; they do not come from your dentist. Also refer to your Summary Plan Description at the back of this tab.
- ☐ If you are pregnant or have diabetes or heart disease, talk with your doctor about getting two additional cleanings.
- ☐ Medical and Dental Health go hand-in-hand

Most people tend to think of their dental health as being completely separate from their general medical well-being. However, in many instances, this is not the case. Oral hygiene —or the lack thereof — can affect a person's medical health. Similarly, a person's medical health can affect his dental welfare. Medical and dental issues are not separate entities.

Updated 10/7/2022

Special Conditions

There are some conditions that can complicate a person's oral health. They can either aggravate dental conditions or they can alter how dental problems are treated and managed. Here are some medical issues that affect dental health. **If you have any of these conditions, please be sure to talk to both your healthcare provider and your dentist**.

Cardiovascular Disease

Gum disease, particularly periodontitis, can affect cardiovascular disease. Although more research needs to be done, some scientists are saying that gum disease can be a cause of heart disease, strokes, clogged arteries and bacterial endocarditis.

Sure, it sounds strange; however, gum disease certainly does spread past a person's mouth. The bacterium from the periodontitis enters a person's bloodstream and can travel to the heart. In this case, the medical problem certainly may be caused by the dental problem.

Osteoporosis

Bone loss from this disease often shows up first in the mouth—dentists are sometimes the first ones to spot it, recommending that patients speak with their medical doctors about possibly having osteoporosis.

If this disease is not managed, the bone loss can worsen from year to year. This can cause problems with the teeth, eventually causing them to fall out.

Diabetes

Not taking care of the teeth—in other words, having poor oral hygiene—can make managing diabetes a difficult prospect. Gum disease infections can cause a person's blood sugar levels to spike, therefore needing larger doses of insulin to keep under control.

What's more, having diabetes makes a person more susceptible to getting gum disease in the first place. So, it is even more essential for people with diabetes to practice excellent dental hygiene habits.

Diabetes also increases the likelihood of a person having dry mouth, cavities and tooth loss. With this condition, the medical and dental problems go hand in hand.

Cancer

Chemotherapy treatments for any type of cancer can cause dental issues, such as dry mouth and gum disease.

Moreover, if a person is receiving radiation in the head or neck area, he may develop lesions in the mouth, very sensitive teeth and rapid tooth decay.

Pregnancy/Birth

Obviously, pregnancy and birth are not diseases. However, gum disease can have a profound effect on pregnancy and birth.

Much like the bacteria from periodontitis can spread from the gums to the heart via the bloodstream, it can also spread through the bloodstream to the placenta in the womb or into the amniotic fluid. This can cause premature birth. Babies who are born too early may not have had a chance to fully develop and may end up with life-threatening problems.

HIV/AIDS

Indications of this medical problem often show up in the mouth first through a serious dental infection. People may also develop white spots or strange lesions in the mouth if the gum disease is left untreated.

Rather than thinking of medical health or dental health separately, people should instead think of body health.

You May Be Eligible for Additional Cleanings

If you have been diagnosed with any of the following conditions, you are eligible for 2 additional cleanings (which is a total of 4) each year:

- Pregnancy with periodontal disease
- Diabetic with periodontal disease
- Renal Failure/Dialysis
- Head and Neck Radiation
- Infective Endocarditis
- Suppressed Immune System
    - Chemotherapy/Radiation
    - HIV Positive
    - Organ Transplant
    - Stem Cell (Bone Marrow) Transplant

Enhanced Benefits for Vulnerable Population

In order to make oral health benefits more accessible and less overwhelming, we offer enhanced dental benefits for members with qualifying special health care needs.

These enhanced benefits include:

- Additional visits to the dentist's office and/or first treatment consultations prior to appointment
- Up to four total dental cleanings in a benefit year (see above).
- Treatment delivery modifications
- The use of anesthesia if necessary

Coverage At A Glance

The following is a snapshot of the Wayne County Dental Plan Design. For further details and description, please refer to the Summary Plan Description (SPD) at the back of this section.

Dental Plan Design

IMPORTANT! Remember to request a <u>Pre-Treatment Estimate</u> if you are having dental work which may cost $300 or more! Please ask your doctor to submit this request to Delta Dental.

TYPE OF SERVICE	Traditional Plan	Orthodontic Plan
Annual Deductible	$25 per person	$25 per person
Maximum Per Person Benefit		
Non-Orthodontics	$2,000 per year	$2,000 per year
Orthodontics	$500 Lifetime	$2,000 Lifetime
Orthodontic Eligibility Requirement	Up to Age 19	Up to Age 19
Preventive and Diagnostic Dental Service	100%	100%
Not calculated towards annual maximum benefit		
Periodic Oral Examinations		
Twice per calendar year		
Bitewing X-Rays - 1 Series per calendar year		
Dental Prophylaxis (Cleanings)		
Twice per calendar year		
Fluoride Treatments		
Twice per calendar year under age 16		
Palliative Treatment (Relief of Pain)		
Covered only if no other services provided		
Sealants Under Age 16 and once per tooth Every 3 Years		
Once per first or second permanent molars		

TYPE OF SERVICE	Traditional Plan	Orthodontic Plan
Basic Dental Services - Subject to Deductible	80%	80%
Complete Series or Panorex X-rays		
Limited to One Time Per 36 Months		
Fillings: Includes Amalgam and Composite/white fillings		
Occlusal Guards – 1 per 5-year period		
Root Canal Treatment		
Root Planing - 1 Time Per Quadrant Per 24 Months		
Periodontal Surgery - Once In Any 36 Month Period		
Simple Extraction		
Surgical Extraction including Impacted Wisdom Teeth		
Repairs to Full or Partial Dentures or Bridges		
Limited to repairs or adjustments done within 12 months after the initial insertion		
Major Dental Services - Subject to Deductible*	80%	50%
Crowns - One Time Per Tooth Every 5 Years		
Only When A Filling Cannot Restore The Tooth		
Fixed Bridges - One Time Per Tooth Every 5 Years		
Only When A Filling Cannot Restore The Tooth		
Full Dentures - Once Every 60 Months		
Implants – please read your SPD for more details as most implants are covered; however, some services related to the implant are not (make sure to request a Pre-Treatment Estimate!)		
Inlays And Onlays - One Time Per 5 Years		
Only When A Filling Cannot Restore The Tooth		
Partial Dentures - Once Every 60 Months; No Allowances		
For Precision or Semi-Precision Attachments		
Re-Cement Bridges, Crowns, Inlays - Once Every 6 Months		
Relining Dentures - Limited To 1 Time Per Year		
Orthodontic Services.....	50% up to $500	50% up to $2,000
Diagnose or Correct Misalignment of the Teeth or Bite		
Including Phase 1 and Phase 2 -		
This is a short recap of your dental benefits. Please see the Summary Plan Description for additional details and terms of your actual coverage.		

*** ***PLEASE NOTE that if you choose to go out-of-network, you may be responsible for the difference between the contracted amount and the cost of service, in addition to any coinsurance/copays.***

Summary Plan Description

Wayne County Dental Benefit Plan

Table of Contents

Important Notice

As used in this book, the terms:

- ☐ Certificate refers to this book describing the benefits directly funded through and provided by your employer;
- ☐ Insurance and Insured refers to the benefits directly funded through and provided by your employer;
- ☐ Plan, We, Us and Our refer to the benefits that are directly funded through and provided by your employer;
- ☐ Premium, Premiums, and Premium Charge refer to payments required from you for coverage under this plan; and
- ☐ Proof of Insurability refers to any evidence of your good health which may be required under this plan.

All terms and provisions, maximums or limitations set forth in this book will be applicable to these benefits provided by your employer.

The plan sponsor reserves the right to interpret, amend and/or terminate this plan, in whole or in part, at any time and for any reason.

Eligibility for Dental Coverage

Elected Official/Employee Coverage

Elected Officials/Employees

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

- ☐ You must be *actively employed* (defined as actively working, using any form of paid leave, or on approved FMLA); and
- ☐ You will need to be in an eligible class, as defined below; and
- ☐ You will need to meet the Eligibility Date criteria described below.
- ☐ You will need to enroll and be accepted for coverage

Determining if You Are in an Eligible Class

You are in an eligible class if:

- ☐ You are an Elected Official or regular full-time employee, as defined by your employer (for purposes of this SPD, full-time is defined as being expected or determined to be a permanent employee working on average 30 or more hours per week).
- ☐ You do not meet the regulations above, but you meet the regulations to be eligible for insurance under Affordable Care Act (ACA) rules.

Determining When You Become Eligible

You become eligible for the plan on your Eligibility Date, which is determined as follows:

On the Plan Coverage Start Date

If you are in an eligible class and are currently enrolled on the plan coverage start date, then your coverage Eligibility Date is the same as the plan coverage start date and there is no

waiting period.

After the Plan Coverage Start Date

If you are hired or enter an eligible class after the plan coverage start date, your Eligibility Date is the first of the month that occurs 1 calendar month *after* the month in which you are hired (this is considered your Administrative Period).

When Your Coverage Begins

If you met the qualifications of an eligible class and completed all requirements for enrollment within the defined time, and you are accepted on the Plan, then your insurance will start as follows:

- ☐ On your Eligibility Date if you enroll as a new employee; or
- ☐ On the first day of the following calendar year if you enroll during Open Enrollment; or
- ☐ On the date of a Life Event if you enroll due to a qualifying Life Event; and

When Your Coverage Ends

Coverage under this Plan always ends on the last day of the month. Your health benefits coverage will end on the last day of the month in which the following occurs if:

- ☐ The health benefits plan is discontinued;
- ☐ You voluntarily stop your coverage;
- ☐ You are no longer eligible for coverage;
- ☐ You do not make any required contributions;
- ☐ You become covered under another plan offered by your employer;
- ☐ Your employer notifies Delta that your employment is ended;
- ☐ Your employment is terminated by your own choice;

If a covered employee dies, the coverage for the existing and covered dependents will continue until the end of the month, following the month of the employee's death.

It is your employer's responsibility to let Delta know when your employment ends.

Inactive Pay Status

An employee who is not in an active pay status (vacation, comp/flex time, sick, paid/unpaid Family Medical Leave) is considered to be Inactive Pay Status and not eligible to be on the Plan. Please note that Workers' Comp is not considered active pay status.

- ☐ Please keep in mind that unpaid time off does not constitute active pay status for purposes of the Plan At the point that they are **not** in an active pay status, their insurance eligibility is over and they are terminated from the Plan on the last day of the month in which they were active. (for instance, an employee who is terminated from the Plan on May 9 would Stay on the Plan through May 31);
- ☐ Employees who return to active pay status within 60 calendar days of the date they are terminated from the Plan (using May 31 from the above example) will be able to start back on the Plan effective on the date they return to active pay status. They will not have to wait to join the Health Plan like a new employee;
- ☐ Employees who return to active pay status 61 or more calendar days from the date they are terminated from the Plan will be treated as a new employee for purposes of their Effective

Date on the Plan;

- ☐ Employees who elect COBRA and are on COBRA on the date of their return to active pay status will start on the Plan effective on the date of their return, no matter if their return is over or under 60 days. These employees never left the Plan, so they do not have to wait like a new employee.

Read this book carefully if your coverage ends. You may have the right to continue certain group benefits for a limited time.

Dependent Coverage

Obtaining Coverage for Dependents

Qualified dependents can be covered under this Plan. You may enroll the following dependents:

- ☐ Your Spouse.
- ☐ Your children.

Delta will rely upon the Plan Administrator to determine whether or not a person meets the definition of a dependent for coverage under this Plan. This determination will be conclusive and binding upon all persons for the purposes of this Plan.

Coverage for Spouses

To be eligible, a Spouse must meet the following definition:

- The marriage is recognized by the State of Ohio as being a legal marriage; and
- You are married and living together as a married couple; or
- You are married and living apart, but not legally separated under a decree of divorce, separate maintenance or legal separation document; or
- You are separated under an interlocutory (not final) decree of divorce.

Married employees cannot be members on separate county insurance plans (unless one of the employees is employed by a noncounty agency that does not allow Spouses on their plan).

Coverage for Eligible Children

To be eligible, a child must be under 26 years of age and qualify as identified below under "An Eligible Child".

An Eligible Child includes:

- Your biological children;
- Your Stepchildren, as long as their parent is included on the insurance plan as a Spouse;
- Your legally adopted children or children placed with you for adoption;
- Any children for whom you (our employee) are responsible under court order.

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

Important Notice: In the case of Stepchildren, whether or not the custodial parent is a member on the plan, they should have access to their covered child's medical card with the

ability to communicate that information to the child's doctor.

Important Reminder: Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

Please note that you will need to provide proof of your dependent(s)' eligibility (such as a Marriage or Birth Certificate and any court orders) when you originally enroll your dependent(s) and whenever an eligibility audit is conducted.

Handicapped Children

Dental Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- ☐ he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- ☐ he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to Delta no later than 31 days after the date your child reaches the maximum age under your plan.
Coverage will cease on the first to occur of:

- ☐ Cessation of the handicap.
- ☐ Failure to give proof that the handicap continues.
- ☐ Failure to have any required exam.
- ☐ Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

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

When Dependent Coverage Begins

If you they met the requirements for an eligible spouse or child, and you are either already insured for employee coverage or will enroll for employee and dependent coverage at the same time, and you completed all requirement for enrollment within the defined time, and your dependent(s) are accepted on the Plan, then dependent coverage will start as follows:

- ☐ On your Eligibility Date if you enroll as a new employee with dependents on a family plan; or
- ☐ On the first day of the following calendar year if you enroll them during Open Enrollment; or
- ☐ On the date of a Life Event if you enroll them due to a qualifying Life Event.

When Dependent Coverage Ends

Coverage under this Plan always ends on the last day of the month. Coverage for dependent(s) will end on the last day of the month in which any of the following events occur.

Coverage for your dependents will end if:

- ☐ You are no longer eligible for dependents' coverage;
- ☐ You do not make the required contribution toward the cost of dependents' coverage;
- ☐ Your own coverage ends for any of the reasons listed under When Coverage Ends for Employees;
- ☐ Your dependent is no longer eligible for coverage. In this case, coverage ends at the end of the calendar month when your dependent no longer meets the plan's definition of a dependent (examples: divorce, child over 26 years of age, etc.); or
- ☐ You remove the dependent from your plan for any reason during a qualifying Life Event enrollment or an Annual/Open Enrollment.
- ☐ As permitted under applicable federal and state law, your dependent becomes eligible for comparable benefits under this or any other group plan offered by your employer.
- ☐ *PLEASE NOTE that failure to notify Wayne County of a dependent termination, due to not meeting the plan's definition of a dependent, will result in the employee being responsible for 100 percent of any and all claims paid for that dependent after the date which they should have been terminated.*

Read this plan carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time.

How and When to Enroll

At any enrollment opportunity, you may elect to enroll in one of the dental plan options offered by your employer, or to transfer to another dental plan option offered by your employer; however, you must remain on the Dental Plan which you chose for three (3) years before you are eligible to switch to another Dental Plan option.

Initial Enrollment in the Plan

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

You will need to enroll within 31 days of your Eligibility Date. If you miss the enrollment period, you will not be able to participate in the plan until the next annual enrollment period, unless you qualify for a Life Event enrollment, as described below.

Late Enrollment

If you do not enroll for coverage when you first become eligible, but wish to do so later, you may

request information from your employer on when and how you can enroll.

Annual Enrollment/Open Enrollment

During the annual enrollment period, you will have the opportunity to review your coverage needs for the upcoming year. During this period, you have the option to change your coverage. Annual enrollment typically occurs from mid-October to mid-November. The choices you make during this annual enrollment period will become effective on January 1 of the following year.

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

Life Event Enrollment

You are not permitted to terminate, add or make changes to a plan or the dependent(s) on a plan at any time other than Open Enrollment, unless you qualify for a Life Event as defined below. You may make changes to your insurance, including your dependent(s) and/or plan options, for a Life Event if you:

- ☐ Are an Eligible Employee in an Eligible Class at the time of the Life Event; and
- ☐ You, or one of your dependents that are on or will be added to/removed from the plan, experience a qualifying Life Event; and
- ☐ You notify your employer and complete an enrollment within 31 days of the event.

Enrollment instructions will be provided by your employer upon request.

The following will be considered as qualifying Life Events and proof may be required as a condition of eligibility and must be supplied upon request:

- ☐ *Marriage.* This plan will allow for the addition or termination of insurance for a marriage, involving you or your child that will be terminating from your plan, that is recognized by the State of Ohio as being a legal marriage and with submission of a certified marriage certificate.
- ☐ *Divorce, Legal Separation or Annulment.* This plan will allow for the addition or termination of insurance for a divorce, legal separation or annulment involving you or your child that will be joining or terminating from your plan and with submission of an applicable certified court certificate.
- ☐ *Death of Spouse or Child*.
- ☐ *Birth, Adoption, or Placement for Adoption.* New children must fit the definition of an Eligible Child and will require submission of a certified birth certificate unless:
    - ■ Birth by a dependent currently covered on the plan is being used as a reason for that dependent to terminate from the Employee's plan; or
    - ■ A new child is placed in your care for adoption and you have taken on the legal obligation for total or partial support of the child and a certified birth certificate is not available and you are able to provide another acceptable form of proof of placement.
- ☐ *Termination of the Employment of Spouse or Child.*
- ☐ *Start of New Employment of Spouse or Child*
- ☐ *Change in Employment Status (between part-time and full-time) by the Employee, Spouse or Child.*

- ☐ *A Strike or Lockout Reducing Hours of Employment of Employee, Spouse or Child*
- ☐ *Start or Return from Unpaid Leave of Absence from Employment by Employee, Spouse or Child*
- ☐ *Significant Change in Health Coverage of Employee, Spouse or Child*
- ☐ *A Change in the Place of Residence or Work of Employee, Spouse or Child, Which Changes that Individual's Plan Service Area*
- ☐ *Child of Employee Becoming Ineligible for Coverage.* This includes a child becoming ineligible due to age limits.
- ☐ *Entitlement to Medicare or Medicaid of Employee, Spouse or Child*
- ☐ *Issuance of a Judgement, Decree or Order That Requires Health Coverage for Employee's Child.* In the case of dependent care benefits under Article VIII, such other events that the Plan Administrator may determine will permit a change or revocation of an election in accordance with the rulings and regulations under Code Section 125. Such events will be triggered by the receipt of a National Medical Support Notice (NMSN) that has been issued by a court or a state child support enforcement agency authorized to issue Child Support Orders that provides for the medical support of a child. This plan will provide coverage for a child who is identified on a NMSN, if:
    - The child meets the plan's definition of an eligible dependent; and
    - A state child support enforcement agency issues a NMSN that the group health plan determines to be qualified; and
    - The issuing state child support enforcement agency does not issue a Notice to Employer/Health Plan Administrator of Expiration or Terminations of Withholding Requirements Under the NMSN.

  Coverage for the dependent will become effective on the date of issuance of the medical Child Support Order if received within 31 days of issuance, or as required by the NMSN.
- ☐ *Enrollment of Employee, Spouse or Child in a State or Federal Healthcare Exchange*

Important Notices:

- If you do not report your Life Event and submit all required documentation and your enrollment is not received within 31 days of the date the Life Event took place, then you will not qualify to make changes to your insurance plan and will need to wait to make changes during the next annual enrollment period.
- You must pay any increase in premiums in full or coverage will not be effective.
- For child(ren) under a NMSN, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims may be paid to the custodial parent.
- All current requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) outlined in the Special Enrollment Notice (behind Tab 10) are covered by the Plan.

Dental Expense Insurance

This insurance will pay many of a covered person's dental expenses. We pay benefits for covered charges incurred by a covered person. What we pay and terms for payment are explained below.

Covered Charges

Covered charges are reasonable and customary charges for the dental services named in this plan's List of Covered Dental Services. To be covered by this plan, a service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the List of Covered Dental Services.

We may use the professional review of a dentist to determine the appropriate benefit for a dental procedure or course of treatment.

By reasonable, we mean the charge is the dentist's usual charge for the service furnished. By customary, we mean the charge made for the given dental condition isn't more than the usual charge made by most other dentists. But, in no event will the covered charge be greater than the 90th percentile of the prevailing fee data for a particular service in a geographic area.

When certain comprehensive dental procedures are performed, other less extensive procedures may be performed prior to, at the same time or at a later date. For benefit purposes under this plan, these less extensive procedures are considered to be part of the more comprehensive procedure. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited to the maximum benefit payable for the more comprehensive procedure. For example, osseous surgery includes the procedure scaling and root planing. If the scaling and root planing is performed one or two weeks prior to the osseous surgery, we may only pay benefits for the osseous surgery.

We only pay benefits for covered charges incurred by a covered person while he or she is insured by this plan. A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is initially prepared. A covered charge for any other dental prosthesis is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. A covered charge for orthodontic treatment is incurred on the date the active orthodontic appliance is first placed. All other covered charges are incurred on the date the services are furnished. If a service is started while a covered person is insured, we'll only pay benefits for services which are completed within 31 days of the date his or her coverage under this plan ends.

Alternate Treatment

If more than one type of service can be used to treat a dental condition, we have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by us. For example, in the case of bilateral multiple adjacent missing teeth, or multiple missing teeth in both quadrants of an arch the benefit will be based on a removable partial denture. In the case of titanium or high noble metal (gold) used in a dental prosthesis, the benefit will be based on the noble metal benefit.

Proof of Claim

So that we may pay benefits accurately, the covered person or his or her dentist must provide us with information that is acceptable to us. This information may, at our discretion, consist of radiographs, study models, periodontal charting, narratives or other diagnostic materials that document proof of claim and support the necessity of the proposed treatment. If we don't receive the necessary information, we may pay no benefits, or minimum benefits. However, if we receive the necessary information within 12 months of the date of service, we will re-determine the covered person's benefits based on the new information.

Pre-Treatment Review

When the expected cost of a proposed course of treatment is $300.00 or more, the covered person's dentist should send us a treatment plan before he or she starts. This must be done on a form acceptable to Delta Dental. The treatment plan must include: (a) a list of the services to be done, using the American Dental Association Nomenclature and codes; (b) the itemized cost of each service; and (c) the estimated length of treatment. In order to evaluate the treatment plan, dental radiographs, study models and whatever else will document the necessity of the proposed course of treatment, must be sent to us.

A treatment plan should always be sent to us before orthodontic treatment starts.

We review the treatment plan and estimate what we will pay. We will send the estimate to the covered person and/or the covered person's dentist. If the treatment plan is not consistent with accepted standards of dental practice, or if one is not sent to us, we have the right to base our benefit payments on treatment appropriate to the covered person's condition using accepted standards of dental practice.

The covered person and his or her dentist have the opportunity to have services or a treatment plan reviewed before treatment begins. Pre-treatment review is not a guarantee of what we will pay. It tells the covered person, and his or her dentist, in advance, what we would pay for the covered dental services listed in the treatment plan. But, payment is conditioned on: (a) the services being performed as proposed and while the covered person is insured; and (b) the deductible, payment rate and payment limits provisions, and all of the other terms of this plan.
Emergency treatment, oral examinations, evaluations, dental radiographs and teeth cleaning are part of a course of treatment, but may be done before the pre-treatment review is made.

We won't deny or reduce benefits if pre-treatment review is not done. But what we pay will be based on the availability and submission of proof of claim.

Benefits From Other Sources

Other plans may furnish benefits similar to the benefits provided by this plan. For instance, you may be covered by this plan and a similar plan through your spouse's employer. You may also be covered by this plan and a medical plan. In such instances, we coordinate our benefits with the benefits from that other plan. We do this so that no one gets more in benefits than the charges he or she incurs. Read "Coordination of Benefits" to see how this works.

After This Insurance Ends

We pay benefits for orthodontic treatment to the end of the month in which the covered person's insurance ends.

Special Limitations

If This Plan Replaces the Prior Plan

This plan may be replacing the prior plan you had with another insurer. If a covered person was insured by the prior plan and is covered by this plan on its effective date, the following provision applys to such covered person.

- Orthodontic Payment Limit Credit

  We reduce a covered person's orthodontic payment limits by the amounts paid or payable under the prior plan. The covered person must give us proof of the amounts applied toward the prior plan's payment limits.

Exclusions That We Will Not Pay For:

- ☐ Any service or supply which is not specifically listed in this plan's List of Covered Dental Services;
- ☐ Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this plan;
- ☐ Educational services, including, but not limited to, oral hygiene instruction, plaque control, tobacco counseling or diet instruction;
- ☐ Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments;
- ☐ Overdentures and related services, including root canal therapy on teeth supporting an overdenture;
- ☐ Any restoration, procedure, appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this plan covers orthodontic treatment; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons;
- ☐ The use of general anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including but not limited to nitrous oxide, except when administered in conjunction with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under the "Other Oral Surgical Procedures" section of this plan. The use of general anesthesia as an exclusion does not pertain to children with "special needs";
- ☐ The use of local anesthetic;
- ☐ Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera, except when performed as part of the orthodontic treatment plan and records for a covered course of orthodontic treatment;
- ☐ Replacement of a lost, missing or stolen appliance or dental prosthesis or the fabrication of a spare appliance or dental prosthesis;
- ☐ Prescription medication;
- ☐ Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges;

- ☐ Pulp vitality tests or caries susceptibility tests;
- ☐ Bite registration or bite analysis;
- ☐ Gingival curettage;
- ☐ The localized delivery of chemotherapeutic agents;
- ☐ Tooth transplants;
- ☐ Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation. This includes Oral and Maxillofacial Treatment unless not covered by your Medical insurance;
- ☐ Temporary or provisional dental prosthesis or appliances except interim partial dentures/stayplates to replace anterior teeth extracted while insured under this plan;
- ☐ Any service or procedure associated with the placement, prosthodontic restoration or maintenance of a dental implant and any incremental charges to other covered services as a result of the presence of a dental implant. Exclusions are listed below, but this is not an exhaustive list, so you will want to request a Pre-Treatment Estimate (dental codes listed in parentheses):
    - o Second stage implant surgery (D6011);
    - o Surgical placements of interim implant body for transitional prosthesis: endosteal implant (D6012);
    - o Surgical placement: eposteal implant (D6040);
    - o Surgical placement: transosteal implant (D6050);
    - o Interim abutment (D6051);
    - o Semi-precision attachment abutment (D6052);
    - o Bone graft for repair of periimplant defect – does not include flap entry and closure; Placement of a barrier membrane or biologic materials to aid in osseous regeneration are reported separately (D6103);
    - o Bone graft at time of implant placement (D6104);
- ☐ Any service furnished solely for cosmetic reasons. This includes, but is not limited to: (1) characterization and personalization of a dental prosthesis; (2) facings on a dental prosthesis for any teeth posterior to the second bicuspid; (3) bleaching of discolored teeth; and (4) odontoplasty;
- ☐ Replacing an existing appliance or dental prosthesis with a like or un-like appliance or dental prosthesis; unless (1) it is at least 10 years old for fixed bridges and labial veneers, at least 5 years old for crowns, inlay and onlays and full or partial dentures and is no longer usable; or (2) it is damaged while in the covered person's mouth in an injury suffered while insured, and can't be made serviceable;
- ☐ A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth;
- ☐ The replacement of extracted or missing third molars/wisdom teeth;
- ☐ Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth;
- ☐ Any endodontic, periodontal, crown or bridge abutment procedure or appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis;
- ☐ Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature;

- ☐ Any procedure, appliance, dental prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ);
- ☐ Treatment needed due to: (1) an on-the-job or job-related injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws;
- ☐ Treatment for which no charge is made. This usually means treatment furnished by: (1) the covered person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body;
- ☐ Evaluations and consultations for non-covered services; detailed and extensive oral evaluations;
- ☐ The repair of an orthodontic appliance;
- ☐ The replacement of a lost or broken orthodontic retainer.
- ☐ Orthodontic services for anyone above the age of 19.

See Addendum A for a full list of Exclusions and Limitations.

List of Covered Dental Services

The services covered by this plan are named in this list. Each service on this list has been placed in one of four groups. A separate payment rate applies to each group. Group I is made up of preventive services. Group II is made up of basic services. Group III is made up of major services. Group IV is made up of orthodontic services.

All covered dental services must be furnished by or under the direct supervision of a dentist. And they must be usual and necessary treatment for a dental condition.

Group I - Preventive Dental Services (Non-Orthodontic)

Preventative and diagnostic services are not calculated towards the annual maximum benefit.

Prophylaxis and Fluorides

Prophylaxis: Limited to 2 prophylaxis per calendar year.

Fluorides: Allowance includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.

- ☐ Adult prophylaxis covered age 12 and older.
- ☐ Fluoride treatment, topical application - limited to covered persons under age 16 and limited to 2 treatment(s) per calendar year.

Office Visits, Evaluations and Examinations

Office visits, oral evaluations, examinations, limited oral evaluation - problem focused or limited problem focused re-evaluations - limited to a total of 2 per calendar year.

Radiographs

Allowance includes evaluation and diagnosis:

- ☐ Full mouth, complete series or panoramic radiograph - Either, but not both, of the following procedures, limited to one in any 36 consecutive month period;
- ☐ Full mouth series, of at least 14 films including bitewings;

- ☐ Panoramic film, maxilla and mandible, with or without bitewing radiographs.

Other diagnostic radiographs:

- ☐ Bitewing films - limited to either a series of 4 bitewing films or a set (7-8 films) of vertical bitewings, in one visit, once in a calendar year;
- ☐ Intraoral periapical or occlusal films - single films.

Dental Sealants

Permanent 1st and 2nd molar teeth only - Topical application of sealants is limited to the 1st and 2nd permanent molar teeth of covered persons under age 16 and limited to one treatment, per tooth, in any 36 consecutive month period.

Diagnostic Services

Bacteriologic cultures.

Group II - Basic Dental Services (Non-Orthodontic)

Diagnostic Services

Allowance includes examination and diagnosis:

- ☐ Consultations - Diagnostic consultation with a dentist other than the one providing treatment, limited to one consultation for each covered dental specialty in any 12 consecutive month period. Covered only when no other treatment, other than radiographs, is performed during the visit.
- ☐ After hours office visit or emergency palliative treatment and other non-routine, unscheduled visits. Covered only when no other treatment, other than radiographs and exam, is performed during the same visit.
- ☐ Diagnostic Services: Allowance includes examination and diagnosis:
    - ■ Diagnostic casts - limited to once in a 24 consecutive month period.
    - ■ Histopathologic examinations when performed in conjunction with a tooth related biopsy.
    - ■ Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures - limited to one test in any 24 consecutive month period for covered persons age 30 and older.

Restorative Services

Multiple restorations on one surface will be considered one restoration. Benefits for the replacement of existing amalgam and resin restorations will only be considered for payment if at least 12 months have passed since the previous restoration was placed if the covered person is under age 19, and 36 months if the covered person is age 19 and older. Also see the "Major Restorative Services" section.

- ☐ Amalgam restorations - Allowance includes bonding agents, liners, bases, polishing and local anesthetic.
- ☐ Resin restorations - Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic.
- ☐ Silicate cement, per restoration.

- ☐ Composite resin.

Endodontic Services

Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

- ☐ Pulp capping, limited to permanent teeth and limited to one pulp cap per tooth, per lifetime;
- ☐ Pulp capping, direct;
- ☐ Pulp capping, indirect - includes sedative filling;
- ☐ Vital pulpotomy, only when root canal therapy is not the definitive treatment;
- ☐ Gross pulpal debridement;
- ☐ Pulpal therapy, limited to primary teeth only;
- ☐ Root Canal Treatment:
  - ■ Root canal therapy;
  - ■ Root canal retreatment, limited to once per tooth, per lifetime;
  - ■ Treatment of root canal obstruction, no-surgical access;
  - ■ Incomplete endodontic therapy, inoperable or fractured tooth;
  - ■ Internal root repair of perforation defects.
- ☐ Other Endodontic Services:
  - ■ Apexification, limited to a maximum of three visits;
  - ■ Apicoectomy, limited to once per root, per lifetime;
  - ■ Root amputation, limited to once per root, per lifetime;
  - ■ Retrograde filling, limited to once per root, per lifetime;
  - ■ Hemisection, including any root removal, once per tooth.

Periodontal Services

Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

- ☐ Periodontal maintenance procedure - limited to a total of two periodontal maintenance procedures per calendar year. Allowance includes periodontal pocket charting, scaling and polishing. Coverage for periodontal maintenance is considered upon evidence of completed active periodontal therapy (periodontal scaling and root planing or periodontal surgery).
- ☐ Scaling and root planing, per quadrant - limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.
- ☐ Full mouth debridement - limited to once in any 36 consecutive month period.
- ☐ Provisional splinting.

Periodontal Surgery

Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

- ☐ The following treatment is limited to a total of one of the following, once per tooth in any 12 consecutive months:
  - Gingivectomy, per tooth (less than 3 teeth);
  - Crown lengthening - hard tissue.
- ☐ The following treatment is limited to a total of one of the following once per quadrant, in any 36 consecutive months:
  - Gingivectomy or gingivoplasty, per quadrant;
  - Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant;
  - Gingival flap procedure, including scaling and root planing, per quadrant;
  - Distal or proximal wedge, not in conjunction with osseous surgery;
  - Surgical revision procedure, per tooth.
- ☐ The following treatment is limited to a total of one of the following, once per quadrant in any 36 consecutive months:
  - Pedicle or free soft tissue grafts, including donor site, or subepithelial connective tissue graft procedure, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.
- ☐ The following treatment is limited to a total of one of the following, once per area or tooth, per lifetime:
  - Guided tissue regeneration, resorbable barrier or nonresorbable barrier Bone replacement grafts, when the tooth is present.
- ☐ Periodontal surgery related:
  - Limited and complete occlusal adjustment;
  - Occlusal guards limited to one in a 5-year period.

Space Maintainers

Limited to covered persons under age 20 and limited to initial appliance only. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, per lifetime:

- ☐ Fixed – unilateral;
- ☐ Fixed – bilateral;
- ☐ Removable – bilateral;
- ☐ Removable – unilateral;
- ☐ Recementation of space maintainer performed more than 12 months after the initial insertion.

Fixed and Removable Appliances

To Inhibit Thumbsucking - limited to covered persons under age 14 and limited to initial appliance only. Allowance includes all adjustments in the first 6 months after insertion.

Non-Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-treatment care:

- ☐ Uncomplicated extraction, one or more teeth;
- ☐ Root removal non-surgical extraction of exposed roots.

Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan:

- ☐ Surgical removal of erupted teeth, involving tissue flap and bone removal;
- ☐ Surgical removal of residual tooth roots;
- ☐ Surgical removal of impacted teeth.

Other Oral Surgical Procedures

Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan:

- ☐ Alveoloplasty, per quadrant;
- ☐ Removal of exostosis, per site;
- ☐ Incision and drainage of abscess;
- ☐ Frenulectomy, Frenectomy, Frenotomy;
- ☐ Biopsy and examination of tooth related oral tissue;
- ☐ Surgical exposure of impacted or unerupted tooth to aid eruption;
- ☐ Excision of tooth related tumors, cysts and neoplasms;
- ☐ Excision or destruction of tooth related lesion(s);
- ☐ Excision of hyperplastic tissue;
- ☐ Excision of pericoronal gingiva, per tooth;
- ☐ Oroantral fistula closure;
- ☐ Sialolithotomy;
- ☐ Sialodochoplasty;
- ☐ Closure of salivary fistula;
- ☐ Excision of salivary gland;
- ☐ Maxillary sinusotomy for removal of tooth fragment or foreign body;
- ☐ Vestibuloplasty.

Other Services

General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including nitrous oxide, when administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, surgical placement of an implant and services listed under the "Other Oral Surgical Procedures" section of this plan.

- ☐ Injectable antibiotics needed solely for treatment of a dental condition;
- ☐ Desensitizing medicaments.

Group III - Major Dental Services (Non-Orthodontic)

Major Restorative Services

Crowns, inlays, onlays, labial veneers, and crown buildups are covered only when needed because of decay or injury, and only when the tooth cannot be restored with amalgam or composite filling material. Post and cores are covered only when needed due to decay or injury. Allowance includes insulating bases, temporary or provisional restorations and associated

gingival involvement. Limited to permanent teeth only. Also see the "Basic Restorative Services" section.

- ☐ Single Crowns:
  - Resin with metal;
  - Porcelain;
  - Porcelain with metal;
  - Full cast metal (other than stainless steel);
  - 3/4 cast metal crowns;
  - 3/4 porcelain crowns.
- ☐ Stainless steel crowns;
- ☐ Prefabricated resin crowns;
- ☐ Inlays;
- ☐ Onlays, including inlay;
- ☐ Labial veneers;
- ☐ Posts and buildups - only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure:
  - Cast post and core in addition to a unit of crown or bridge, per tooth;
  - Prefabricated post and composite or amalgam core in addition to a unit of crown or bridge, per tooth;
  - Crown or core buildup, including pins.
- ☐ Pin retention, per tooth, limited to two pins per tooth. Covered only in conjunction with a permanent amalgam or composite restoration, exclusive of restorative material. Protective restoration, per tooth, covered as a separate benefit only if no other service, other than radiographs and exam, is performed during the same visit;
- ☐ Implant supported prosthetics - Allowance includes the treatment plan and local anesthetic:
  - Abutment supported crown;
  - Implant supported crown;
  - Abutment supported retainer for fixed partial denture;
  - Implant supported retainer for fixed partial denture;
  - Implant/abutment supported fixed denture for completely edentulous arch;
  - Implant/abutment supported fixed denture for partially edentulous arch.

Prosthodontic Services

Specialized techniques and characterizations are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only.

- ☐ Fixed bridges - Each abutment and each pontic makes up a unit in a bridge:
  - Bridge abutments - See inlays, onlays and crowns under "Major Restorative Services";
  - Bridge Pontics;
  - Resin with metal:
    - Porcelain;
    - Porcelain with metal;
    - Full cast metal.

- ☐ Dentures - Allowance includes all adjustments and repairs done by the dentist furnishing the denture in the first 6 consecutive months after installation and all temporary or provisional dentures. Temporary or provisional dentures, stayplates and interim dentures older than one year are considered to be a permanent appliance:
  - Complete or Immediate dentures, upper or lower;
  - Partial dentures - Allowance includes base, clasps, rests and teeth:
    - Upper, resin base, including any conventional clasps, rests and teeth.
  - Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth;
  - Lower, resin base, including any conventional clasps, rests and teeth;
  - Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth;
  - Interim partial denture (stayplate), upper or lower, covered on anterior teeth only;
  - Removable unilateral partial, one piece cast metal, including clasps and teeth.
- ☐ Simple stress breakers, per unit.

Crown and Prosthodontic Restorative Services

Also see the "Major Restorative Services" section.

- ☐ Crown and bridge repairs - allowance based on the extent and nature of damage and the type of material involved.
- ☐ Recementation, limited to recementations performed more than 12 months after the initial insertion.
  - Inlay or onlay;
  - Crown;
  - Bridge.
- ☐ Adding teeth to partial dentures to replace extracted natural teeth.
- ☐ Denture repairs - Allowance based on the extent and nature of damage and on the type of materials involved. Limited to repairs done more than 12 consecutive months after the insertion of the denture.
  - Denture repairs, metal;
  - Denture repairs, acrylic;
  - Denture repair, no teeth damaged;
  - Denture repair, replace one or more broken teeth;
  - Replacing one or more broken teeth, no other damage.
- ☐ Denture rebase, full or partial denture - limited to once per denture in any 12 consecutive month period. Denture rebases done within 6 months are considered to be part of the denture placement when the rebase is done by the dentist who furnished the denture. Limited to rebase done more than 6 consecutive months after the insertion of the denture.
- ☐ Denture reline, full or partial denture - limited to once per denture in any 12 consecutive month period. Denture relines done within 6 months are considered to be part of the denture placement when the reline is done by the dentist who furnished the denture. Limited to reline done more than 6 consecutive months after a denture rebase or the insertion of the denture.
- ☐ Denture adjustments - Denture adjustments done within 12 months are considered to be part of the denture placement when the adjustment is done by the dentist who furnished

the denture. Limited to adjustments that are done more than 12 consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

- ☐ Tissue conditioning - Tissue conditioning done within 6 months is considered to be part of the denture placement when the tissue conditioning is done by the dentist who furnished the denture.

Group IV - Orthodontic Services (only for members who are 19 years or younger)

Any covered Group I, II or III service in connection with orthodontic treatment.

- ☐ Transseptal fiberotomy.
- ☐ Surgical exposure of impacted or unerupted teeth in connection with orthodontic treatment - Allowance includes treatment and final radiographs, local anesthetics and post-surgical care.
- ☐ Treatment plan and records, including initial, interim and final records.
- ☐ Limited orthodontic treatment, Interceptive orthodontic treatment or Comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances and periodic visits.
- ☐ Orthodontic retention, including any and all necessary fixed and removable appliances and related visits - limited to initial appliance(s) only.

Network Access

The dental PPO is made up of preferred providers in a covered person's geographic area with whom Delta Dental has contracted and who may provide services at a discount. What we pay is subject to all the terms and conditions of the plan. You can obtain a listing of preferred providers by going to www.deltadentaloh.com.

Coordination of Benefits

Purpose

When a covered person has dental coverage under more than one plan, this section allows this plan to coordinate what it pays with what other plans pay. This is done so that the covered person does not collect more in benefits than he or she incurs in charges.

Definitions

Allowable Expense

This term means any necessary, reasonable, and customary item of health care expense that is covered, at least in part, by any of the plans which cover the person. This includes: (a) deductibles; (b) coinsurance; and (c) copayments. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

An expense or service that is not covered by any of the plans is not an allowable expense. Examples of other expenses or services that are not allowable expenses are:

1. The amount a benefit is reduced by the primary plan because a person does not comply with the plan's provisions is not an allowable expense. Examples of these provisions are: (a) precertification of admissions and procedures; (b) continued stay reviews; and (c) preferred provider arrangements.
2. If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable and customary charges, any amount in excess of the primary plan's reasonable and customary charges for a specific benefit is not an allowable expense.
3. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the primary plan's negotiated fees for a specific benefit is not an allowable expense.

If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans.

Claim

This term means a request that benefits of a plan be provided or paid.

Claim Determination Period

This term means a calendar year. It does not include any part of a year during which a person has no coverage under this plan, or before the date this section takes effect.

Closed Panel Plan

This term means a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), or other plan that provides health benefits to

covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan; and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Coordination of Benefits

This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Custodial Parent

This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan

This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance; (2) closed panel or other forms of group coverage, whether insured or uninsured; (3) group-type contracts; (4) medical benefits under group or individual automobile contracts; and (5) governmental benefits, except Medicare, as permitted by law.

This term does not include: (a) individual or family insurance; (b) closed panel or other individual coverage, except for group-type coverage; (c) amounts of group or group-type hospital indemnity benefits of $200.00 or less per day; (d) school accident type coverage; (e) benefits for non-medical components of group long-term care policies; or (f) Medicare, Medicare supplement policies, Medicaid, and coverage under other governmental plans, unless permitted by law.

This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description.

Each type of coverage listed above is treated separately. If a plan has two parts and coordination of benefits applies only to one of the two, each of the parts is treated separately.

Primary Plan

This term means a plan that pays first without regard that another plan may cover some expenses. A plan is a primary plan if either of the following is true: (1) the plan either has no order of benefit determination rules, or its rules differ from those explained in this section; or (2) all plans that cover the person use the order of benefit determination rules explained in this section, and under those rules the plan pays its benefits first.

Secondary Plan

This term means a plan that is not a primary plan.

This Plan

This term means the group health benefits provided under this group plan.

Order Of Benefit Determination

The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

A plan may consider the benefits paid or provided by another plan to determine its benefits only when it is secondary to that other plan. If a person is covered by more than one secondary plan, the rules explained below decide the order in which secondary plan benefits are determined in relation to each other.

A plan that does not contain a coordination of benefits provision is always primary.

This Plan **always** pays secondary to any motor vehicle policy available to a covered person, including any medpay, PIP, No Fault or any plan or program which is required by law. All covered persons should review their automobile insurance policy and ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer. When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the rules that applies is the rule to use.

Non-Dependent Or Dependent

The plan that covers the person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is primary. The plan that covers the person as a dependent is secondary.

But, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan that covers the person as a dependent; and primary to the plan that covers the person other than as a dependent (for example, as a retiree); then the order of payment between the two plans is reversed. In that case, the plan that covers the person as an employee, member, subscriber, or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan

The order of benefit determination when a child is covered by more than one plan is:

1. If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.
2. If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that

plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.

3. In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; (c) the plan of the noncustodial parent; and (d) the plan of the spouse of the noncustodial parent.

Active or Inactive Employee

The plan that covers a person as an active employee, or as that person's dependent, is primary. An active employee is one who is neither laid off nor retired. The plan that covers a person as a laid off or retired employee, or as that person's dependent, is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Continuation Coverage

The plan that covers a person as an active employee, member, subscriber, or retired employee, or as that person's dependent, is primary. The plan that covers a person under a right of continuation provided by federal or state law is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Length Of Coverage

The plan that covered the person longer is primary.

Other

If the above rules do not determine the primary plan, the allowable expenses will be shared equally between the plans that meet the definition of plan under this section. But, this plan will not pay more than it would have had it been the primary plan.

Effect On The Benefits Of This Plan

When This Plan is Primary

When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.

When This Plan is Secondary

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses.

Closed Panel Plans

If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan will pay or provide benefits as if it were primary when a covered person

uses a non-panel provider; except for emergency services or authorized referrals that are paid or provided by the primary plan.

A person may be covered by two or more closed panel plans. If, for any reason including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, coordination of benefits will not apply between that plan and other closed panel plans.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these rules and to determine benefits payable under this plan and other plans. This plan may get the facts it needs from, or give them to, other organizations or persons to apply these rules and determine benefits payable under this plan and other plans which cover the person claiming benefits. This plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts it needs to apply these rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid by this plan. If it does, this plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this plan. This plan will not have to pay that amount again.

As used here, the term "payment made" includes the reasonable cash value of any benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by this plan is more than it should have paid under this section, it may recover the excess: (a) from one or more of the persons it has paid or for whom it has paid; or (b) from any other person or organization that may be responsible for benefits or services provided for the covered person.

As used here, the term "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination and you think that Delta Dental incorrectly denied all or part of your Claim, you or your Dentist may contact Delta Dental's Customer Service department and ask them to reconsider the Claim to make sure it was processed correctly. You may do this by calling the toll-free number, 800-524-0149, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089.

When writing, please enclose a copy of your explanation of benefits and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like

considered about your Claim. A request for reconsideration is not required and should not be considered a formal request for review of a denied Claim.

Delta Dental provides this opportunity for you to describe problems, or submit an explanation or additional information that might indicate your Claim was improperly denied, and allow Delta Dental to correct any errors quickly and immediately. Whether or not you have asked Delta Dental informally to reconsider its initial determination, you can request a formal review using the Formal Claims Appeal Procedure described below.

Formal Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination, you, or your Authorized Representative, should seek a review as soon as possible, but you must file your request for review within 180 days of the date that you received that Adverse Benefit Determination. To request a formal review of your Claim, send your request in writing to:

Dental Director Delta Dental
P.O. Box 30416
Lansing, Michigan 48909-7916

Please include your name and address, the Enrollee's Member ID, the reason why you believe your Claim was wrongly denied, and any other information you believe supports your Claim. You also have the right to review the contract between Delta Dental and the Contractor and any documents related to it. If you would like a record of your request and proof that Delta Dental received it, mail your request certified mail, return receipt requested.

The Dental Director or any person reviewing your Claim will not be the same as, nor subordinate to, the person(s) who initially decided your Claim. The reviewer will grant no deference to the prior decision about your Claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the Claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to your Claim even if the information was not available when your Claim was initially decided.

If the decision is based, in whole or in part, on a dental or medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the reviewer will consult a dental health care professional with appropriate training and experience, if necessary. The dental health care professional will not be the same individual or that person's subordinate consulted during the initial determination. The reviewer will make a determination within 60 days of receipt of your request. If your Claim is denied on review (in whole or in part), you will be notified in writing. The notice of an Adverse Benefit Determination during the Formal Claims Appeal Procedure will meet the requirements described below.

Manner and Content of Notice

Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the denial, the pertinent plan provisions(s) on which the denial is based, the applicable review procedures for dental Claims, including time limits and that, upon request, you are entitled to access all documents, records and other information relevant to your Claim free of charge. This notice will also contain a description of any additional materials necessary to complete your Claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an Adverse Benefit Determination after your Claim has been completely reviewed according to this Formal Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination, and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge. The Adverse Benefit Determination notice will inform you of your right to a managerial-level conference to complete the formal grievance procedure.

Subrogation and Right of Recovery

Important Notice

This section applies to any health care or loss of earnings benefits under this plan.

Purpose

When a covered person has the right to recover amounts paid by this plan for health care or loss of earnings benefits, this plan also has certain rights. These are explained below.

Definitions

As used in this section, the terms listed below have the meanings shown below:

Covered Person:

This term means any employee or dependent on whose behalf this plan pays health care or loss of earnings benefits. It includes the parent or guardian of any such covered employee or dependent who is a minor or incompetent.

Health Care:

This term means any: (a) major medical; (b) prescription drug; (c) dental; or (d) vision benefits.

Insurance Coverage:

This term means any insurance which provides coverage for: (a) medical expense payments; or (b) liability. This includes, but is not limited to: (i) uninsured motorist coverage; (ii) underinsured motorist coverage; (iii) personal umbrella coverage; (iv) medical payments

coverage; (v) workers compensation coverage; (vi) no-fault automobile insurance coverage; or (vii) any first party insurance.

Third Party:

This term means any party actually, possibly, or potentially responsible for making any payment to a covered person due to the covered person's injury, sickness or condition. This term also means such party's: (a) the liability insurer; or (b) any insurance coverage. But, this term does not mean: (i) this plan; or (ii) the covered person.

Subrogation

When this plan pays a benefit, it will immediately be subrogated to the covered person's rights of recovery from any third party to the full extent of benefits paid.

Recovery

If a covered person receives a payment from any third party or insurance coverage due to an injury, sickness or condition, this plan has the right to recover from, and be repaid by, the covered person for all amounts this plan has paid and will pay due to that injury, sickness or condition, from such payment, up to and including the full amount he or she receives from any third party or insurance coverage.

Constructive Trust

The covered person must serve as a constructive trustee over the funds that constitute payment from any third party or insurance coverage due to his or her injury, sickness or condition. This is the case whether the payment of benefits from the plan is: (a) made to the covered person; or (b) made on his or her behalf to any provider. If the covered person fails to hold such funds in trust, it will be deemed a breach of his or her fiduciary duty to the plan.

Lien Rights

This plan will have a lien to the extent of benefits this plan paid due to the covered person's injury, sickness or condition for which the third party is liable. The lien will be imposed on any recovery, whether by settlement, judgement, or otherwise, including from any insurance coverage, that a covered person receives due to his or her injury, sickness or condition. The lien may be enforced against any party who holds funds or proceeds which represent the amount of benefits paid by this plan. This includes, but is not limited to: (a) the covered person; (b) the covered person's representative or agent; (c) the third party; (d) the third party's insurer, representative or agent; and (e) any other source who holds such funds.

First Priority Claim

This plan's recovery rights are a first priority claim against all third parties or insurance coverage and are to be paid to the plan before any other claim for the covered person's damages. This is the case whether the payment of benefits from the plan is: (a) made to the covered person; or (b) made on his or her behalf to any provider. This plan will be entitled to full repayment on a first dollar basis from any third party's or insurance coverage's payments, even if such payment to the plan will result in a recovery to the covered person which is not sufficient: (i) to make him or her whole; or (ii) to compensate him or her in part or in whole for the damages sustained. This plan is not required to

participate in or pay court costs or attorney fees to the attorney hired by the covered person to pursue his or her damage claim.

Applicable to all Settlements and Judgments

This plan is entitled to full recovery regardless of whether: (a) any liability for payment is admitted by a third party; or (b) the settlement or judgment received by the covered person identifies the benefits the plan paid. This plan is entitled to recover from any and all settlements or judgments, even those designated as: (i) pain and suffering; or (ii) non-economic damages only.

Cooperation

The covered person must fully cooperate with this plan's efforts to recover the benefits it paid. He or she must notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of his or her intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, sickness or condition sustained by him or her. He or she, and his or her agents, must provide all information requested by the plan or its representative. This includes, but is not limited to, completing and submitting any applications or other forms or statements as the plan or its representative may reasonably request. Failure to do this may result in the termination of benefits or the instigation of legal action against him or her.

The covered person must do nothing: (a) to prejudice this plan's rights as described in this section; or (b) to prejudice the plan's ability to enforce the terms of this section. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full amount of all benefits paid by this plan. Failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery obtained by the covered person may result in the termination of benefits or the instigation of legal action against him or her.

The plan or its representative has the right to conduct an investigation regarding the injury, sickness or condition to identify any third party. The plan reserves the right to notify the third party and his or her agents of this plan's lien. Agents include, but are not limited to: (a) insurance companies; and (b) attorneys.

Interpretation

In the event that any claim is made that any part of this section is ambiguous, or questions arise as to the meaning or intent of any of its terms, the plan has the sole authority and discretion to resolve all disputes regarding the interpretation of this section.

Jurisdiction

Any legal action or proceeding with respect to this section may be brought in any court of competent jurisdiction as the plan may choose. The covered person must submit to each such jurisdiction and waive whatever rights may correspond to him or her by reason of his or her present or future domicile.

Glossary

This Glossary defines certain terms appearing in your book.

Active Orthodontic means an appliance, like a fixed or removable appliance, braces or a functional orthotic used for orthodontic treatment to move teeth or reposition the jaw.

Anterior Teeth means the incisor and cuspid teeth. The teeth are located in front of the bicuspids (pre-molars).

Appliance means any dental device other than a dental prosthesis.

Benefit Year means a 12-month period which starts on January 1st and ends on December 31st of each year.

Covered Dental Specialty means any group of procedures which falls under one of the following categories, whether performed by a specialist dentist or a general dentist: restorative/prosthodontic services; endodontic services, periodontic services, oral surgery and pedodontics.

Covered Family means an employee and those of his or her dependents who are covered by this plan.

Covered Person means an employee or any of his or her covered dependents.

Dentist means any dental or medical practitioner we are required by law to recognize who: (a) is properly licensed or certified under the laws of the state where he or she practices; and (b) provides services which are within the scope of his or her license or certificate and covered by this plan.

Eligibility Date for dependent coverage is the earliest date on which: (a) you have initial dependents; and (b) are eligible for dependent coverage.

Eligible Dependent is defined in the provision entitled "Dependent Coverage."

Emergency Treatment means bona fide emergency services which: (a) are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort, or to prevent the imminent loss of teeth; and (b) are covered by this plan.

Employee means a person who works for the employer at the employer's place of business, and whose income is reported for tax purposes using a W-2 form.

Employer means WAYNE COUNTY.

Enrollment Period with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.

Full-time means the employee regularly works at least the number of hours in the normal work week set by the employer (but not less than 30 hours per week), at his employer's place of business.

Initial Dependents means those eligible dependents you have at the time you first become eligible for employee coverage. If at this time you do not have any eligible dependents, but you later acquire them, the first eligible dependents you acquire are your initial dependents.

Injury means all damage to a covered person's mouth due to an accident which occurred while he or she is covered by this plan, and all complications arising from that damage. But the term injury does not include damage to teeth, appliances or dental prostheses which results solely from chewing or biting food or other substances.

Newly Acquired Dependent means an eligible dependent you acquire after you already have coverage in force for initial dependents.

Orthodontic Treatment means the movement of one or more teeth by the use of active appliances. it includes: (a) treatment plan and records, including initial, interim and final records; (b) periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances; (c) orthodontic retention, including any and all necessary fixed and removable appliances and related visits.

Payment Limit means the maximum amount this plan pays for covered services during either a benefit year or a covered person's lifetime, as applicable.

Payment Rate means the percentage rate that this plan pays for covered services.

Posterior Teeth means the bicuspid (pre-molars) and molar teeth. These are the teeth located behind the cuspids.

Plan means the Delta Dental group dental plan purchased by the planholder.

Prior Plan means the planholder's plan or policy of group dental insurance which was in force immediately prior to this plan. To be considered a prior plan, this plan must start immediately after the prior coverage ends.

Proof Of Claim means dental radiographs, study models, periodontal charting, written narrative or any documentation that may validate the necessity of the proposed treatment.

We, Us, Our and Delta Dental mean The Delta Dental Insurance Company.

Delta Dental's Responsibilities

The dental expense benefits provided by this plan are funded solely by the employer. The benefits are not guaranteed by a policy of insurance issued by Delta Dental. Delta Dental does supply administrative services, such as claims services, including the payment of claims, preparation of employee benefit books, and changes to such benefit books.

Delta Dental is located at 5600 Blazer Parkway, Suite 150, Dublin, OH 43017.

Termination of This Group Plan

Your employer may terminate this group plan at any time.

When this plan ends, you may be eligible to continue your coverage. Your rights, if any, upon termination of the plan are explained in this benefit book.

Addendum A: Delta Exclusions & Limitations

VIII. Exclusions and Limitations

Exclusions

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for these services will be your responsibility:

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Services received from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Medicaid or Medicare.
2. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations, with the exception of congenitally missing teeth.
3. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
4. Services completed or appliances completed before a person became eligible under This Plan. This exclusion does not apply to orthodontic treatment in progress (if a Covered Service).
5. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions, and relative analgesia.
6. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
7. Charges for hospitalization, laboratory tests, histopathological examinations and miscellaneous tests.
8. Charges for failure to keep a scheduled visit with the Dentist.
9. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
10. Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
11. Services or supplies, as determined by Delta Dental, which are specialized procedures or techniques.
12. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the supervision of a licensed Dentist. Treatment rendered by any other licensed dental professional may be covered only as solely determined by the Contractor and/or Delta Dental.
13. Services or supplies for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
14. Services or supplies received due to an act of war, declared or undeclared, or terrorism.
15. Services or supplies covered under a hospital, surgical/medical, or prescription drug program.
16. Services or supplies that are not within the categories of Benefits selected by the Contractor and that are not covered under the terms of this Certificate.
17. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
18. Caries preventive medicament.
19. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
20. Space maintainers for maintaining space due to premature loss of anterior primary teeth.
21. Lost, missing, or stolen appliances of any type, or replacement or repair of orthodontic appliances or space maintainers.
22. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
23. Veneers.
24. Prefabricated crowns used as final restorations on permanent teeth.
25. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If Orthodontic Services are Covered Services, this exclusion will not apply to Orthodontic Services as limited by the terms and conditions of the Contract between Delta Dental and the Contractor.
26. Implant/abutment supported interim fixed denture for edentulous arch.
27. Soft occlusal guard appliances.
28. Paste-type root canal fillings on permanent teeth.
29. Replacement, repair, relines, or adjustments of occlusal guards.
30. Chemical curettage.

31. Services associated with overdentures.
32. Metal bases on removable prostheses.
33. The replacement of teeth beyond the normal complement of teeth.
34. Personalization or characterization of any service or appliance.
35. Temporary crowns used for temporization during crown or bridge fabrication.
36. Posterior bridges in conjunction with partial dentures in the same arch, sharing at least one posterior edentulous space in common.
37. Precision abutments, attachments and stress breakers.
38. Biologic materials to aid in soft and osseous tissue regeneration when submitted on the same day as tooth extraction, periradicular surgery, soft tissue grafting, guided tissue regeneration, implants, ridge augmentation, ridge preservation/extraction sites, periradicular surgery, apicoectomy sites, hemisections, and periodontal or implant bone grafting.
39. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
40. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint.
41. Diagnostic photographs and cephalometric films, unless done for orthodontics and orthodontics are a Covered Service.
42. 3-D scans and images.
43. Myofunctional therapy.
44. Mounted case analyses.
45. Molecular, antigen or antibody testing for a public health related pathogen.
46. Vaccinations.
47. Bone replacement grafts when performed in conjunction with a hemisection.
48. Fabrication, adjustment, reline, or repair of sleep apnea appliances.
49. Removal of non-resorbable barrier.
50. Intraoral tomosynthesis images.
51. Any and all taxes applicable to the services.
52. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Delta Dental will make no payment for the following services or supplies. Participating Dentists may not charge Members for these services or supplies. All charges from Non-Participating Dentists for the following services or supplies are your responsibility:

1. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
2. The completion of forms or submission of Claims.
3. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.
4. Caries risk assessment performed on a Member age two or under.
5. Local anesthesia.
6. Acid etching, cement bases, cavity liners, and bases or temporary fillings.
7. Infection control.
8. Temporary, interim, or provisional crowns.
9. Gingivectomy as an aid to the placement of a restoration.
10. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
11. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
12. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the condition.
13. Post-operative X-rays, when done following any completed service or procedure.
14. Periodontal charting.
15. Pins and preformed posts, when done with core buildups.
16. Any substructure when done for inlays, onlays, and veneers.
17. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy

or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.

18. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
19. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
20. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
21. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.
22. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
23. Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within 30 days of three or four quadrants of scaling and root planing or other periodontal treatment.
24. Full mouth debridement when done within 30 days of scaling and root planing.
25. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces without flap entry and closure, when performed within 12 months of implant restorations, provisional implant crowns and implant or abutment supported interim dentures.
26. Scaling and debridement in the presence of inflammation or mucositis of a single implant, when done on the same day as a prophylaxis, scaling in the presence of gingival inflammation, periodontal maintenance, full mouth debridement, periodontal scaling and root planing, periodontal surgery or debridement of a peri-implant defect.
27. Full mouth debridement, when done on the same day as a comprehensive periodontal evaluation.
28. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as a sealant, sealant repair, preventive resin restoration or interim caries arresting medicament performed on the same tooth.
29. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
30. Reline, rebase, or any adjustment or repair within six months of the delivery of a denture.
31. Reline or any adjustment or repair to a sleep apnea appliance within six months of the delivery.
32. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
33. Adjustments, temporary relines, or tissue conditioning within three months of delivery of an immediate denture.
34. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period of time of performing panoramic and/or full mouth X-rays, as determined solely by Delta Dental.
35. Charges or fees for overhead, internet/video connections, software, hardware or other equipment necessary to deliver services, including but not limited to teledentistry services.
36. Capture only images which are not associated with any interpretation or reporting.
37. Frenulectomy when performed on the same day as any other surgical procedure(s) in the same surgical area by the same dentist or dental office.
38. Surgical removal of implant body when performed within three months of an implant/mini-implant on the same tooth by the same dentist or dental office.
39. Non-surgical implant removal when performed within six months of an implant/mini-implant on the same tooth by the same dentist or dental office.
40. Scaling and root planing when performed on the same day as surgical root repair or exposures.
41. Surgical repair or exposure of root when performed on the same day as endodontic or periodontal surgical procedures.
42. Intraorifice barriers.
43. Removal of non-resorbable barrier when performed by the same dentist who placed the barrier.
44. Excision of benign or malignant lesions when performed in the same area and on the same day as another surgical procedure by the same dentist or dental office.
45. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Limitations

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the actual date (i.e., to

the day) of the applicable prior dates of services in our records with any Delta Dental Member Plan or, at the request of your Contractor, any dental plan:

1. Bitewing X-rays are payable once per calendar year, unless a full mouth X-ray which include bitewings has been paid in that same year.
2. Panoramic or full mouth X-rays (which may include bitewing X-rays) are payable once in any five-year period.
3. Any combination of teeth cleanings (prophylaxes (general or periodontal cleanings), full mouth debridement, scaling in the presence of inflammation, and periodontal maintenance procedures) are payable twice per calendar year. Full mouth debridement is payable once in a lifetime.
4. Oral examinations and evaluations (not including limited problem focused evaluations or patient screenings) are only payable twice per calendar year, regardless of the Dentist's specialty.
5. Patient screening is payable once per calendar year.
6. Preventive fluoride treatments are payable twice per calendar year for people age 18 and under.
7. Bilateral space maintainers are payable once per arch in a lifetime for people age 13 and under.
8. Unilateral space maintainers are payable once per quadrant in a lifetime for people age 13 and under.
9. A distal shoe space maintainer is payable for first permanent molars once per quadrant for people age eight and under.
10. Cast restorations (including jackets, crowns and onlays) and associated procedures (such as core buildups and post substructures) are payable once in any five-year period per tooth. Subsequent minor restorations on the same tooth are also subject to this five-year limitation.
11. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture (lost or mobile tooth structure).
12. Individual crowns over implants are payable at the prosthodontic benefit level once in a five-year period.
13. Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people age 11 and under.
14. Hard full or partial arch occlusal guards are payable once in any five-year period.
15. An interim partial denture is payable only for the replacement of permanent anterior teeth for people age 16 and under or during the healing period for people age 17 and over.
16. Biologic materials to aid in soft and osseous tissue regeneration are payable once per natural tooth in a 36-month period.
17. Prosthodontic Services limitations:
    a. One complete upper and one complete lower denture, and any implant used to support a denture, are payable once in any five-year period.
    b. A removable partial denture, endosteal implant (other than to support a denture), or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
    c. A removable unilateral partial denture is payable once per quadrant in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
    d. Fixed bridges and removable partial dentures are not payable for people age 15 and under.
    e. Rebase hybrid prostheses are payable once in any five-year period per appliance.
    f. A reline or the complete replacement of denture base material is payable once in any three-year period per appliance.
    g. Implant removal is payable once per tooth or area in a five-year period.
    h. Implant maintenance is payable once per any 12-month period.
    i. Removal of a broken implant retaining screw is payable once in a five-year period.
18. Orthodontic Services limitations, if covered under your Plan pursuant to your Summary of Dental Plan Benefits:
    a. Orthodontic Services are payable for Members pursuant to the age limits specified in your Summary of Dental Plan Benefits.
    b. If the treatment plan terminates before completion for any reason, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
    c. Upon written notification to Delta Dental and to the patient, a Dentist may terminate treatment for lack of patient interest and cooperation. In those cases, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.

19. Delta Dental's obligation for payment of Benefits ends on the last day of coverage. However, Delta Dental will make payment for Covered Services provided on or before the last day of coverage, as long as Delta Dental receives a Claim for those services within one year of the date of service.
20. When services in progress are interrupted, Delta Dental will not issue payment for any incomplete services; however, Delta Dental will calculate the Maximum Approved Fee that the dentist may charge you for such incomplete services, and those charges will be your responsibility. In the event the interrupted services are completed later by a Dentist, Delta Dental will review the Claim to determine the amount of payment, if any, to the Dentist in accordance with Delta Dental's policies at the time services are completed.
21. Care terminated due to the death of a Member will be paid to the limit of Delta Dental's liability for the services completed or in progress.
22. Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.
    Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment.
    a. Resin, porcelain fused to metal, and porcelain crowns (including implant crowns), bridge retainers, or pontics on posterior teeth – Delta Dental will pay only the amount that it would pay for a full metal crown.
    b. Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
    c. Resin, or porcelain/ceramic onlays on posterior teeth – Delta Dental will pay only the amount that it would pay for a metallic onlay.
    d. Inlays, regardless of the material used – Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.
    e. All-porcelain/ceramic bridges – Delta Dental will pay only the amount that it would pay for a conventional fixed bridge.
    f. Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
    g. Gold foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.
    h. Posterior stainless steel crowns with esthetic facings, veneers or coatings – Delta Dental will pay only the amount that it would pay for a conventional stainless steel crown.
23. Maximum Payment: All Benefits available under This Plan are subject to the Maximum Payment limitations set forth in your Summary of Dental Plan Benefits.
24. If a Deductible amount is stated in the Summary of Dental Plan Benefits, Delta Dental will not pay for any services or supplies, in whole or in part, to which the Deductible applies until the Deductible amount is met.
25. Caries risk assessments are payable once in any 12- month period for Members age 3-18.
26. Assessments of salivary flow by measurement are payable once in any 36-month period.
27. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period.
28. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restorations involving the occlusal surface.
29. Interim caries arresting medicament is payable twice per tooth per Benefit Year and is limited to five applications per day.
30. Sealants are covered once per tooth per lifetime on first permanent molars for Members age 9 and under.
31. Sealants are covered once per tooth per lifetime on second permanent molars for Members age 14 and under.
32. One cone beam CT is allowed within a 12-month period except when performed for TMD treatment.
33. Restorations performed within two months of caries arresting medicament.
34. Processing policies may otherwise limit payment by Delta Dental for services or supplies.

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. However, Participating Dentists may not charge Members for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the actual date (i.e., to the day) of the applicable prior dates of services in our records with any Delta Dental Member Plan or, at the request of your Contractor, any dental plan.

1. Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.
2. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
3. Recementation of a crown, onlay, inlay, veneer, space maintainer, or bridge within six months of the seating date.
4. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.
5. Root planing is payable once in any two-year period.
6. Periodontal surgery is payable once in any three- year period.
7. A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
8. Tissue conditioning is payable twice per arch in any three-year period.
9. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
10. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
11. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period when performed by the same office.
12. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restorations involving the occlusal surface when performed by the same office.
13. A sealant, sealant repair or preventive resin restoration is not payable when performed within 24 months of a sealant, sealant repair or preventive resin restoration performed on the same tooth.
14. One caries risk assessment is allowed on the same date of service.
15. One caries risk assessment is allowed within a 12- month period when done by the same dentist/dental office.
16. One assessment of salivary flow by measurement is allowed within a 12-month period when done by the same dentist/dental office.
17. Processing policies may otherwise limit payment by Delta Dental for services or supplies.

Forms

The following pages contain frequently used forms for your convenience!

Forms not contained in this section can be found at:
www.deltadentaloh.com

Please photocopy all forms, keeping the originals in your binder, so that you can continue to use in future years.

DELTA DENTAL

DENTAL CLAIM STATEMENT

TYPE OF TRANSACTION

1. ☐ STATEMENT OF ACTUAL SERVICES ☐ PRE-TREATMENT ESTIMATE

MAIL CLAIMS TO

DELTA DENTAL
PO BOX 9085
FARMINGTON HILLS, MI 48333-9085

OTHER COVERAGE

2. OTHER DENTAL OR MEDICAL COVERAGE?
☐ NO IF NO, SKIP TO #11 ☐ YES

3. AMOUNT OF PRIMARY PAYMENT
$

4. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP

5. DATE OF BIRTH

6. GENDER
☐ M ☐ F

7. SUBSCRIBER/POLICYHOLDER ID (SSN OR ID#)

8. PLAN/GROUP NUMBER

9. RELATIONSHIP TO PATIENT
☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

10. OTHER INSURANCE COMPANY/DENTAL BENEFIT PLAN NAME

SUBSCRIBER INFORMATION

11. SUBSCRIBER NAME (LAST, FIRST, MIDDLE INITIAL), ADDRESS, CITY, STATE, ZIP

12. DATE OF BIRTH

13. GENDER
M F

14. SUBSCRIBER ID (SSN OR ID#)

15. PLAN/GROUP NUMBER

16. EMPLOYER NAME

PATIENT INFORMATION

17. PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)

18. RELATIONSHIP TO SUBSCRIBER
☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

19. DATE OF BIRTH

20. GENDER
☐ M ☐ F

21. IF PATIENT IS A DEPENDENT OVER AGE 19, PLEASE INDICATE STATUS
☐ FULL TIME STUDENT ☐ TOTALLY & PERM DISABLED ☐ IRS DEPENDENT ☐ SPONSORED DEPENDENT

DENTAL SERVICES

	22. DATE OF SERVICE MM/DD/CCYY	23. AREA OF ORAL CAVITY	24. TOOTH NO. OR LETTER	25. TOOTH SURFACE	26. CURRENT CDT PROCEDURE CODE	27. DESCRIPTION	28. FEE
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

MISSING TEETH	PERMANENT															PRIMARY										29. TOTAL FEE CHARGED
30. PLACE X ON MISSING TOOTH NUMBERS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	

REMARKS

31.

AUTHORIZATIONS

32. AS PERMITTED UNDER LAW, I CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR PURPOSES OF PAYMENT OF THIS CLAIM.

PATIENT/GUARDIAN SIGNATURE DATE

33. IF PERMITTED, I HEREBY ASSIGN AND AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME TO THE TREATING DENTIST.

SUBSCRIBER SIGNATURE DATE

ADDITIONAL CLAIM INFORMATION

34. PLACE OF TREATMENT
☐ DENTAL OFFICE ☐ HOSPITAL ☐ ECF ☐ OTHER

35. NUMBER OF ENCLOSURES
RADIOGRAPHS _____ DIGITAL IMAGES _____ MODELS _____

36. IS TREATMENT RELATED TO ORTHODONTICS?
☐ NO ☐ YES DATE APPLIANCE PLACED _____ MONTHS OF TREATMENT REMAINING _____

37. TREATMENT RESULTING FROM:
☐ OCCUPATIONAL ILLNESS/INJURY ☐ AUTO ACCIDENT ☐ OTHER ACCIDENT

38. REPLACEMENT OF PROSTHESIS?
☐ YES DATE PRIOR PLACEMENT _____ ☐ NO

BILLING DENTIST/DENTAL ENTITY (#40 - #43: USE FOR GROUP PRACTICE/MULTIPLE LOCATIONS)

39. NAME, ADDRESS, CITY, STATE, ZIP

40. NPI

41. LICENSE NUMBER

42. TIN

43. PHONE NUMBER
( )

TREATING DENTIST AND LOCATION

44. I HEREBY CERTIFY THAT I HAVE PERFORMED THE PROCEDURES AS INDICATED BY DATE AND/OR WISH TO OBTAIN A PRE-TREATMENT ESTIMATE FOR THE PROCEDURES WHICH ARE NOT DATED. THE PROCEDURES WERE/ARE NECESSARY IN MY PROFESSIONAL JUDGMENT.

X _____
SIGNED (TREATING DENTIST) DATE

45. NPI

46. LICENSE NUMBER

47. TIN

48. ADDRESS, CITY, STATE, ZIP (IF DIFFERENT THAN #39)

49. PHONE NUMBER
( )

50. ADDITIONAL DENTIST ID

51. SPECIALTY CODE

For the fastest processing, submit claims electronically through our **Dental Office Toolkit**!
It's free, easy, and available to all dentists. Check our Web sites for more information.

INSTRUCTIONS FOR COMPLETING THE SCANNABLE CLAIM

Optical scanning of paper claims can decrease total processing time by two to three days over those claims that must be manually keyed.

FOR CLAIMS TO BE OPTICALLY SCANNED:

- **Clearly type, hand write, or use a computer printer to enter information.**
- **Use all upper-case (capital) letters, if possible.**
- **Write, type, or print in black or blue pen/ink—do not use red or green ink or any color of highlighter.**
- **Keep information within the correct field.**
- **Make sure the typewriter or printer ribbon is dark and the print can be easily read.**
- **Cover mistakes with line tape and print or type over—do not use liquid correction fluid.**
- **Use paperclips to hold attachments whenever possible. Place stapled items only at the lower edge of the form.**

FIELDS 2 THROUGH 21—PATIENT/SUBSCRIBER INFORMATION:

- **If the patient has dental coverage through another carrier(s), complete the other coverage section, fields #2 through #10 (if not, leave them blank). Fill in the amount of primary payment (#3) ONLY when the claim is billing for secondary benefits. Do not enter $0 unless the primary carrier's determination of payment was $0. DO NOT ATTACH the primary carrier's voucher.**
- **Enter the patient's and subscriber's names in this order: last, first, middle initial. Do not use titles, such as Mrs. or Dr.**

FIELDS 22 THROUGH 31—DENTAL SERVICES AND REMARKS:

- **Hand or machine print**
- **When machine printing, double-space lines and enter information in between the correct column guidelines. Dates may be entered without separators (/).**
- **Use current ADA CDT procedure codes.**
- **Use the REMARKS section (#31) for information necessary to process the claim, such as non-standard COB, miscellaneous codes, codes for which Delta Dental requires a report, or supporting documentation that will assist in accurately processing the claim. Keep documentation within the designated field. Unnecessary documentation delays processing.**

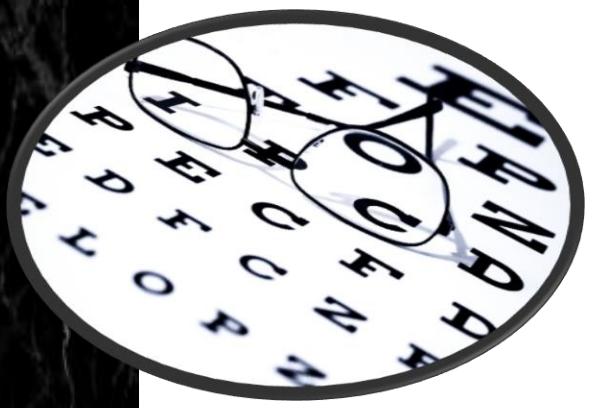
FIELDS 39 THROUGH 51—BILLING DENTIST AND TREATING DENTIST:

- **The dentist's name or business name entered in field #39 must match the name on file with Delta Dental.**
- **Enter the license number and Tax Identification number (TIN) of the treating dentist in fields #46 and #47. Enter his/her National Provider Identifier (NPI) in field #45.**
- **Fields #40 through #43 are optional for group practices or practices with more than one location who have more than one NPI, license number and/or TIN.**

NOTICE TO ALL PARTIES COMPLETING THIS FORM:

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

MAIL CLAIMS TO:	MAIL INQUIRIES TO:	TELEPHONE FOR ELIGIBILITY AND BENEFIT INFO
Delta Dental P.O. Box 9085 Farmington Hills, MI 48333-9085	Delta Dental Attn: Customer Service P.O. Box 9089 Farmington Hills, MI 48333-9089	800-524-0149



Vision Insurance

- VSP Website
- Coverage At A Glance
- Forms

Wayne County Commissioners

VSP Website

vsp vision care

www.VSP.com

VSP vision care is your vision provider. Wayne County's vision plan allows you to improve your health through a routine eye exam, while saving you money on your eye care purchases. **To begin using the VSP member website, you will need to create an online account. It's quick and easy!** Once you have an account, you'll be able to:

- ☐ Find a Doctor
- ☐ Benefit information including plan members, claim status, and benefit history
- ☐ Special Offers
- ☐ Eyewear and Wellness tips
- ☐ Shop contacts, eyewear, etc.

Using Your VSP Plan Is Easy!

1. ***Locate An In-Network Provider***
   From your VSP member website, choose Find a Doctor to find nearby VSP in-network doctors and VSP Premier Edge locations. You'll have access to preferred private practice, retail, and online in-network choices.

2. ***Schedule An Appointment***
   Mention that you are a VSP member when you schedule and when you arrive for your appointment. They may locate you and verify your plan using your social security number.

3. ***The Provider's Staff Will Do The Rest!***
   You will only pay for applicable copays, as well as any amounts over the allowances offered by your plan. Your provider will supply you with these amounts.

Using A Non-Network Provider?

The most up to date information regarding VSP's policy to submit an Out-of-Network Claim can be found online at https://www.vsp.com/claims/submit-oon-claim. Click "Start a New Claim" button at the bottom of the webpage.

If you've received eye care services (exam, contacts, or glasses) from an out-of-network provider, you may be able to submit a claim to request partial reimbursement. Your benefits will always go further when you select an in-network doctor. However, if you'd like to submit an out-of-network claim, be sure to answer all the questions and attach any itemized receipts related to your claim.

To submit a claim request, you'll need the following:

1. Please attach a readable copy of itemized receipts, invoices, or statements that contain all of the following information:
   - Name of provider (ex. doctor, office, website, or retailer)
   - Name of patient
   - Date service was received (ex. date of exam or date glasses were ordered)
   - Complete description and amount paid for each service

2. After completing the claim form, you may upload your receipt(s) OR print and mail copies of your claim form and receipt(s) to:
   Vision Service Plan
   Attention: Claims Services
   P.O. Box 495918
   Cincinnati, OH 45249-5918

Tip: If you are submitting for materials (contacts, lens, or frame) only, you will not need to input your doctor's information. You will need the information of the location from which your materials were purchased. Missing information and receipts can delay your reimbursement. Fill out the form completely and if you're filling it out online, snap a legible picture of your receipt and attach it to your claim to get your reimbursement faster. If you have receipts for other services you must complete a separate claim form.

You typically have 12 months from the date of service to submit for reimbursement. Failure to submit your out-of-network claim within 12 months of the date of service may cause your claim request to be denied. Please allow up to 20 business days (plus mailing time to and from VSP) for us to process your reimbursement.

Questions? View Claims & Reimbursement FAQs online at: https://www.vsp.com/faqs/claims-reimbursement.

Once you've completed the out-of-network claim form, you can check your claim status on the Benefits History page on your account dashboard.

Please Remember:

This is for a non-network provider only;
You will not file claims if you use an in-network provider.

Coverage At A Glance

Vision Plan Design

TYPE OF SERVICE	In-Network Member Cost	Out-of-Network Reimbursement
Exam with Dilation as Necessary *Every calendar year*	$15 Copay	$45
Retinal Imaging Benefit *Every calendar year*	**Up to $39**	**n/a**
Essential Medical Eye Care *Available as needed*	**$20 per exam**	**n/a**
Contact Lens Fit and Follow-Up *Available once a comprehensive eye exam has been completed*	Up To $60	n/a
Frames *Every other calendar year* *Any available frame at provider location* *Frame Allowance • $150 Featured Frame Brands allowance • $130 frame allowance • $130 Walmart/Sam's Club frame allowance • $70 Costco frame allowance	$0 Copay; $70-150Allowance;* 20% Savings on Amount Over Allowance	$70
Standard Plastic Lenses:		
Single Vision	$15 Copay	$30
Bifocal	$15 Copay	$50
Trifocal	$15 Copay	$65
Lenticular	$15 Copay	$100
Lens Options *Every year allowance; choose between this and contact lenses* *Paid by the member and added to the base price of the lens*		
Tint (Solid and Gradient)	$15	n/a
UV Treatment	$15	n/a
Standard Plastic Scratch-Resistance	$0	n/a
Standard Polycarbonate	$0	n/a
Standard Anti-Reflective Coating	$45	n/a
Standard Progressive **	$0	n/a
Premium Progressive**	$95 - $105	n/a
Custom Progressive	$150 - $175	
Polarized	20% Off Retail	n/a
Other Add-Ons and Services	20% Off Retail	n/a

TYPE OF SERVICE	In-Network Member Cost	Out-of-Network Reimbursement
Contact Lenses *Every year allowance; choose between this and glasses' lens* *Allowance covers materials only;* *Allowance must be used all at once, one submission per year* Conventional (Gas Permeable)	$0 Copay; $130 Allowance	$105
Disposables (Soft)	$0 Copay; $130 Allowance;	$105
Medically Necessary	$0 Copay; Paid In Full	$210
VSP Lightcare *Every other calendar year, instead of prescription glasses or contacts* Ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses.	$15 copay $130 allowance	n/a
Laser Vision Correction *Discounts available at contracted facilities*	15% Off Retail or 5% Off Promotional Price	n/a
Glasses and Sunglasses • *Extra $20 to spend on Featured Frame Brands. Go to vsp.com/offers for details.* • *20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam*		n/a
Digital Hearing Aids • Save up to 60% on digital hearing aids with TruHearing. Visit vsp.com/offers/special-offers/hearing-aids for details. (Check your medical insurance benefits first.)		n/a
Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at vsp.com/offers. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		n/a

***Standard/Premium progressive lenses which are out of network are not covered; fund as a bifocal lens*

Essential Medical Eye Care

Additional visits are available as needed.

- ☐ Retinal imaging for members with diabetes covered-in-full
- ☐ Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more.
- ☐ Coordination with your medical coverage may apply. Ask your VSP network doctor for details.

Limitations

- ☐ Benefits are not provided for services or materials arising from: Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; medical and/or surgical treatment of the eye, eyes or supporting structures; any eye or vision examination or any corrective eyewear required by a policyholder as a condition of employment; safety eyewear; services provided as a result of any Workers' Compensation law or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (non-prescription) lenses and/or contact lenses; non-prescription sunglasses; two pair of glasses in lieu of bifocals; services or materials provided by any other group benefit plan providing vision care; certain brand name vision materials in which the manufacturer imposes a no-discount policy; or services rendered after the date an insured person ceases to be covered under the policy, except when Vision Materials ordered before coverage ended are delivered and the services rendered to the insured person are within 31 days from the date of such order.
- ☐ Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available.
- ☐ Benefits may not be combined with any discount, promotional offering or other group benefit plans. Standard/Premium Progressive Lens not covered – fund as a Bifocal Lens. Standard Progressive Lens covered – fund Premium Progressive as a Standard.

Updated 1/1/2024

Additional Services and Savings

VSP offers additional services to employees. While these may include medical, prescription, and/or dental, it is always best to refer to the Wayne County Health Plan first.

If you have any questions, please call Barb Winey, HR Director, at 330-287-5409.

Enjoy Savings Beyond Your Vision Benefits!

VSP exclusive member extras

Take advantage of Exclusive Member Extras for you and the whole family! Get access to more than $3,000 in savings from VSP® and other popular brands. Offers shown below are available at all VSP network doctor locations or participating partner locations.

Click on the offers below to learn how to save on everyday products and services **that go beyond vision care** and help make your life healthier and easier.

Glasses and Sunglasses

Extra **$20** to Spend

Get an **Extra $20** to spend on Featured Frame Brands.[1,2]

Extra **$40** to Spend

Get an **Extra $40** to spend on select Featured Frame Brands.[1,2]

Up to **40% Off** Lens Enhancements

Save up to 40% off popular lens enhancements.[2,3]

eyeconic
a vsp vision company

Shop and save online for glasses, sunglasses, and contacts with your VSP benefits.

enchroma.

Get up to 20% off popular EnChroma collections.

HOYA

Get 6-month satisfaction guaranteed protection on HOYA lenses.

Save 20% on additional pairs of Nike glasses and sunglasses.

sunsync

Save up to 40% on SunSync® Light-Reactive Lenses.[2,3]

techshield

Save up to 40% on all TechShield® Anti-Reflective Coatings.[2,3]

unity

Try Unity® lenses worry-free for six months with The Unity Promise.

Try ZEISS Lenses risk-free for six months.

Maximize your savings with VSP Premier Edge™ Offers only available at Premier Edge locations.

BAUSCH + LOMB

Save up to $310 on an annual supply of contact lenses.

BAUSCH + LOMB Biotrue ONEday lenses

Get a free 30-day supply of Biotrue ONEday contact lenses and an exclusive up to $210 rebate.

HOYA

Get 12-month satisfaction guaranteed protection on HOYA lenses.

Premier Edge Promise

Get a worry-free eyewear guarantee with triple protection.[4]

unity

Try Unity lenses worry-free with The Unity Promise for 12 months.

Try ZEISS Lenses risk-free for 12 months.

Improve Your Health and Increase Your Savings

vsp exclusive member extras

As a member, you can save on everyday products and services that fit your needs beyond vision care—like discounts on fitness, nutrition, prescription drugs, and access to diabetes resources.

Contacts

BAUSCH + LOMB
See better. Live better.

Save up to $300 on an annual supply of contact lenses.

Health and Wellness

Diabetes Management Support

Save on testing supplies and find resources to help prevent or manage Diabetes.

optomap

Get not-to-exceed $39 special pricing on optomap images.[3]

LASIK*

LasikPlus

Save up to $1,100 off LASIK.

The LASIK Vision Institute

Save up to $1,100 off LASIK.

NVISION EYE CENTERS

Save up to $1,200 off all custom LASIK and PRK.

TLC Laser Eye Centers

Save up to $1,100 off LASIK.

Hearing Health

TruHearing

Save up to 60% on prescription and over-the-counter hearing aids, get deals on batteries, and access a free online hearing screening.[4]

Leisure and Lifestyle

vsp simple values

Access a variety of savings on fitness, prescription drugs, entertainment, travel, cash rewards, and more.[7]

Home and Financial Well-Being

CareCredit

Get instant, in-office promotional financing offers for eye care and eyewear.

everplans

Organize, securely store, and assign access to important documents like wills, passwords, and more. All for just $27 a year.

smartcredit

Get smart about your credit, money, and privacy with SmartCredit, helping you meet your financial goals for just $8.95 a month.

See how your savings can add up at vsp.com/offers.

Offers subject to change without notice. Some members may not be eligible for all offers. Members who participate in a Medicaid/state-funded plan are not eligible for the above offer. Visit **vsp.com/offers** for terms and conditions on specific offers.

1. Brands and promotions are subject to change. 2. Available to VSP members with applicable plan benefits. Check your benefits to see if this offer applies. 3. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. 4. Restrictions may apply; visit **vsp.com/offers/premier-edge-offers/glasses-and-sunglasses/Premier-Edge-Promise** for terms and conditions. 5. Not all locations are on the VSP Laser VisionCare Network. Please call VSP Member Services at **800.877.7195** to confirm the location you're interested in visiting is in-network. 6. VSP is providing information to its members but does not offer or provide any discount hearing program. VSP makes no endorsement, representations, or warranties regarding any products or services offered by TruHearing, a third-party vendor. TruHearing is not insurance and not subject to state insurance regulations. For additional information please visit **vsp.com/offers/special-offers/hearing-aids/truhearing**. For questions, contact TruHearing directly. Not available directly from VSP in the states of Washington and California. 7. Some members may not be eligible for this program; visit **vsp.com/simplevalues** for terms and conditions.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.

Save Now on Health, Wellness, Lifestyle Products, and Services

Enjoy VSP® Simple Values—an exclusive member extra that gives you and your family access to valuable discounts and everyday savings.

vsp simple values

Exclusive Member Extras

Health and Wellness:

- Fitness—discounts on nationwide gym memberships, virtual coaching and workouts, and personal fitness equipment
- Nutrition—access to weight loss programs and nutrition and planning services
- Prescription drugs—**save up to 85%**
  Accepted at CVS pharmacy, COSTCO Wholesale, Walmart, Target, Walgreens, and others
- Doctor visits—**save up to 25%**
  Includes 24/7 doctor access via phone or video visit
- Dental—**save up to 50%**
- Lab work, MRI, and imaging—**save up to 60%**
- Hearing—**save up to 60%**
- Diabetic care services and supplies—**save up to 75%**
- Pet care—access to veterinary experts **24/7**

Family Fun:

- Live entertainment, movie tickets, and theme park passes—**save up to 40%**
- Travel and hotels—**save up to 60%**

Everyday Savings:

- Retail rewards—**cash back**

Find the savings available to you. Visit vsp.com/simplevalues and sign up to download your card today!

TruHearing Hearing Aid Discount Program

vsp exclusive member extras

TruHearing
truhearing.com/vsp

VSP® Vision Care members can save up to 60% on the latest brand-name prescription and over-the-counter hearing aids. Dependents and even extended family members are eligible for exclusive savings too.

Hearing loss is growing in the workplace

Like vision loss, hearing loss can have a huge impact on productivity and overall quality of life. Unfortunately, 38 million Americans need hearing aids, 70% of the people with hearing loss don't treat it, and only 30% seek treatment.[1] And the high cost of hearing aids is a major factor keeping people from addressing their hearing loss.

Ninety-six percent of customers surveyed would recommend TruHearing to their friends and family.[2]

More than just great pricing

TruHearing also provides members with:

- One year of follow-up visits for fittings, adjustments, and cleanings
- A 60-day trial
- Three-year manufacturer warranty for repairs and one-time loss and damage replacement
- 80 free batteries per hearing aid on all non-rechargeable aids

Plus, members get:

- Access to a national network of more than 7,000 hearing healthcare providers
- Straightforward, nationally fixed pricing on a wide selection of the latest brand-name hearing aids
- High-quality, low-cost batteries delivered to your door

Best of all, if your organization already offers a hearing aid allowance, members can combine it with TruHearing prices to reduce their out-of-pocket expense even more!

Here's how it works:

Contact TruHearing.
Members and their family call **877.396.7194** and mention VSP.

Schedule exam.
TruHearing will answer questions and schedule a hearing exam with a local provider.

Attend appointment.
The provider will perform a hearing exam, make a recommendation, order the hearing aids through TruHearing, and fit them for you.

Over-the-counter hearing aids are also available through phone or online orders.[3]

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or call 877.396.7194 with questions.

1. Kochkin S. MarkeTrak VIII: The key influencing factors in hearing aid purchase intent. Hearing Review. 2012; 19(2):12-25. "Quantifying the Obvious: The Impact of Hearing Instruments on Quality of Life." The Hearing Review. Kochkin and Rogin. Jan 2000. 2. Based on a 2018 satisfaction study of VSP members. 3. Over-the-counter hearing aids are different from prescription hearing aids.

Forms

The following pages contain forms that may be useful!

Please photocopy all forms, keeping the original in your binder so you can continue to use them.

VSP Member Reimbursement Form

To request reimbursement, complete this form (in blue or black ink), enclose a legible copy of your itemized receipt(s), and send them to the following address. Be sure to keep a copy for your records.

VSP
PO Box 385018
Birmingham, AL 35238-0518

Ref #

Member Information

Policyholder/Employee ID or Last 4 Digits of SSN

Date of Birth

First Name

Last Name

Address

Apt

City

State

Zip

( ) -

Daytime Phone #

Employer/ Group

Patient Information

First Name

Last Name

Member ☐ Spouse ☐ Child ☐ Domestic Partner ☐

Date of Birth

If the patient is a child over the age of 18:

Is the child a full-time student? Yes ☐ No ☐ Is the child disabled? Yes ☐ No ☐

Claim Information (Dollar amounts must match the attached receipts)

Exam $.

Frame $.

Lens $.

Lens tints or coatings $.

Contacts $.

Total Paid $.
(Do not add tax or shipping)

Lens Type: (Choose One)

Single ☐ Progressive ☐

Bi-focal ☐ Lenticular ☐

Tri-focal ☐ Contacts ☐

Date services were received

Check here if another insurance company has made payment to you, another insurer or the doctor's office. ☐

If so, attach a copy of the statement showing payment.

Provider Information

Store or Dr Name

( ) -

Store or Dr Phone Number

I acknowledge that the above-named provider is not a VSP Preferred Provider and that VSP cannot guarantee eye care and/or eyewear satisfaction. By signing this claim form, I certify that I have read the applicable claim fraud warnings included with this form, and that all the information I have provided above is complete and accurate.

Claimant Signature:_____ Date: ____/____/_____

VSP Vision care for life

FRAUD WARNINGS

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly presents false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oregon: Any person who knowingly presents a materially false statement of claim may be guilty of a criminal offense and may be subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Texas: Any person who knowingly presents a false or fraudulent claim for penalty of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

HIPAA

This section will explain the benefit and features of the Health Insurance Portability & Accountability Act (HIPAA)

Wayne County Commissioners

HIPAA

Health Insurance Portability & Accountability Act (HIPAA) Special Enrollment Rights

If you or your eligible dependent(s) experience a special enrollment event as described below, you or your eligible dependent(s) may be entitled to enroll in the plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the plan, you may request enrollment for you and your eligible dependent(s) under a different option offered by the employer for which you are currently eligible. If you are not already enrolled in the plan, you must request special enrollment for yourself in addition to your eligible dependent(s). In order to elect a special enrollment as outlined below, you and any dependents must be eligible for coverage under the Medical plan. You and all of your eligible dependents must be covered under the same option. The special enrollment events include:

- ☐ **Acquiring A New Dependent** – If you acquire a new dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals, if not already enrolled in the plan: employee only; spouse only; employee and spouse; dependent child(ren) only; employee and dependent child(ren); employee, spouse and dependent child(ren). Enrollment of dependent children is limited to the newborn or adopted children or children who became dependent children of the employee due to marriage. Dependent children who were already dependents of the employee but not currently enrolled in the plan are not entitled to special enrollment. Coverage for step-children is limited to step-children subject to a court order requiring coverage and the employee and spouse are also enrolled in the Plan.
- ☐ **Loss of Eligibility for State Medicaid or Children's Health Insurance Program (CHIP)** – If you and / or your dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected dependent(s) who are not already enrolled in the plan. You must request enrollment within 30 days after termination of Medicaid or CHIP coverage and be eligible for coverage.
- ☐ **Loss of Eligibility For Other Coverage (Excluding Continuation Coverage)** – If coverage was declined under the plan due to coverage under another plan, and eligibility for the other

coverage is lost, you and all your eligible dependent(s) may request special enrollment in the plan. This provision applies to loss of eligibility as a result of any of the following:

- divorce;
- cessation of dependent status (such as reaching the limiting age);
- death of the employee;
- involuntary loss of coverage;
- reduction in work hours to below the minimum required for eligibility;
- you or your dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
- the other plan no longer offers any benefits to a class of similarly situation individuals.

☐ **Termination of Employer Contributions (Excluding Continuation Coverage)** – If a current or former employer ceases all contributions towards the employee's or dependent's other coverage, special enrollment may be requested in the plan for you and all of your eligible dependent(s).

☐ **Exhaustion of COBRA or Other Continuation Coverage** – Special enrollment may be requested in the plan for you and all of your eligible dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under the plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: (a) due to failure of the employer or other responsible entity to remit premiums on a timely basis; or (b) when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan. The does not include termination of an employer's limited period of contributions towards COBRA or other continuation coverage as provided under any severance or other agreement.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. Coverage will be effective immediately on the date of the special event. Individuals who enroll in the plan due to a special enrollment event will not be considered late entrants.

HIPAA PRIVACY

The Plan provides each Covered Person with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Covered Person's personal health information. It also describes certain rights the Covered Person has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling 330-287-5409

Definitions:

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information: The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Covered Persons. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Administrator and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Covered Person's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Covered Person's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Covered Person's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May Be Used and Disclosed: In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.
2. For health care operations.
3. For treatment purposes.
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Administrator for Plan Administration Purposes: In order that the Plan Administrator may receive and use PHI for plan administration purposes, the Plan Administrator agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Administrator provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Administrator with respect to such PHI.
3. Establish safeguards for information, including security systems for data processing and storage.
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
6. ***If a Plan engages in underwriting****:* Not use or disclose Genetic Information for underwriting purposes.
7. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Administrator, except pursuant to an authorization which meets the requirements of the Privacy Standards.
8. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Administrator becomes aware.
9. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
10. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
11. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528).
12. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
13. Train Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
14. If feasible, return or destroy all PHI received from the Plan that the Plan Administrator still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for 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 PHI infeasible.
15. Ensure that adequate separation between the Plan and the Plan Administrator, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Administrator, shall be given access to the PHI to be disclosed:
        i. Privacy Officer.
    b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Administrator performs for the Plan.
    c. In the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or noncompliance to the Plan, and will cooperate with the Plan to correct violation or noncompliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written

warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor: The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the Claims history, Claims expenses, or the type of Claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor: Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage: The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Sponsor or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Covered Person's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information.
3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Covered Person has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.
2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

a. A public health authority or other appropriate government authority authorized by law to receive reports of Child abuse or neglect.
b. Report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration (FDA) or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities.
c. Locate and notify persons of recalls of products they may be using.
d. A person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law.

3. Government Authority: The Plan may disclose PHI to a government authority, except for reports of Child abuse or neglect, when required or authorized by law, or with the Covered Person's agreement, if the Plan reasonably believes he or she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Covered Person that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.
4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.
5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Covered Person's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Covered Person of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.
6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Covered Person's PHI in response to a law enforcement official's request if he or she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.
7. Decedents: The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years.
8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.
9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.
10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
11. Military and National Security: The Plan may disclose PHI to military authorities or armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

1. Disclosures to Covered Persons: The Plan is required to disclose to a Covered Person most of the PHI in a Designated Record Set when the Covered Person requests access to this information. The Plan will disclose a Covered Person's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Covered Person's personal representative if it has a reasonable belief that the Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Covered Person's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Covered Person.

2. Disclosures to the Secretary of the U.S. Dept of Health and Human Services: The Plan is required to disclose the Covered Person's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Instances When Required Authorization Is Needed From Covered Persons Before Disclosing PHI

1. ***If the Plan maintains psychotherapy notes***: Most uses and disclosures of psychotherapy notes.
2. Uses and disclosures for marketing.
3. Sale of PHI.
4. Other uses and disclosures not described in this section can only be made with authorization from the Covered Person. The Covered Person may revoke this authorization at any time.

Covered Person's Rights: The Covered Person has the following rights regarding PHI about him/her:

1. Request Restrictions: The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Covered Person has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Covered Person is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. Accounting of Disclosures: The Covered Person has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person of the basis of the

disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Officer.

5. Access: The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Covered Person wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Covered Person and the recipient must be clearly identified. The Plan must respond to the Covered Person's request within thirty (30) days (in some cases, the Plan can request a thirty (30) day extension). In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial.
6. Amendment: The Covered Person has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. Fund raising contacts: The Covered Person has the right to opt out of fundraising contacts.

Questions or Complaints: If the Covered Person wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Covered Person may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Covered Person with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Covered Person for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information:

Privacy Officer Contact Information:
Barb Winey, HR Manager
428 West Liberty Street
Wooster, Ohio 44691
Phone: 330-287-5409
Fax: 330-287-5407
Email: bwiney@wayneohio.org

Additional Contact Information for HIPAA Questions:
Patrick Herron, County Administrator
428 West Liberty Street
Wooster, Ohio 44691
Phone: 330-287-5400
Fax: 330-287-5407
Email: pherron@wayneohio.org

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions: STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions:

- **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents,** as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations: To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI: The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the Covered Person whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than sixty (60) calendar days after discovery of the breach. Breach notification must be provided to the affected individual(s) by:
    a. Written notice by first-class mail to the Covered Person (or next of kin) at the last known address or, if specified by the Covered Person, e-mail.

b. If the Plan has insufficient or out-of-date contact information for the Covered Person, the Covered Person must be notified by a "substitute form".
c. If an urgent notice is required, the Plan may contact the Covered Person by telephone. The breach notification will have the following content:
    i. Brief description of what happened, including date of breach and date discovered.
    ii. Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number).
    iii. Steps the Covered Person should take to protect from potential harm.
    iv. What the Plan is doing to investigate the breach, mitigate losses and protect against further breaches.

2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than sixty (60) calendar days after the date the breach was discovered.
3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within sixty (60) days after the end of each Calendar Year.
4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach so that the affected Covered Persons may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

COBRA & USERRA

This section will explain the benefit, features and requirements of COBRA and USERRA, should you and/or your dependents lose coverage under the plan.

Wayne County Commissioners

COBRA & USERRA

COBRA & USERRA Continuation Rights

What is COBRA Continuation Coverage?

Under federal law, you and/or your dependents must be given the opportunity to continue health coverage when there is a "qualifying event" that would result in loss of coverage under the plan. You and/or your dependents will be permitted to continue to same coverage under which you or your dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your dependents cannot change coverage options until the next open enrollment period. *Please note that COBRA members on the Consumer Driven Health Plan (CDHP) are not eligible for Health Savings Account (HSA) cash contributions, and after January 1, 2023, they will not be eligible to earn HSA Wellness Incentives either.*

How Long is COBRA Continuation Available?

COBRA continuation is available, for you and your dependents, for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the plan:

- ☐ your termination of employment for any reason; or
- ☐ your reduction in work hours.

COBRA continuation coverage is available, for your dependents, for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the plan:

- ☐ your death;
- ☐ your divorce; or
- ☐ for a dependent child, failure to continue to qualify as a dependent under the plan.

Under the Uniformed Services Employment and Reemployment Rights Act **(USERRA)**, COBRA continuation is available, for you and your dependents, for up to 24 months, while on active status in the US Marine Corps, Army, Navy, Air Force, Coast Guard, and/or Public Health Service Commissioned Corps, as well as the reserve components of each of these services, from the date of the following qualifying events if the event would result in a loss of coverage under the plan:

- ☐ your termination of employment due to being called to active service;
- ☐ your reduction in work hours due to being called to active service.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your dependent(s) have elected COBRA continuation coverage, and one or more dependents experience another COBRA qualifying event, the affected dependent(s) may elect to extent their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce; or, for a dependent child, failure to continue to qualify as a dependent under the plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all your dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

1. SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
2. A copy of the written SSA determination must be provided to the plan administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disable, you must notify the plan administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you become enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your dependents will last up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- ☐ the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- ☐ failure to pay the required premium within 45 calendar days after the due date;
- ☐ cancellation of your company's policy with the vendor, as applicable;
- ☐ after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- ☐ after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or
- ☐ any reason the plan would terminate coverage of you or your dependents or beneficiary who is not receiving continuation coverage (e.g., fraud).

Moving Out of Employer's Service Area or Elimination of a Service Area

If you and/or your dependents move out of the employer's service area or the employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available outside of the employer's service area. If the employer offers another benefit option, you may elect COBRA continuation coverage under that option.

Employer's Notification Requirements

Your employer is required to provide you and/or your dependents with the following notices:

- ☐ An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the plan begins (or the plan first becomes subject to COBRA continuation requirements, if later). If you and/or your dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time-frame required for the COBRA continuation coverage election notice as explained below.
- ☐ A COBRA continuation coverage election notice must be provided to your and/or your dependents within the following time-frames:
    a. if the plan provides that COBRA continuation coverage and the period within which an employer must notify the plan administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the plan;
    b. if the plan provides that COBRA continuation coverage and the period within which an employer must notify the plan administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
    c. in the case of a multi-employer plan, no later than 14 days after the end of the period in which employers must provide notice of a qualifying event to the plan administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the plan administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active employee or family member. The premium during the 11-month disability extension may not exceed 150 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active employee or family member. For example:

If the employee alone elects COBRA continuation coverage, the employee will be charged 102 percent (or 150 percent) of the active employee premium. If the spouse or one dependent child alone elects COBRA continuation coverage, they will be charged 102 percent (or 150 percent) of the active employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102 percent (or 150 percent) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make you first payment within that 45 days, you will lose all COBRA continuation rights under that Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the plan may be suspended during this time. Any providers who contact the plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. <u>If you fail to make a payment before the end of the grace period for the coverage period, you will lose all rights to COBRA continuation coverage under the Plan.</u>

You Must Give Notice of Certain Qualifying Events

If you or your dependent(s) experience one of the following qualifying events while enrolled in COBRA, you must notify the plan administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- ☐ Your divorce;
- ☐ Your child ceases to qualify as a dependent under the plan; or
- ☐ The occurrence of a secondary qualifying event as discussed under "Secondary Qualifying Events", on page 1 of this section (this notice must be received prior to the end of the initial 18-or 29-month COBRA period).

(Also refer to the section titled "Disability Extension", on page 2 of this section, for additional notice requirements.)

Notice must be made in writing and must include: the name of the plan, name and address of the employee covered under the plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such dependent under your COBRA continuation coverage. However, only your newborn or adopted dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your dependent spouse and

any dependent children who are not your children (e.g., step-children or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

The only way to receive prescription coverage under COBRA is to elect to receive the Medical Benefit under COBRA.

AD&D / Life Insurance

Eligible employees have an Accidental Death & Dismemberment / Life Insurance Policy available to them at no charge.

It is your responsibility to change your beneficiary if your circumstances change!

Wayne County Commissioners

AD&D/Life Insurance

If you are an eligible full-time employee, you are entitled to an Accidental Death & Dismemberment / Life Insurance Policy at no charge. **You do not need to carry other benefit plans to receive this benefit!** Eligible individuals are full-time employees of the following agencies:

Wayne County
Chester Township
Congress Township
Dalton Village
East Union Township
Franklin Township
Shreve Village
Smithville Village
Wayne Township

KEEP YOUR BENEFICIARIES UPDATED! It is the employee's responsibility to maintain current beneficiary information. If, for any reason, you want to change your beneficiary for life insurance, please update your beneficiaries in Dayforce (County employees) or request and complete a form from your payroll person (Villages and Township employees).

This insurance starts your first day worked and terminates on your last day of employment. Life Insurance information was provided to you at the time of your hire and is available to you anytime online at https://www.wayneohio.org/employee-portal/health-benefits-manual/.

Wayne County cannot offer additional life insurance to what is currently offered.

Additional Services

Transamerica offers additional services to employees. While these may include medical, dental, vision and/or counseling services, it is <u>always</u> best to refer to the Wayne County Health Plan and EAP (Employee Assistance Program) first.

If you have any questions, please call Barb Winey, HR Director, at 330-287-5409.

IDENTITY PROTECTION

provided by assist america®

TRANSAMERICA®

Transamerica policyholders now have access to protection from identity fraud with Identity Theft Protection, an Assist America program that offers robust tools to help prevent theft of your personal data, and restores its integrity if it is used fraudulently.

IDENTITY FRAUD PREVENTION TOOLS

Secure Credit Card & Document Registration

You can store information from credit cards, banks, and important documents in one secure, centralized location. If any of the registered items becomes lost or stolen, retrieving the information is fast and simple, and the resolution process of cancelling and replacing cards and documents is just a simple click away, enabling the fastest possible resolution.

Internet Fraud Monitoring via Card Patrol

Once you register credit/debit card information on our secure site, Identity Protection uses real-time web crawling technology to monitor any sign of the cards in underground chat rooms and websites and blogs where thieves trade and sell stolen data. If we find any serial numbers or personal information on these web portals, we automatically send out an alert to the member, providing enough time to foil a thief's attempt to use the data.

For more information or to register cards, visit https://www.assistamerica.com/Additional-Services/Identity-Protection/Login.aspx/. Use Access Code 18327 to link to our secure provider, Card Patrol.

24/7 ID THEFT RESOLUTION TOOLS

If you become a victim of ID-theft, or even suspect it may have occurred, a single toll-free call is all that is necessary to put our professional fraud support team into action. A dedicated Fair Credit Reporting Act (FCRA)-certified caseworker who will act as a trusted guide through the maze of forms and agencies, will provide you with a customized Identity Fraud Support Service Kit, and help you:

- Regain ownership of your data by contacting the major credit reporting agencies, filing disputes, notifying the U.S. Postal Service, and alert the Social Security Administration and IRS
- Notify your bank and credit card issuers of the fraudelent activity
- Restore peace of mind by acting as partners to bring about speedy problem resolution

If you suspect fraudulent activity in association with your identity, call 1-877-409-9597.

EB3 2474380 S 10/22

ID THEFT PROTECTION SERVICES

Assist America offers prevention and resolution tools to safeguard your data and restore its integrity if it is used fraudulently. These services include:

24/7 Access to Identity Protection Experts

Members have 24/7 direct emergency access to ID Theft Protection experts who can provide guidance in dealing with identity fraud issues.

Credit Card and Document Registration

Register your details using our secure website to store information from credit cards, banks and other important document in a single, centralized and secured location.

Internet Fraud Monitoring

Upon registration, we use a real-time web-crawling technology to monitor any sign of your registered personal data on suspicious sites. Members will receive automatic warning notifications if it is discovered that your data is being used fraudulently.

24/7 Identity Fraud Support

If you are a victim of identity fraud, a dedicated ID Theft Protection expert will guide you in mitigating the consequences of the fraud. Your caseworker will also notify credit and debit card issuers if your credit or debit card(s) is lost or stolen.

To activate these identity protection services, visit:
www.assistamerica.com

CONDITIONS & EXCLUSIONS

Assist America will not provide services in the following instances:

- Travel undertaken specifically for securing medical treatment
- Travel by a member's spouse when it is for the benefit of the spouse's employer
- Injuries resulting from participation in acts of war or insurrection
- Commission of unlawful act(s)
- Incidents involving the use of drugs unless prescribed by a physician
- Transfer of member from one medical facility to another medical facility of similar capabilities and providing the same level of care

Assist America will not evacuate or repatriate a member:

- Without medical authorization
- With mild lesions, simple injuries such as sprains, simple fractures, or mild sickness which can be treated by local doctors and do not prevent the member from continuing his/her trip or returning home
- With a pregnancy over 28 weeks
- With mental or nervous disorders unless hospitalized

Services will not be provided for the following types of travel:

- Trips exceeding 90 days from legal residence without prior notification to Assist America (separate purchase of Expatriate Coverage is available at www.assistamerica.com/expatriate)

While assistance services are available worldwide, transportation response time is directly related to the location/jurisdiction where an event occurs. Assist America is not responsible for failing to provide services or for delays in the delivery of services caused by strikes or conditions beyond its control, including by way of example and not by limitation, weather conditions, availability of airports, flight conditions, availability of hyperbaric chambers, communications systems, or where rendering of service is limited or prohibited by local law or edict.

All consulting physicians and attorneys are independent contractors and not under the control or responsibility of Assist America.

DOWNLOAD THE MOBILE APP

Access a wide range of global emergency assistance services from your phone by downloading the free Assist America Mobile App for iPhone and Android.

The Mobile App's features include:

- **Tap for Help:** One-touch call to our 24/7 Operations Center
- **Voice Over Internet Protocol:** Avoid international phone charges by calling Assist America for free using a Wi-Fi connection
- **Pre-Trip Information:** Access detailed country-specific information to prepare your trip
- **Digital ID Card:** Your Assist America membership card is stored inside the App
- **Travel Alerts:** Receive alerts on urgent global situations that may impact travel
- **Travel Status Indicator:** This feature indicates when you are eligible for services
- **Embassy & U.S. Pharmacy Locator:** Locate the nearest embassy/consulate of 23 countries around the world and the nearest pharmacies in the U.S.
- **Available in 7 Languages:** English, Spanish, Arabic, Mandarin, Thai, Bahasa, and French

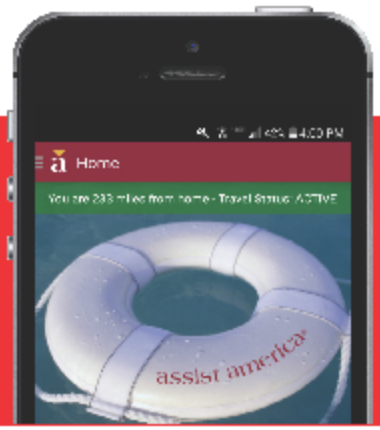
Complete the set-up process by entering your Assist America reference number: **01-AA-TLI-10221**

Download on the App Store

ANDROID APP ON Google play

DISCLAIMER

Assist America is a third-party service provider for Transamerica Life Insurance Company. Assist America and Transamerica are not affiliated in any way.



TRANSAMERICA

assist america

The Assist America Mobile App

Wherever your travels take you, you can conveniently access a wide range of travel emergency assistance services from your phone by downloading the free Assist America Mobile App for iPhone and Android.

AVAILABLE FEATURES

TAP FOR HELP
One-touch call to our 24/7 Emergency Operations Center

VOICE OVER INTERNET PROTOCOL
Avoid international phone charges by calling us for free using a Wi-Fi connection

TRAVEL STATUS INDICATOR
This feature lets you know when you are eligible for services

MOBILE ID CARDS
Your Assist America ID card is conveniently stored within the app

7 LANGUAGES
The app is available in English, Spanish, Arabic, Mandarin, Thai, Bahasa, and French

U.S. PHARMACY LOCATOR
Locate U.S. pharmacies near your current location

EMBASSY LOCATOR
Locate the nearest embassy / consulate of 23 countries

PRE-TRIP INFORMATION
Detailed country-specific information to assist you as you prepare your trip

ASSIST ALERTS
Receive alerts on urgent global situations that may impact travel

DOWNLOAD & SET UP

Scan the code below to download the Mobile App for free

Set up the app by entering your reference number

01-AA-TLI-10221

Enter your home address to enable the Travel Status Indicator feature

ANDROID APP ON Google play

Available on the App Store

For more information on Assist America's services, visit www.assistamerica.com.

Assist America is a third-party service provider for Transamerica Life Insurance Company. Assist America and Transamerica are not affiliated in any way.

EB3 2462469 S 10/22

GLOBAL EMERGENCY SERVICES

TRANSAMERICA

assist america

CONGRATULATIONS!

Transamerica policyholders have access to a Global Emergency Travel Assistance program and Identity Theft Protection services provided by Assist America.

This travel emergency assistance program immediately connects the member to doctors, hospitals, pharmacies and other services if a member experiences a medical or travel emergency while traveling more than 100 miles away from their permanent residence, or in another country for less than 90 days. Calling Assist America will connect members to:

- A state-of-the-art 24/7 Operations Center
- Experienced assistance professionals
- Worldwide emergency response capabilities

KEY SERVICES

MEDICAL EMERGENCY SERVICES

Medical Consultation, Evaluation & Referral
The Assist America Operations Center is staffed by trained, multilingual assistance personnel who can make immediate recommendations for any emergency situation.

Foreign Hospital Admission Assistance
Assist America fosters prompt hospital admission by validating the member's health insurance or by advancing funds as needed to the hospital.

Emergency Medical Evacuation
If appropriate care is not available, Assist America will safely evacuate the member to the nearest facility capable of providing the required care.

Medical Monitoring
Assist America maintains regular communication with patients, their families and attending medical staff, closely monitoring the quality and course of treatment.

Medical Repatriation
When deemed medically necessary, Assist America will provide commercial transportation home or to a specified health facility with a medical or non-medical escort as required.

Prescription Assistance
When a prescription is lost or left behind, Assist America works with the prescribing physician and a local pharmacy to replace the member's medicine.

TRAVEL ASSISTANCE SERVICES

Care of Minor Children
If an injured member has minor children left unattended, Assist America will pay for them to return home to a family member, or will arrange childcare locally or at home.

Compassionate Visit
Assist America will arrange and pay for a loved one to join a member who is traveling alone and is expected to be hospitalized for more than seven days.

Return of Mortal Remains
In the event that a member passes away, Assist America will arrange and pay for the required documents, remains preparation and transport to bring the mortal remains to a funeral home near the member's place of residence.

Other travel assistance services include:

Return of Vehicle

Lost Luggage & Document Assistance

Legal & Interpreter Referrals

Bereavement Reunion

Pet Assistance

Please cut on dotted line to remove card.

GLOBAL EMERGENCY SERVICES

assist america

Reference # 01-AA-TLI-10221

If a member requires assistance when traveling 100 miles from your permanent residence, or in another country, call Assist America's Operations Center at:

+1 609 986 1234 (outside USA)

+1 800 872 1414 (inside USA - Toll Free)

Or email: medservices@assistamerica.com

Please provide the following information when you call:

- Your name, phone number and relationship to the patient
- Patient's name and age
- The Assist America reference number
- Name, location and phone number of hospital or treating doctor if applicable

Attention: This card is not a medical insurance card. All services must be provided by Assist America. No claims for reimbursement will be accepted. The holder of this card is a member of Assist America and is entitled to its medical and personal services.

EB3 2462454 S 10/22

Global Emergency Assistance
Frequently Asked Questions

TRANSAMERICA

You're vacationing in the Dominican Republic. On the last day of your trip, you get hurt. Maybe you slip by the pool, you strain your back while windsurfing or get stung by a sea urchin. You don't speak the local language. What do you do?

As a Transamerica policyholder, you can call Assist America, our global emergency assistance service provider who will provide you with all the help you need while you are away from home.

When Should I Contact Assist America?

Contact Assist America for assistance when experiencing a medical or non-medical emergency while traveling more than 100 miles away from home or in another country, for less than 90 days.

Don't hesitate to contact Assist America prior to your trip or go to the Pre-Trip Information platform on the Assist America website (www.assistamerica.com/Pre-Trip-Information) or the Mobile App if you need more information regarding your destination.

How Do I Contact Assist America?

You can contact Assist America's 24/7 Operations Center via:

- **Assist America Mobile App**: Download the app and use the Tap for Help button to connect with the Operations Center.
- **Phone**: 1-800-872-1414 (Toll Free - within the U.S.) or +1-609-986-1234 (outside the U.S.)
- **Email**: medservices@assistamerica.com
- **Text**: +1 609-334-0807

How Do I Set Up The Mobile App?

The Assist America Mobile App is available for free on the Apple App Store and Google Play. Once you have downloaded the app, enter your name and Assist America reference number to activate all the features.

What Information Will I Need to Provide?

When speaking to a coordinator, you will be asked to provide the following information:

- Your name, phone number, and relationship to the member
- The member's name, age, and home address
- Assist America reference number: **01-AA-TLI-10221**
- Description of the emergency and current location
- Name, location and phone number of the local hospital, if applicable

How Much Does It Cost to Get Assistance From Assist America?

Assist America is included with your Group Term Life insurance at no cost to you, and pays for any services they arrange. This alleviates many of the obstacles and expenses that can be caused by medical emergencies away from home. See the Assist America mobile app for details regarding covered services. All services must be arranged by Assist America. No claims for reimbursement of services will be accepted.

What if I plan on traveling for more than 90 consecutive days?

If you plan on traveling for more than 90 days, you can enroll in the Expatriate/Extended Program on the Assist America website at (www.assistamerica.com/expatriate) to ensure coverage for up to a year. Your Transamerica policy must be in force for this extended period as well.

Will Assist America Cover My Medical Bills?

No, **Assist America is not medical or travel insurance.** Medical services rendered is subject to the limitations and parameters of your health plan.

Provided by

assist america

EB3 2462473 S 10/22

Contact Us... Anytime, Anywhere

No-cost, confidential solutions to life's challenges.

Confidential Emotional Support

Up to 3 sessions per issue, per year

Provides 24/7 professional assistance for life beneficiaries. Includes up to 3 sessions per claim with our on staff attorneys, CPA/CFPs, behavioral health, financial and legal professionals to meet the varying needs of the claimant. 24/7 telephonic access is available through a toll free line for legal, financial and emotional/adjustment counseling. Examples of assistance include:

- Adjusting finances due to change in income
- College planning using life insurance funds
- Emotional/grief counseling and power of attorney questions

Work-Life Solutions

Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care

Legal Guidance

Talk to our attorneys for practical assistance with your most pressing legal issues, including:

- Divorce, adoption, family law, wills, trusts and more

Need representation? Get a free 30-minute consultation and a 25% reduction in fees.

Financial Resources

Our financial experts can assist with a wide range of issues. Talk to us about:

- Retirement planning, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy and more

Online Support

GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions

Free Online Will Preparation

EstateGuidance® lets you quickly and easily create a will online.

- Specify your wishes for your property
- Provide funeral and burial instructions
- Choose a guardian for your children

SKU 1958677

ComPsych®

Your ComPsych® GuidanceResources® program offers someone to talk to and resources to consult whenever and wherever you need them.

Call: 866.569.0326
TTY: 800.697.0353

Your toll-free number gives you direct, 24/7 access to a GuidanceConsultant℠, who will answer your questions and, if needed, refer you to a counselor or other resources.

Online: guidanceresources.com
App: GuidanceNow℠
Web ID: EAP Core

Log on today to connect directly with a GuidanceConsultant℠ about your issue or to consult articles, podcasts, videos and other helpful tools.

24/7 Support, Resources & Information

Contact Your ComPsych® GuidanceResources® Program

Call: 866.569.0326
TTY: 800.697.0353
Online: guidanceresources.com
App: GuidanceNow℠
Web ID: EAP Core

TRANSAMERICA LIFE INSURANCE COMPANY

Cedar Rapids, IA
Contact us at: PO Box 219, Cedar Rapids, IA 52406-0219
Telephone: 1-888-763-7474
E-Mail Address: TEBcustresp@Transamerica.com
Website: www.transamerica.com

TITLE PAGE (CERTIFICATE COVER PAGE)

About Your Insurance – This Certificate explains the benefits provided under the Group Master Policy ("Policy") issued to the Policyholder named on the Benefit Schedule. The benefits and rights of all Covered Persons under the Policy shall not be less than those stated in this Certificate, subject to the Insured's class, salary and annual benefit elections in effect for the Plan Year at time of loss.

The Policy is a legal contract between the Policyholder and the Insurer and may be changed or terminated without the Insured's consent. Premiums are subject to change.

The Insured may inspect a copy of the Policy by contacting the Policyholder at reasonable times during normal business hours.

PLEASE READ YOUR CERTIFICATE CAREFULLY. BENEFITS MAY BE SUBJECT TO CERTAIN REQUIREMENTS, REDUCTIONS, LIMITATIONS AND EXCLUSIONS.

Terms important to understanding this Certificate are defined in the Definitions section or in separate Certificate provisions and are capitalized.

The Insurer certifies that the Insured and covered Dependents are insured for the benefits described in this Certificate, subject to the provisions of the Certificate.

The benefits for Dependents described in this Certificate, if available under the Policy, are applicable only if the employee is insured under this Policy, applies for Dependent insurance, receives our approval of such Dependents, and pays the premium required for each Dependent.

This Certificate replaces any Certificates previously issued under the Policy.

This Certificate is signed for us at our home office to take effect on the same date that insurance becomes effective.

Blake Bostwick
President

Karyn S.W. Polak
Secretary

Group Basic Term Life Insurance Certificate

Annually Renewable Term Life Insurance
Nonparticipating - No Annual Dividends

If you have a complaint, you can contact the Ohio Department of Insurance at: (614) 644-2658

TABLE OF CONTENTS

BENEFIT SCHEDULE (WHO PAYS WHAT)
SUBJECT TO ANNUAL BENEFIT ELECTIONS

Policyholder: **WAYNE COUNTY**
Address: **428 WEST LIBERTY STREET WOOSTER, OH 44691**
Policyholder Phone Number: **330-287-5401**
Policy Number: **BS00084756**

Class 1 **Class Description: All Active Full Time W2 Employees working a minimum of 30 hours per week in the United States. Excluding part time, temporary, and seasonal. Waiting Period: None**

Please refer to your annual benefit elections to determine benefits amounts in effect for the Plan Year.

Plan Year Beginning: **January 1, 2024**

Coverage Limits and Underwriting Requirements:

Employee Basic Term Life Insurance (Non-Contributory)
$20,000
Guaranteed Issue Limit: $20,000

Evidence of Insurability:
- Evidence of Insurability is required for any amounts elected above the Guarantee Issue Limits.
- Late enrollees, who decline to purchase supplemental insurance when initially eligible, may purchase up to 1x salary or one increment of coverage during the renewal open enrollment window. Purchase amount must be below the Guarantee Issue Limit.

Salary means the Insured's annualized regular wages rounded up to the next highest $1,000. Salary does not include overtime or bonuses, cash awards, expense allowances, shift differential, goal sharing, variable pay, stock option earnings, incentive items or other extra pay items. Salary will be recalculated on each Anniversary Date.

Benefit Reduction Schedule - Life Insurance Proceeds automatically reduce to the following percentages on the Policy Anniversary that follows your birthday, as follows:

Birthday	Life Insurance Proceeds Payable
Age 70	45% of pre-age 70 death benefit
Age 75	30% of pre-age 70 death benefit
Age 80	20% of pre-age 70 death benefit

Included Riders:

Accelerated Death Benefit for Terminal Illness Rider

Benefit: The lesser of: (a) 75% of your Proceeds; or (b) $250,000

Accidental Death and Dismemberment Rider

Accidental Death Benefit Amount: 100% of Proceeds
Common Carrier Benefit Amount: 100% of the Accidental Death Benefit
Airbag Benefit Amount: 5% of the Accidental Death Benefit
Seatbelt Benefit Amount: 10% of the Accidental Death Benefit
Transportation of Remains Benefit Amount: 10% of the Accidental Death Benefit not to exceed $5,000

The following benefits are subject to an aggregate Lifetime Benefit Limit of $15,000
Spouse Training Benefit Amount: 3% of the Accidental Death Benefit not to exceed $3,500
Elder Care Benefit Amount: 3% of the Accidental Death Benefit not to exceed $3,500
Child Education Benefit Amount: 3% of the Accidental Death Benefit not to exceed $3,500
Child Care Center Benefit Amount: 3% of the Accidental Death Benefit not to exceed $3,500

Dismemberment Benefits:
Loss of two or more: hand, foot, arm, leg or sight of one eye: 100% of Proceeds
Loss of speech and loss of hearing in both ears: 100% of Proceeds
Quadriplegia: 100% of Proceeds
Paraplegia: 75% of Proceeds
Hemiplegia: 50% of Proceeds
Loss of one: hand, foot, arm, leg or sight of one eye: 50% of Proceeds
Loss of speech or loss of hearing in both ears: 50% of Proceeds
Loss of hearing of one ear: 25% of Proceeds
Loss of thumb and index finger on same hand: 25% of Proceeds

Waiver of Premium Benefit Rider, Applicable Only to the Employee

Waiting Period: 6 months
Rider benefits cease on the Policy Anniversary on or immediately following the Insured's 60th birthday
If Totally Disabled on this date, Rider benefits will end on the Policy Anniversary on or immediately following the insured's 65th birthday

Portability Rider

Continuation for Approved Leave of Absence

Maximum Benefit Period: 6 months

Change of Insurance Carriers:

Maximum Benefit Period 6 months

WHO IS ELIGIBLE FOR COVERAGE

Eligible Person: To become insured under the Policy, an Eligible Person:

1. Must be a member of an eligible class as listed on the Policyholder Application;
2. Must meet the eligibility requirements listed on the Policyholder Application; and
3. Must be in Active Service on the day his or her coverage becomes effective.

Dependent: If Dependent coverage is available under the Policy, the Insured may elect coverage for his or her Spouse and/or Child(ren). To be covered as a Dependent under this Policy, the Dependent must not be an Eligible Person under this Policy.

WHEN IS COVERAGE EFFECTIVE – INITIAL ENROLLMENT

Basic Life Insurance – You are automatically enrolled for Basic Life Insurance on the Policy Effective Date or the date you first become an Eligible Person, whichever is later. You are not required to contribute toward the cost of Basic Life Insurance. Coverage will become effective the Policy Effective Date or first day of the month following the date you become an Eligible Person, whichever is later.

Supplemental Life Insurance – If available, you may elect Supplemental Life Insurance during the initial enrollment period or within 31 days of becoming an Eligible Person, whichever is later. You can enroll by completing the Policyholder's benefit election process and authorizing the payment of premiums due for the amount of supplemental coverage elected, if any. If you fail to make an election within the timeframe stated above, you will not be permitted to enroll in Supplemental Life Insurance until the next annual enrollment period. Supplemental Life Insurance will become effective the Policy Effective Date or the first day of the month following the date you elect coverage, whichever is later.

Delayed Effective Date - If the Insured is not in Active Service on the day coverage is scheduled to become effective, coverage will become effective on the date the Insured returns to Active Service. If a Dependent is confined in a hospital on the date coverage is scheduled to become effective, that Dependent's coverage will become effective on the day following discharge from the hospital.

Evidence of Insurability – Evidence of Insurability may be required, as shown on the Benefit Schedule. If so, we must receive a completed Evidence of Insurability Form prior to the Policy Effective Date or the Policy Anniversary and approve the Evidence of Insurability before the insurance subject to Evidence of Insurability will become effective. There will be no cost to the Insured for providing Evidence of Insurability.

WHEN CAN COVERAGE BE CHANGED

Annual Benefit Elections – Benefits are elected on an annual basis. Benefit elections will become effective on the next Policy Anniversary and will remain in effect for the Plan Year, subject to the terms of the Policy and Certificate. Changes in benefit elections are not allowed during the Plan Year unless made in accordance with the Change in Family Status provision of this Policy.

If the Insured is not in Active Service on the day coverage is scheduled to become effective, any changes will not take effect until the Insured returns to Active Service. If a Dependent is confined in a hospital on the date coverage is scheduled to become effective, any changes for that Dependent's coverage will become effective on the day following discharge from the hospital.

Coverage Options Subject to Change - Basic Life Insurance and Supplemental Life Insurance options are subject to change on any Policy Anniversary, as agreed upon between the Policyholder and the Insurer.

Automatic Coverage Amount Change - If the Insured's coverage amount is based on Salary, Basic Life Insurance and Supplemental Life Insurance will be adjusted automatically on the next Policy Anniversary as the Insured's Salary increases or decreases.

Change In Family Status – An Insured may request to change coverage during any Plan Year due to a change in family status (marriage, divorce, birth/adoption, death of a family member, or a Spouse losing coverage through his or her employer). A request to change coverage as a result of a change in family status must be consistent with the event. Requests for a change in coverage as a result of a change in family status must be submitted to the Policyholder in writing within 31 days following the event. Approval of the change in coverage will become effective on the date the change in family status occurred. If the Insured fails to request a change in coverage within 31 days following the change in family status, the Insured will not be permitted to make such a change until the next Policy Anniversary.

WHAT IS COVERED (LIFE INSURANCE PROCEEDS)

Amount of Proceeds - Upon receipt of satisfactory proof of a Covered Person's death, we will pay the Beneficiary the amount of Basic Life Insurance and Supplemental Life Insurance in force for such person on the date of death. We will either pay the death benefit in a lump sum or in a method comparable to one sum.

The amount of Proceeds applicable to a Child between the Ages of 15 days and 6 months old is limited to 10% of the Child's life insurance coverage.

Adjustments to the Proceeds - The Proceeds will be reduced by any due and unpaid premiums.

Protection of the Proceeds - To the extent permitted by law, the Proceeds will not be subject to the claims of the Beneficiary's creditors or to any legal process against the Beneficiary.

How to Designate or Change the Beneficiary – The Insured may designate or change the Beneficiary for his or her Proceeds at any time. Designations must be submitted to the Policyholder in writing and shall take effect as of the date the notice of change is signed unless a different date is specified by the Insured. The notice of change will be subject to any payments made or actions taken prior to receipt of the notice of change. If an irrevocable Beneficiary is designated, a Beneficiary change will not be allowed without the consent of the irrevocable Beneficiary. The Insured will be the Beneficiary for any Dependent Life Insurance coverage.

The existence of multiple Beneficiaries will not increase the benefit payable. If multiple Beneficiaries are designated and their shares are not specified, the Beneficiaries will equally share the benefit payable.

If No Beneficiary is Named or the Designated Beneficiary Dies - The rights of any Beneficiary to receive Proceeds will end if the Beneficiary dies prior to, at the time of, or within 30 days after, the death of the Covered Person, except to the extent that benefits have already been paid. If the rights of all designated Beneficiaries have ended, or if the Insured did not designate a Beneficiary, benefits will be payable to the Insured's survivors in the following order of priority:

1. Spouse;
2. Child(ren) (in equal amounts);
3. The executor or administrator of the Insured's estate.

Payment in good faith by us will fully discharge our obligations with respect to the amount(s) paid.

WHAT IS NOT COVERED (SUICIDE EXCLUSION)

We will not pay benefits if the Covered Person dies by suicide, whether sane or insane, within two years from the effective date of the initial election of such benefits under this Policy.

We will not pay any applicable increase in benefits if the Covered Person dies by suicide, whether sane or insane, within two years from the effective date of such increase. However, an increase due to a change in your Salary is not subject to this limitation.

If a Covered Person dies by suicide within the timeframes stated above, the only sum we will pay to the Beneficiary is an amount equal to the premiums paid for the decedent's Supplemental Life Insurance coverage or applicable increase thereof. Any premium paid for the Basic Life Insurance will be returned to the Policyholder.

HOW TO FILE A CLAIM

Claim Forms – A Beneficiary or personal representative can obtain a claim form by calling our toll-free number listed on the cover page of this Certificate. The process for completing the claim form and submitting the claim will be explained in the claim form kit.

Proof of Loss - Proof of Loss will consist of a certified copy of the death certificate of the Covered Person, or other lawful evidence providing equivalent information, and proof of the claimant's interest in the Proceeds. Proof of Loss should be sent to the address shown on the claim form. Upon receipt of the claim form and due Proof of Loss, we will review your Proof of Loss and if approved, pay the claim, subject to the terms of the certificate.

Interest from Date of Death - We will pay interest on the Proceeds after we receive due Proof of Loss. We will pay interest on the Proceeds from the date of death to the date of payment. Interest paid on Proceeds will accrue at the rate we have established for funds left on deposit. We will pay additional interest at a rate of 10% annually, beginning with the date that is 31 calendar days from the latest of items 1, 2 and 3 below to the date payment is made:

1. The date we receive due Proof of Loss;
2. The date we receive sufficient information to determine our liability, the extent of our liability and the appropriate payee legally entitled to the death benefit; and.
3. The date that legal impediments to payment of the Proceeds that depend on the action of parties other than us are resolved and sufficient evidence is provided to us. Legal impediments include, but are not limited to:
   a) The establishment of guardianships and conservatorships;
   b) The appointment and qualification of trustees, executors and administrators; and
   c) The submission of information required to satisfy state and federal reporting requirements.

Legal Action – The time limits for legal actions for loss covered by the Policy are subject to the applicable law in the state where the Policy was issued.

GENERAL PROVISIONS

Misstatement of A Covered Person's Age or Tobacco User Status - If the Age or Tobacco User status of any Covered Person is misstated, we will make an equitable adjustment in either the premium or amount of insurance. We will adjust any claims payable under the Policy to that amount of insurance that the premiums paid would have purchased based on your correct Age or Tobacco User status.

Incontestability - All statements made by an Insured shall be considered representations and not warranties. We will not use any statements to void coverage, reduce benefits or defend a claim unless included in a written statement of insurability form which has been signed by the Insured and a copy has been given to the Insured or the Beneficiary. We will not use such written statement after coverage has been in force for two years during the Covered Person's life. Such statement must be material to the acceptance of the risk or hazard assumed by us.

For increases in Supplemental Life Insurance benefits, our two-year right to contest starts anew, but will only apply to the amount of the increase. We will not use such statement to contest an increase or benefit addition to such insurance, or reinstatement of insurance, if applicable, after the increase, benefit, or reinstatement , as applicable, has been in force for two years during the Covered Person's life.

Fraud in the procurement of coverage under the Policy shall only be contestable when permitted by applicable law in the state where the Insured resides.

Policyholder As Your Agent - For all purposes related to this insurance, the Policyholder serves as your agent and not as our agent.

Assignment - The Insured may assign benefits under this Certificate with a written request to us. The assignment will take effect as of the date you sign the notice of assignment unless you specify a different date. However, we will not be bound by any assignment until we record it. The assignment will be subject to any payments made or actions taken before we record the assignment. We assume no responsibility for the validity or effect of any assignment of this Certificate or any interest in it.

Conformity with Interstate Insurance Product Regulation Commission Standards - This Policy was approved under the authority of the Interstate Product Regulation Commission (IIPRC) and issued under the Commission standards. Any provision of this Policy that on the provision's effective date is in conflict with IIPRC standards for this product type is hereby amended to conform to the IIPRC standards for this product type as of the provision's effective date.

Entire Contract – This insurance is provided under a contract of group term insurance with the Policyholder. The entire contract consists of the Policy; the Policyholder Application; the Certificates; and any attached amendments, endorsements, or riders.

Entire Contract Changes - The Policy is a legal contract between the Policyholder and us and may be changed or terminated without the Insured's consent. Premiums are subject to change. We may issue riders, endorsements or other amendments that effect such changes. Such forms are subject to prior approval by the Interstate Insurance Product Regulation Commission (IIPRC) and become effective on the effective date of the change, unless retroactivity is required by the IIPRC. We will only make changes that are consistent with IIPRC standards. Any change or waiver of the terms and provisions of the Policy and Certificate will be made in a rider, endorsement or amendment signed by an officer of the Company. No sales representative or other employee has authority to approve such changes or waivers. A copy of the rider, endorsement or amendment will be provided to the Policyholder for attachment to the Policy, and to the Insureds for attachment to the certificate, if applicable.

Grace Period – A Grace Period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during the Grace Period. If the premium due has not been paid in full by the due date, we will give the Policyholder written notice of termination and this Policy will terminate the day after the Grace Period ends. If we fail to give such written notice, this Policy will continue in effect until the date notice is given. The Policyholder must still pay us all premiums due through the termination date, including the premium due for the time the Policy was in force during the Grace Period. Premium shall be paid for any Grace Period, any extension of such period, and any period for which insurance under this Policy was in effect and premium was not paid.

If the Policyholder replaces this Policy with another group policy without providing us written notice of intent to terminate this Policy, the Grace Period provision will apply. The Grace Period will not apply if coverage is terminated on a premium due date and the premium has been paid through that date. If the Policyholder provides written notice of termination during the Grace Period, the Policyholder will be liable for any unpaid premium including the pro rata premium for that part of the Grace Period during which coverage was in force.

WHEN INSURANCE STOPS

Subject to the Conversion Option or any Continuation or Portability Option, if included in the Policy, coverage will end on the earliest of the following:

Basic Life Insurance (Insured):

1. the date of the Insured's death;
2. the last day of the month in which the Insured no longer qualifies for coverage as an Eligible Person;
3. the date the Policy Lapses due to non-payment of premium, subject to the Grace Period; or
4. the date the Policy terminates.

Supplemental Life Insurance (Insured):

1. the date the Insured's Basic Life Insurance terminates;
2. the date the Supplemental Life Insurance Lapses, subject to the Grace Period;
3. the Policy Anniversary, if the Insured elects not to enroll in Supplemental Life Insurance for the next Plan Year; or
4. the date the Policyholder discontinues offering Supplemental Life Insurance for the Insured's class.

Basic Life Insurance (Dependent):

1. the date the Insured's Basic Life Insurance terminates;
2. the date of the Dependent's death;
3. the date the Dependent no longer qualifies for coverage as a Dependent;
4. the date the Dependent becomes an Eligible Person under the Policy; or
5. the date the Policyholder discontinues Basic Life Insurance for Dependents.

Supplemental Life Insurance (Dependent):

1. the date the Insured's Basic Life Insurance terminates;
2. the date of the Dependent's death;
3. the date the Supplemental Life Insurance Lapses due to non-payment of premium, subject to the Grace Period;
4. the date the Spouse no longer meets the definition of Spouse (for Spouse only);
5. the Policy Anniversary on or immediately following a Dependent Child's 26th birthday (for that Child only), unless the Child is incapable of self-sustaining employment because of a mental or physical disability;
6. the date the Dependent becomes an Eligible Person under the Policy;
7. the Policy Anniversary, if the Insured elects not to enroll in Supplemental Life Insurance for the Dependent for the next Plan Year; or
8. the date the Policyholder discontinues offering Supplemental Life Insurance for Dependents for the Insured's class.

Coverage will also end if a Covered Person submits a fraudulent claim to us.

CONTINUATION DUE TO TOTAL DISABILITY

If coverage terminates while the Insured is Totally Disabled, coverage (including coverage on the Insured's Dependents) will be continued for up to 6 months, provided:

1. The Total Disability began on or after the Insured's 16th birthday and prior to the Insured's 60th birthday;
2. The Insured has been Totally Disabled for at least 6 consecutive months immediately preceding such termination;
3. We receive written notice and satisfactory proof of Total Disability while the Insured is living, and such notice and proof is received within 31 days of coverage termination;
4. The Insured continues to be Totally Disabled; and
5. The Insured is not eligible for coverage under any new policy being issued to the Policyholder to provide group term life insurance to its employees.

During this continuation period, the Policyholder must continue to pay the premium for the Basic Life Insurance and the Insured must continue to pay the premium for any Supplemental Life Insurance on the same basis as premium was paid on the day before Total Disability began, except when the Waiver of Premium Benefit Rider is part of the Policy for the Insured's classification. At the end of the continuation period, the Insured's coverage will terminate, subject to the Conversion Option.

If the Insured dies during the continuation period, we will pay the Proceeds to the Beneficiary upon receipt of satisfactory proof of the Insured's death and documentation that Total Disability continued without interruption from the date of continuation to the date of death.

CONVERSION OPTION

Insured – If an Insured's coverage is terminated or reduced, the Insured can convert coverage to permanent life insurance in an amount not to exceed the amount of insurance that is terminating or the amount of the benefit reduction, less the amount of life insurance for which the Insured becomes eligible under any group policy within 31 days after the date his or her insurance ended or was reduced. To be eligible for conversion, coverage must be ending or reducing due to one of the following:

1. The Insured's group term life insurance is ending for one or more of the following reasons:
   (A) The Insured ceases to be in an eligible class;
   (B) The Insured's employment ends;
   (C) The Insured's continuation of insurance, if any, ends;
   (D) The Policy ends; or
   (E) The Policy is changed to end life insurance for the eligible class to which the Insured belongs to; or
2. The Insured's life insurance is reduced:
   (A) On or after the Insured attains a specified age;
   (B) Because the Insured changes from one eligible class to another; or
   (C) Due to a Policy change.

Dependent – If a Dependent's coverage is terminated or reduced, the Insured can convert the Dependent's coverage to permanent life insurance in an amount not to exceed the amount of insurance that is terminating or the amount of the benefit reduction, less the amount of Dependent life insurance for which the Insured becomes eligible under any group policy within 31 days after the date his or her insurance ended or was reduced.

To be eligible for conversion, coverage must be ending or reducing for any reason other than:
(A) Nonpayment of premium;
(B) A spouse ceases to be a Spouse as defined in the Certificate;
(C) A Child attains the limiting age for coverage under the Certificate;

The Insured may convert the Dependent's coverage if it is reduced'
(A) On or after the Dependent attains a specified age;
(B) Because the Insured changes from one eligible class to another; or
(C) Due to a Policy change.

A Spouse may convert coverage if it ends because the Spouse ceases to be a Spouse as defined under the Certificate.

A Child may convert coverage if it ends because the Child attains the limiting age for coverage under the Certificate.

The permanent life insurance will be issued on any policy form, other than individual term life insurance, that we then customarily offer, without any optional riders. The premium for the permanent coverage will be based upon our premium rates then in use, the Covered Person's Attained Age and class of risk at the time of conversion, together with the form and amount of insurance chosen. No Evidence of Insurability will be required. The policy will take effect on the day following the end of the conversion period.

We must receive the conversion application and any required premium within 31 days of termination or benefit reduction under the Policy. If the Covered Person elects not to convert within the 31-day conversion period, the Covered Person will not have the right to convert such amount at a later date. During the 31-day conversion period, coverage will continue under the terms of the certificate. If the Covered Person dies within the 31-day conversion period, benefits under the Policy will be paid as if coverage had continued regardless of whether the Covered Person applied for conversion coverage. If the conversion application and premium payment has been made for the conversion policy, any premiums paid for the conversion policy will be refunded. In no event shall we be liable to pay a death benefit under both the group policy and the conversion policy.

DEFINITIONS

Terms important to understanding this Certificate are defined in this section and are capitalized in this Certificate.

Active Service means the Insured is performing in the usual manner all the regular duties of his or her occupation on a scheduled work day at the normal place of business or other location as directed by the Policyholder. An Insured is deemed to be in Active Service on weekends or Policyholder-approved vacations, holidays or business closures if the Insured was in Active Service on the last scheduled work day preceding such time off.

Active Service does not apply to retired employees, if eligible under the Policy.

Age or Attained Age means the Covered Person's Age as of the date his or her coverage first becomes effective or on the last Policy Anniversary, whichever is later. Attained Age will increase by one year on each Policy Anniversary.

Basic Life Insurance means the noncontributory life insurance coverage paid for by the Policyholder and provided at no cost to the Insured.

Certificate means this document that describes the Insured's benefits and rights under the policy, including any riders, endorsements, amendments, notices or other attachments to the Policy.

Child(ren) means a child of the Insured who is at least 15 days old and under the age of 26 who is:

1. A natural child;
2. A legally adopted child, or a child who has been placed for adoption with the Insured;
3. A stepchild;
4. A child for whom the Insured has been appointed legal guardian; or
5. Any other children required to be covered under the civil union, domestic partnership, marriage or other family or domesic relations laws of the state where the Policy is issued for delivery or where the Insured resides.

Beginning at age 19, a Child must:

- Not be employed on a full-time basis and eligible for life insurance coverage through his or her employer.
- Must be a student at an accredited secondary school, college, university, or trade school for a minimum of 12 credit hours.

Child(ren) does not include anyone who is an Eligible Person under the Policy.

If a Child covered under this Certificate has reached age 26 but is incapable of self-sustaining employment because of mental or physical impairment, we will continue the Child's insurance under the following conditions:

1. The Child is and continues to be incapacitated;
2. The Child continues to meet the definition of Child, except for the age limit;
3. We must receive proof of incapacity within 31 days after the Child attains age 26; and
4. We may require proof of continued incapacity from time to time, but not more often than once a year after the Child attains age 26.

Subject to the Conversion Option, coverage on an incapacitated Child will end on the earlier of:

1. The date the conditions listed above are no longer satisfied; or
2. The Insured's insurance terminates.

Covered Person means the Insured and the Insured's Dependents who have been enrolled and accepted for insurance by us.

Dependent means the Insured's Spouse and Child(ren).

Eligible Person means an employee of the Policyholder that meets all of the eligibility requirements for becoming insured for Basic Life Insurance coverage.

Insured (you, your, yours) means the Eligible Person covered under the Policy.

Lapse means the termination of the Policy due to nonpayment of premium or insufficient payment of the premium due. The term also applies to the termination of Supplemental Life Insurance coverage for nonpayment or insufficient payment of the contributions due.

Life Insurance Proceeds or Proceeds means the coverage amount payable upon the Covered Person's death.

Plan Year means the 12-month period beginning on the Policy Effective Date. Subsequent Plan Years begin on the Policy Anniversary each year.

Policy means the document that is issued to the Policyholder that describes the life insurance coverage for Insureds and their covered Dependents, if any, including any riders, endorsements, amendment, notices or other attachments to the Policy.

Policy Anniversary means the month and day beginning each Plan Year and is the same month and day as the Policy Effective Date, unless stated otherwise in the Policy.

Policy Effective Date means the date the Policy first became effective.

Policyholder Application means the application completed by the Policyholder to apply for the Policy.

Spouse means a person under the age of 70 who is the Insured's lawful spouse or any other person required be covered as a Spouse under the civil union, domestic partnership, marriage or other family or domestic relations laws, including case law, of the state where the Policy is issued or delivered and where the Insured resides, if different. Spouse may also include similar relationships in states not required by law, if agreed upon between the Policyholder and us. Spouse does not include anyone who is an Eligible Person under the Policy.

Supplemental Life Insurance means the contributory life insurance coverage available to the Insured. The Insured must pay the premium for this coverage.

Tobacco User means a person who has used any of the following tobacco products within the last 12 months: cigarettes, cigars, pipes, snuff, and chewing tobacco, or nicotine replacement products, such as patches or gum.

Total Disability or Totally Disabled means, due to an injury or sickness, the Insured's inability to perform the material duties of his or her regular job and is unable to perform any other job for which the Insured is fit by education, training or experience.

Transamerica Life Insurance Company, the Company, Insurer, we, us, or our – The Insurer that underwrites this life insurance coverage and pays the benefits upon a claim.

TRANSAMERICA LIFE INSURANCE COMPANY

ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS RIDER

(This Rider may only be accelerated once per Covered Person)

This Rider is attached to and made part of the Policy/Certificate as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the Policy/Certificate not in conflict with the provisions of this Rider apply to this Rider. This Rider has no cash value.

NOTICE: Benefits paid under this Rider may be taxable in certain circumstances. As with all tax matters, you should consult your tax advisor regarding the tax treatment of receiving an Accelerated Death Benefit.

Payment of an Accelerated Death Benefit may affect eligibility for Medicaid or other government benefits and entitlements.

The Life Insurance Proceeds, as well as any benefits provided by affected Riders, will be reduced if an Accelerated Death Benefit is paid under this Rider. The premium amount may remain the same or reduce based on the rate structure and benefit elections.

DEFINITIONS

In addition to the definitions contained in the Policy/Certificate, the following definitions apply to this Rider:

Accelerated Death Benefit means a portion of the Life Insurance Proceeds that is paid prior to the death of the Covered Person due to the Covered Person's being diagnosed with a Terminal Illness. The payment of an Accelerated Death Benefit reduces the Proceeds, as well as any benefits provided by affected riders, and the amount of Proceeds payable to the Beneficiary upon death.

Immediate Family Member means the Insured, Spouse, Child, brother, sister, mother, father, and the spouse of any of these individuals.

Physician means a person who is a practitioner of healing arts, other than an Immediate Family Member, providing services within the scope of his or her license.

Prior Policy means a group term life insurance policy issued by another insurance carrier that is being replaced by our Policy. The Prior Policy must have been in effect the day immediately prior to our Policy Effective Date.

Terminally Ill means that the Covered Person has a medical condition that, in the best medical judgment of a Physician, will result in death within 12 months.

Written Proof of Loss means a written statement signed by a Physician certifying that the Covered Person has been diagnosed as being Terminally Ill.

BENEFITS

We will pay the Accelerated Death Benefit for Terminal Illness Benefit shown in the Benefit Schedule if a Covered Person becomes Terminally Ill while this Rider is in effect. If the Covered Person became Terminally Ill while covered under a Prior Policy, the amount available to be accelerated under our Policy will be reduced by the amount the Covered Person accelerated or is eligible to accelerate under the Prior Policy.

We will deduct the following from the accelerated benefit:
1. An administrative fee of $250; and

2. 12 months' interest, in advance, on the amount that we accelerate. The annual interest rate we use will be a discount rate that is the greater of:

a. The current yield on the 90-day Treasury Bills available at the date of application for an accelerated payment; and
b. The then current maximum adjustable policy loan interest rate based on Moody's Corporate Bond Yield Averages – Monthly Average Corporates – published by Moody's Investors Service, Inc., or any successor thereto for the calendar month ending two months before the date of application for an accelerated payment.

This benefit is payable only once per Covered Person and will be paid in a lump sum. The Proceeds will be reduced by the amount accelerated under this Rider. The remaining Proceeds will be paid to the Beneficiary upon the Covered Person's death.

Upon a request to accelerate the death benefit and upon payment of the Accelerated Death Benefit , we will provide to the Insured and any assignee or irrevocable Beneficiary of record a statement demonstrating the effect of the acceleration on the death benefit and premium of the Certificate. The statement shall also disclose any premium necessary to continue any remaining coverage following the acceleration.

If a Covered Person dies after the Insured elects to receive Accelerated Death Benefits but before any such benefits are received, the election shall be cancelled, and the benefit paid in accordance with the terms of the Certificate.

HOW EXERCISING THIS RIDER WILL AFFECT BENEFITS

When an Insured exercises this Rider due to being diagnosed as Terminally Ill, benefit election changes will no longer be allowed. When the Insured exercises this Rider due to a Dependent being diagnosed as Terminally Ill, benefit election changes for that Dependent will no longer be allowed.

The acceleration of part of the Insured's death benefit will not impact Dependent coverage under the Certificate, whether or not the Dependent coverage is based on a percentage of the Insured's death benefit.

The Accidental Death and Dismemberment Benefit Rider will not be affected by the payment of the Accelerated Death Benefit.

CLAIMS

Notice of Claim - We must be notified of a claim for benefits under this Rider, in writing, within 90 days of the initial date that the Covered Person is first diagnosed as being Terminally Ill. The written notice must be sent to us. The notice must include sufficient information to identify the claimant. If notice cannot reasonably be given within 90 days of the diagnosis, notice must be sent as soon as reasonably possible.

Claim Forms - After we receive notice of claim, we will send claim forms to the claimant within 15 days. If the forms have not been received within 15 days, the claimant may send us written proof of loss describing the nature and extent of the claim. The written proof of loss must be sent to us within the time limit stated in the following paragraph.

Written Proof of Loss - We will pay benefits under this Rider after we receive Written Proof of Loss satisfactory to us. We must receive such proof within 90 days after the Covered Person is diagnosed as being Terminally Ill. If it is not reasonably possible to provide this information within such time, Written Proof of Loss must be submitted as soon as reasonably possible but no later than one year from the time specified after the date of diagnosis.

Physical Examination - At our expense, we reserve the right to require a second or third medical opinion to confirm benefit eligibility. The second medical opinion may include a physical examination by a Physician of our choosing. In the case of conflicting opinions, eligibility for the accelerated death benefits shall be determined by a third medical opinion that is provided by a Physician that is mutually acceptable to you and the insurance company.

Time of Payment of Claims - All benefits described in this Rider will be paid as soon as we have received Written Proof of Loss satisfactory to us.

Payment of Claims - We will pay the benefit under this Rider to the Insured, unless a different payee is designated. Prior to the payment of the benefit, we will obtain from the Insured a signed acknowledgement of concurrence for payout from any assignee of record or irrevocable Beneficiary of record.

Legal Actions - No legal action may be brought to recover under the Policy within 60 days after Written Proof of Loss has been provided to us as required nor more than 3 years from the time Written Proof of Loss is required to be furnished.

RIDER EFFECTIVE DATE

This Rider is only available when the Policy is initially issued and becomes effective on the same date as the Policy.

TERMINATION

Termination of Rider - This Rider will terminate on the earliest of the following dates or events:
1. The date we receive the Policyholder's request to cancel this Rider; or
2. The date the Policy terminates.

Termination of Coverage – A Covered Person's coverage under this Rider will end on the earliest of:
1. The date the Rider terminates;
2. The date the Insured requests to terminate his or her coverage under this Rider;
3. The date the Covered Person's coverage ends under the Policy; or
4. The date an Accelerated Death Benefit is paid on a Covered Person (for that Covered Person only).

Termination of this Rider will not prejudice the payment of benefits for any Terminally Ill diagnosis that occurred while the Rider was in force.

This Rider is signed for the Company at our home office to take effect on the Rider Effective Date.

Blake Bostwick
President

TRANSAMERICA LIFE INSURANCE COMPANY

ACCIDENTAL DEATH AND DISMEMBERMENT RIDER

This Rider is attached to and made part of the Policy/Certificate as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the Policy/Certificate not in conflict with the provisions of this Rider apply to this Rider. This Rider has no cash value.

DEFINITIONS

In addition to the definitions contained in the Policy/Certificate, the following definitions apply to this Rider:

Accidental Bodily Injury means an injury resulting, directly and independently of disease or bodily or mental illness or infirmity or any other causes.

Accidental Death means loss of life resulting from an Accidental Bodily Injury.

Air Bag System means an automatically inflatable passive restraint system that is designed to provide automatic crash protection in front or side impact Automobile accidents and meets the Federal Vehicle Safety Standards of the National Highway Traffic Safety Administration.

Automobile means a four-wheeled private passenger motor vehicle licensed for use on public highways and not used to transport passengers for hire.

Covered Loss means an Accidental Death or a Dismemberment. Covered Loss also includes an Accidental Death or a Dismemberment resulting from unavoidable exposure to the elements.

Dismemberment means an Accidental Bodily Injury that, directly and independently of all other causes, results in the loss of:

1. A hand – the permanent severance at or above the wrist, but below the elbow.
2. A foot – the permanent severance at or above the ankle but below the knee.
3. The thumb and index finger on the same hand - the permanent severance through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.
4. An arm – the permanent severance at or above the elbow.
5. A leg – the permanent severance at or above the knee.
6. Sight - the permanent and uncorrectable loss of sight in the eye that continues for 180 days following the date of loss; the visual acuity shall be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.
7. Speech – the total and irrecoverable loss of speech that continues for 180 days following the date of loss.
8. Hearing – the total and permanent loss of hearing.
9. Paralysis means total and permanent impairment of voluntary movement and sensory function of a limb without severance; a Physician must determine the paralysis to be permanent, complete and irreversible.
   - Hemiplegia – the total and permanent paralysis of both an arm and a leg on the same side of the body.
   - Paraplegia – the total and permanent paralysis of both legs.
   - Quadriplegia – the total and permanent paralysis of both arms and both legs.

Elder
means an adult who is at least 70 years of age and who depends primarily on the Insured for financial support.

Elder Care means the non-medical care provided in a home for the aged or a community living center that provides domiciliary, residential, or retirement care. Elder Care does not include:

1. Medical care in a hospital;
2. Psychiatric care in a facility that treats mental illness of a non-organic origin; or
3. Treatment in a facility for voluntary chemical dependence.

Immediate Family Member means the Insured, Spouse, Child, brother, sister, mother, father, and the spouse of any of these individuals.

Physician means a person who is a practitioner of healing arts, other than an Immediate Family Member, providing services within the scope of his or her license.

Public Transportation means a public passenger conveyance operated by a licensed common carrier for the transportation of the general public for a fare and operating on regularly scheduled passenger routes with a definite schedule of departures and arrival times. (This definition excludes taxis, ride sharing services, limousines, and chartered vehicles.)

Seatbelt means a properly installed combination lap and shoulder restraint system that meets the Federal Vehicle Safety Standards of the National Highway Traffic Safety Administration. Seatbelt will include a lap belt only if the Automobile was not equipped with a combination lap and shoulder restraint system when manufactured. This benefit is not payable if a seatbelt is not worn or the seatbelt is not available in the Automobile.

DEATH BENEFITS

The following benefits are payable in addition to the Life Insurance Proceeds payable under the Policy, subject to the Exclusions and Limitations provision of this Rider. Death must occur within 365 days of the Accidental Bodily Injury. This Rider must be in force at the time of death. Death benefits will be paid to the Beneficiary, unless otherwise stated below.

Accidental Death Benefit – We will pay the Accidental Death Benefit shown in the Benefit Schedule if a Covered Person dies as the result of an Accidental Bodily Injury.

Common Carrier Benefit – We will pay the Common Carrier Benefit shown in the Benefit Schedule if a Covered Person dies as the result of an Accident that occurs while the Covered Person was riding as a fare-paying passenger on Public Transportation.

Air Bag Benefit – We will pay the Air Bag Benefit shown in the Benefit Schedule if:
1. The Covered Person's death is the result of an Automobile accident;
2. The Automobile is equipped with an Air Bag System that was installed as original equipment by the Automobile manufacturer;
3. The deceased was seated in the driver's or a passenger's seating position intended to be protected by the Air Bag System; and
4. The Air Bag System deployed, as evidenced by a police accident report.

Seatbelt Benefit – We will pay the Seatbelt Benefit shown on the Benefit Schedule if the Covered Person's death was the result of an Automobile accident and the deceased was wearing and properly utilizing a Seatbelt at the time of the accident, as evidenced by a police accident report. This benefit will not be payable if the Covered Person was the driver of the Automobile and did not hold a current and valid driver's license.

Transportation of Remains Benefit - We will pay the Transportation of Remains Benefit shown in the Benefit the Covered Person dies more than 200 miles from his or her primary residence and expenses are incurred to transport the Covered Person's body to a mortuary near his or her primary place of residence.

Spouse Training Benefit - We will pay the Spouse Training Benefit shown in the Benefit Schedule to the Insured's Spouse if the Spouse enrolls in a training program within 365 days of the Insured's death. The training program must be for the purpose of obtaining an independent source of income for the Spouse. This benefit is subject to the Lifetime Benefits Limitation shown in the Benefit Schedule.

Elder Care Benefit - We will pay the Elder Care Benefit shown in the Benefit Schedule to the Insured's surviving Spouse to care for an Elder as long as an Elder is receiving Elder Care before this Rider's Effective Date. This benefit is subject to the Lifetime Benefits Limitation of this Rider.

Child Educational Benefit – We will pay the Child Educational Benefit shown in the Benefit Schedule to the Insured's Spouse if the Insured is survived by a Child, within the Age range of 17 through Age 21, who is enrolled, or enrolls within 365 days of the Insured's death, as a regular, full-time student at an accredited secondary school, college, university, or trade school. We will pay this benefit each year, for up to four consecutive years, while a Child remains enrolled as a full-time student. We will pay this benefit in equal installments over the four-year period. We will pay separate benefits for each Child who meets the requirements for this benefit. Evidence of student status must be provided annually. This benefit is subject to the Lifetime Benefits Limitation of this Rider.

If there is no Spouse, we will pay this benefit directly to the Child, if of legal age of majority. Otherwise we will pay this benefit to the legally appointed guardian of the Child.

Child Care Center Benefit - We will pay the Child Care Center Benefit shown in the Benefit Schedule to the Insured's Spouse if the Insured is survived by a Child, within the Age range of 15 days through Age 12, who is enrolled, or enrolls within 90 days of the Insured's death, in a qualified child care center on less than a 24-hour per day basis for which an expense is incurred. We will pay this benefit each year, for up to four years, while the Child remains enrolled in a childcare center. We will pay this benefit in equal installments over the four-year period. We will pay separate benefits for each Dependent Child who meets the requirements for this benefit. This benefit is subject to the Lifetime Benefits Limitation of this Rider.

A qualified childcare center means a facility that operates pursuant to law, including any licensing or other laws or regulations applicable to child care facilities and primarily provides care and supervision for children in a group setting on a regular, daily basis. A child care center does not include any of the following: a hospital; the child's home; a nursing home or convalescent home; a facility or part thereof for the treatment of mental disorders; a place or part thereof used primarily for the care of drug addicts, or alcoholics; or an orphanage.

Lifetime Benefits Limitation - A claim can be made for the Spouse Training, Elder Care, Child Education, or Child Care Center provisions, concurrently or separately. We do, however, limit the aggregate lifetime benefit for all four of these benefits the maximum shown in the Benefit Schedule.

DISMEMBERMENT BENEFITS

We will pay the applicable benefit shown in the Benefit Schedule if a Covered Person suffers a Dismemberment, subject to the Exclusions and Limitations provision of this Rider. Dismemberment must occur within 365 days of the Accidental Bodily Injury. This Rider must be in force at time of Dismemberment. Dismemberment benefits will be paid to the Insured.

If more than one Dismemberment occurs as a result of the same Accidental Bodily Injury, we will pay a single benefit for the loss which has the largest benefit.

EXCLUSIONS AND LIMITATIONS

Benefits for Accidental Death or Dismemberment will not be payable for any loss caused in whole or in part by, or resulting from, any of the following:

1. Suicide, attempted suicide or intentionally self-inflicted injury while sane or insane;
2. Disease, physical or mental infirmity or any medical or surgical treatment for such condition;
3. An infection not occurring as a direct result or consequence of the accidental bodily injury;
4. Committing or attempting to commit a felony or engaging in an illegal occupation;
5. Voluntary taking or use of any drug, whether legal or illegal, unless prescribed or administered in accordance with a Physician's instruction; or an over the counter drug, taken in accordance with the instructions.
6. Voluntary taking, absorbing, or inhaling a poison, gas, or fumes, unless a direct result of an occupational accident;
7. Involvement in an accident that occurs while intoxicated according to the laws of the jurisdiction in which the accident occurs;

8. Travel in or descent from an aircraft, if a Covered Person acted in a capacity other than as a passenger;
9. Travel in an aircraft or device used for testing or experimental purposes, used by or for any military authority, or used for travel beyond the earth's atmosphere;
10. War or any act of war, whether declared or undeclared;
11. Riding or driving an air, land, or, water vehicle in a race, speed, or endurance contest;
12. Hang gliding, sky diving, mountain or rock climbing, bungee jumping, parachuting, ultralight, soaring, ballooning and parasailing;
13. The Insured's incarceration; or
14. The release of nuclear energy.

CLAIMS

Notice of Claim - We must be notified of a claim for benefits under this Rider, in writing, within 90 days of the Covered Loss. The written notice must be sent to our agent or us. The notice must include sufficient information to identify the claimant. If notice cannot reasonably be given within 90 days of a loss, notice must be sent as soon as reasonably possible.

Claim Forms - After we receive notice of claim, we will send claim forms to the claimant within 15 days. If the forms have not been received within 15 days, the claimant may send us written proof of loss describing the nature and extent of the claim. The written proof of loss must be sent to us within the time limit stated in the following paragraph.

Written Proof of Loss - We will pay benefits under this Rider after we receive written proof of loss satisfactory to us. We must receive such proof within 90 days after the Covered Loss. If it is not reasonably possible to provide this information within such time, written proof of loss must be submitted as soon as reasonably possible but not later than one year after the Covered Loss.

Written proof of loss means the completion and submission of all documents needed to support a Covered Loss, such as a claimant's statement, attending Physician's statement, Accident report, and death certificate, if applicable.

Physical Examination and Autopsy - At our expense, we reserve the right to have a Physician of our choosing examine the Covered Person while a claim is pending to determine eligibility for benefits. At our expense, we may have an autopsy performed, if necessary, unless prohibited by law.

Time of Payment of Claims - All benefits described in this Rider will be paid as soon as we have received written proof of loss satisfactory to us.

Payment of Claims – Benefits other than loss of life are payable to the Insured, unless a different payee is designated. Life Insurance Proceeds are payable to the Beneficiary.

Legal Actions - No legal action may be brought to recover under the Policy within 60 days after written proof of loss has been provided to us as required nor more than 3 years from the time written proof of loss is required to be furnished.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the Policy, unless we inform the Policyholder in writing of a different date.

TERMINATION

Termination of Rider - This Rider will terminate on the earliest of the following dates or events:
1. The date we receive the Policyholder's request to cancel this Rider; or
2. The date the Policy terminates.

Termination of Coverage – A Covered Person's coverage under this Rider will end on the earliest of:
1. The date the Rider terminates; or
2. The date the Covered Person's coverage ends under the Policy.

Termination of this Rider will not affect payment of benefits for any accident that occurred while the benefit was in force.

This Rider is signed for the Company at our home office to take effect on the Rider Effective Date.

Blake Bostwick
President

TRANSAMERICA LIFE INSURANCE COMPANY

WAIVER OF PREMIUM RIDER

This Rider is attached to and made part of the Policy/Certificate as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the Policy/Certificate not in conflict with the provisions of this Rider apply to this Rider. This Rider has no cash value.

DEFINITIONS

In addition to the definitions contained in the Policy/Certificate, the following definitions apply to this Rider:

Immediate Family Member means the Insured, Spouse, Child, brother, sister, mother, father, and the spouse of any of these individuals.

Physician means a person who is a practitioner of healing arts, other than an Immediate Family Member, providing services within the scope of his or her license.

Total Disability or Totally Disabled means, due to an injury or sickness, the Insured's inability to perform the material duties of his or her regular job and is unable to perform any other job for which the Insured is fit by education, training or experience.

Total Disability must begin on or after the Insured's 16th birthday and prior to the Insured's 60th birthday.

An injury must occur or sickness must manifest itself after the date the Insured's coverage under this Rider begins. Total Disability will be presumed to be total, for the purpose of determining the beginning of liability under this Rider, when it is present and has existed continuously during the Waiting Period.

We will also recognize as Total Disability the Insured's complete and irrecoverable loss of any one of the following:
1. Sight of both eyes;
2. Use of both hands or both feet;
3. Use of one hand and one foot;
4. Hearing in both ears.

Waiting Period means the consecutive period shown on the Benefit Schedule that starts on the date the Insured's Total Disability begins.

BENEFIT

Once an Insured has satisfied the Waiting Period, we will issue a Waiver of Premium credit in an amount equal to the premiums that were due, and which were paid, for the Insured's coverage during the Waiting Period, including any Dependent coverage. We will continue to issue a monthly Waiver of Premium credit for each month that the Insured continues to be Totally Disabled, subject to the Termination provisions in this Rider. You must continue to include the Totally Disabled Insured in your monthly premium calculation and then apply the credit that is issued.

No benefit will be provided that falls due:
1. More than one year prior to our receipt of a written notice of claim;
2. After the Insured's recovery from Total Disability; or
3. After the Insured's coverage under this Rider ends.

No premiums will be waived during periods of Total Disability if the Insured is not under the normal and customary care of a Physician. No premiums will be waived after the Insured ceases to be Totally Disabled. Premiums waived by us will not be deducted from the Proceeds.

CLAIMS

NOTICE AND PROOF OF LOSS - Before we waive any premium, we must receive written notice and satisfactory proof of Total Disability. The notice and proof must reach us:

1. While the Insured is living;
2. While the Insured is Totally Disabled; and
3. Not later than one year after the due date of any premium that is to be waived.

Failure to provide timely notice and proof will not invalidate a claim or cause it to be reduced if it is shown that it was not reasonably possible to give such notice and proof and that it was given as soon as was reasonably possible.

We will provide written notice advising whether the Insured is approved for the waiver benefit and, if approved, the amount of the Premium being waived.

At reasonable intervals, but not more than once every six months, we can require satisfactory proof that the Total Disability is continuing. If we do not receive this continuing proof of loss, we will stop waiving premiums. After the first two years of Total Disability, we will not ordinarily require proof more often than once a year. As part of satisfactory proof, we can require, at our expense, that the Insured be examined by a Physician of our choice. In the case of conflicting opinions, eligibility for waiver benefits shall be determined by a third medical opinion that is provided by a Physician that is mutually acceptable to the Insured and us, at our expense. The Insured has the obligation to inform us immediately if he or she is no longer Totally Disabled or returns to work.

If the Insured dies during the waiver benefit period, Proof of Loss should be submitted to us after the date of death. Proof of Loss includes supporting documentation that Total Disability continued without interruption from the date the waiver benefit started to the date of death.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the Policy, unless we inform the Policyholder in writing of a different date.

TERMINATION

Benefit Payments – Benefits under this Rider stop on the earliest of the following dates:

1. The date of the Insured's death;
2. The date the Insured's Total Disability ends;
3. The date the Insured refuses to give us proof of his or her continuing Total Disability if we have asked for it;
4. The date the Insured refuses to be examined by a Physician of our choice if asked to do so;
5. The date the Insured's coverage under this rider ends; or
6. The date the Policy ends.

When benefit payments under this Rider end, the Insured can convert his or her life insurance, and any Dependent life insurance that was in effect on the date that waiver benefits end. The Conversion provision of the Certificate describes the Conversion Option. Conversion is not available when:

1. The Insured has returned to Active Service in an eligible class and becomes insured under the policy; or
2. The Insured has already converted the life insurance or portion thereof.

Termination of Rider - This Rider will terminate on the earliest of the following dates or events:

1. The date we receive the Policyholder's request to cancel this Rider; or
2. The date the Policy terminates.

Termination of Coverage - An Insured's coverage under this Rider will end on the earliest of:

1. The Anniversary Date on or following the Insured's 60th birthday, unless the Insured is Totally Disabled prior to that date and remains Totally Disabled, in which case coverage under this Rider will end no later than the Anniversary Date on or following the Insured's 65th birthday;
2. The date the Rider terminates; or
3. The date the Insured's coverage ends under the Policy.

This Rider is signed for the Company at our home office to take effect on the Rider Effective Date.

Blake Bostwick
President

TRANSAMERICA LIFE INSURANCE COMPANY

PORTABILITY RIDER

This Rider is attached to and made part of the Policy/Certificate as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the Policy/Certificate not in conflict with the provisions of this Rider apply to this Rider. This Rider has no cash value.

DEFINITIONS

In addition to the definitions contained in the Policy/Certificate, the following definitions apply to this Rider:

Portability Plan or Portability means coverage issued under a different group term life insurance policy that has been issued specifically for, and limited to, providing portability coverage for Covered Persons whose coverage ends under an employer's plan.

WHO QUALIFIES FOR COVERAGE

A Covered Person can apply for coverage under the Portability Plan if coverage under the Policy terminates due to:
1. The Insured's employment ends;
2. The Insured's membership in an eligible class under the Policy ends;
3. The Insured's membership in a class eligible for Dependent coverage ends;
4. The Insured dies with active Dependent coverage; or
5. The Dependent no longer meets the Dependent definition.

To qualify for the Portability Plan:
1. The Insured cannot be on continuation under the Continuation Due to Total Disability provision of the Policy;
2. The Covered Person must be covered under the Policy on the day before coverage terminates under the Policy;
3. The Covered Person must be under the Age of 60 on the date Portability will take effect; and
4. The Covered Person cannot also apply for conversion under the Conversion Option provision of the Policy.

Coverage continued under this rider is in lieu of all other benefits under the Policy, including conversion, continuation, or waiver of premium.

Coverage that does not qualify for Portability may be converted as specified in the "Conversion Option" provision.

HOW TO APPLY FOR PORTABILITY

A Covered Person must apply for Portability in writing to us within 31 days after coverage under the Policy ends.

After we verify eligibility for coverage, we will issue a new certificate which describes the benefits provided and includes a conversion provision that provides the right to convert if Portability coverage ends at any time. The new certificate will be issued without Evidence of Insurability.

Portability may not be available in all states. If Portability is not allowed in the state where the Covered Person resides, coverage may be converted under the Conversion Option of the Policy.

If the Covered Person dies within 31 days after the date coverage under the Policy ends, we will pay the Proceeds as if coverage had continued under the Policy, regardless of whether or not the Covered Person had applied for Portability. Any premium paid for Portability will be refunded. In no event will we be required to pay benefits under this Portability Rider and the Conversion Option and Continuation of Coverage Due to Total Disability provisions.

WHAT BENEFITS ARE AVAILABLE

Benefit Amount – The amount of insurance a Covered Person can apply for without Evidence of Insurability cannot exceed the amount of coverage in effect on the day before coverage terminates under the Policy. Benefit amount will be rounded to the next $1,000 if not already a multiple of $1,000.

The minimum amount of insurance available under the Portability Plan is $10,000 for adults and $5,000 for Children. The maximum amount of insurance available under the Portability Plan is $1,000,000 for adults and $100,000 for Children.

Terms and Conditions – A new certificate will be issued based on the Covered Person's state of residence when the portability application is submitted. The new certificate will describe the benefits provided. The new benefits may not be the same as those that end under the Policyholder's group policy.

Rates - Rates will be based on the Covered Person's Attained Age, Tobacco Use status and benefit amount.

Riders - The only rider available under the Portability Plan will be the Accelerated Death Benefit for Terminal Illness Rider, where available. No other riders are available.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the Policy unless we inform the Policyholder in writing of a different date.

TERMINATION

Termination of Rider - This Rider will terminate on the earliest of the following dates or events:
1. The date we receive the Policyholder's request to cancel this Rider; or
2. The date the Policy terminates.

Termination of Coverage – A Covered Person's coverage under this Rider will end on the earliest of:
1. The date the Rider terminates; or
2. The date the Covered Person's coverage ends under the Policy.

This Rider is signed for the Company at our home office to take effect on the Rider Effective Date.

Blake Bostwick
President

TRANSAMERICA LIFE INSURANCE COMPANY

CONTINUATION FOR APPROVED LEAVE OF ABSENCE RIDER

This Rider is attached to and made part of the Policy/Certificate as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the Policy/Certificate not in conflict with the provisions of this Rider apply to this Rider. This Rider has no cash value.

DEFINITIONS

In addition to the definitions contained in the Policy/Certificate, the following definitions apply to this Rider:

Approved Leave of Absence means the Insured is not in Active Service for a period of time under a leave granted in writing by the Policyholder that is in accordance with the Policyholder's formal leave policies.

For purposes of this rider, the following absences are not eligible for continuation under this rider:
1. The Insured's normal vacation time;
2. The Insured's paid sick leave;
3. Any time period for which coverage is being continued under the Continuation Due to Total Disability provision;
4. Any time period for which the premium is being waived due to the Insured's Total Disability, if included in the Policy; or
5. Any leave the Policyholder determines as not being eligible for continuation under this rider.

BENEFIT AND COST

If an Insured is not in Active Service due to an Approved Leave of Absence for which the Policyholder has determined as eligible for continuation under this rider, coverage can be continued for up to the Maximum Benefit Period shown on the Benefit Schedule, including Dependent coverage, if any. During this continuation period, the amount of coverage will be the same as it would be if the Insured were in Active Service.

The Insured must fill out any paperwork required by the Policyholder for a leave of absence. The Policyholder will determine eligibility and the terms, conditions and cost for continuation of coverage during an Approved Leave of Absence. The Insured must pay any required premium to the Policyholder to keep coverage in force.

Continuation will end on the earliest of:
1. The end of the continuation period as indicated above;
2. The date the Insured returns to Active Service;
3. The end of the period for which Premiums are paid if the next Premium is not paid by its due date, subject to the Grace Period;
4. The date the Insured becomes covered under another group term life insurance policy as an employee or member;
5. The date premiums begin being waived under the Waiver of Premium Benefit Rider, if part of this Policy;
6. The date this rider terminates; or
7. The date the Policy terminates.

If the insured resumes Active Service in an eligible class when continuation under this rider ends, the Insured's coverage will continue under the Policy. If the Insured is no longer eligible for coverage under the Policy when continuation under this rider ends, coverage under the Policy (including Dependent coverage) will end and may be converted as specified in the "Conversion Option" provision.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the Policy unless we inform the Policyholder in writing of a different date.

TERMINATION

Termination of Rider - This Rider will terminate on the earliest of the following dates or events:
1. The date we receive the Policyholder's request to cancel this Rider; or
2. The date the Policy terminates.

Termination of Coverage – A Covered Person's coverage under this Rider will end on the earliest of:
1. The date the Rider terminates; or
2. The date the Covered Person's coverage ends under the Policy.

This Rider is signed for the Company at our home office to take effect on the Rider Effective Date.

Blake Bostwick
President

TRANSAMERICA LIFE INSURANCE COMPANY

CHANGE OF INSURANCE CARRIERS

This Rider is attached to and made part of the Policy/Certificate as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the Policy/Certificate not in conflict with the provisions of this Rider apply to this Rider. This Rider has no cash value.

DEFINITIONS

In addition to the definitions contained in the Policy/Certificate, the following definitions apply to this Rider:

Prior Policy means a group term life insurance policy issued by another insurance carrier that is being replaced by our Policy. The Prior Policy must have been in effect the day immediately prior to our Policy Effective Date.

CONTINUITY OF COVERAGE (LIMITED COVERAGE)

We will provide continuity of coverage under our Policy to any employee who meets the criteria below and is specifically named by the Policyholder and approved by us to be issued a specified amount of coverage for a specified period of time. The amount of coverage cannot exceed the amount of coverage the employee would have under the Prior Policy had it remained in force or the amount of coverage the employee is eligible for under our Policy, whichever is less. Benefits paid under our Policy will be reduced by any amount paid under the Prior Policy. Premium must be paid for coverage under this Rider to become effective and to remain in force.

Employees are eligible for continuity of coverage if all of the following are true on the Policy Effective Date:
1. The employee meets the definition of an Eligible Person, except for the Active Service requirement;
2. The employee is not in Active Service due to sickness or injury other than Total Disability and
3. The employee was covered under the Prior Policy on the day immediately prior to the Policy Effective Date.

Continuity of coverage is not available on an employee if any of the following are true:
a. The employee's coverage is being continued under a waiver or premium or similar provision of the Prior Policy;
b. The employee's coverage is being continued under a continuation or portability provision of the Prior Policy;
c. The employee converted, or was eligible to convert coverage with the prior insurance carrier; or
d. The employee is not in Active Service due to reasons other than stated in item 2 above.

Limited coverage issued under this Rider will begin on the Policy Effective Date and will continue until the earliest of:
a. The date the specified period of time approved by us has expired;
b. The date the employee returns to Active Service;
c. The date the employee's employment terminates; or
d. The date coverage would otherwise terminate under our Policy.

If the employee returns to Active Service in an eligible class, coverage will continue under the Policy. If the employee is no longer eligible for coverage under the Policy when the limited coverage ends, coverage may be converted as specified in the "Conversion Option" provision of the Policy.

RIDER EFFECTIVE DATE

This Rider is only available when the Policy is initially issued and becomes effective on the same date as the Policy.

TERMINATION

Termination of Rider - This Rider will terminate on the earliest of the following dates or events:

1. The date the limited coverage has ended for all employees covered under this Rider; or
2. The date the Policy terminates.

This Rider is signed for the Company at our home office to take effect on the Rider Effective Date.

Blake Bostwick
President

Employee Assistance Program (EAP)

This section will explain the benefit and features of the Employee Assistance Program (EAP). This program was put into place to help you and your dependents in times of personal, financial, family or work concern.

Wayne County Commissioners

Employee Assistance Program (EAP)

www.guidanceresources.com

As a Wayne County employee and/or as a member of the Wayne County Health Insurance Plan, you have an added benefit of having an Employee Assistance Program (EAP).

An Employee Assistance Program (EAP) is a service that your employer provides to help you and your dependents in the time of personal, financial, family or work stress. Anything you talk about with the counselor/therapist is confidential, just like seeing a doctor. Unless you sign a release of information, nothing can be shared with anyone else.

YOU DO NOT NEED TO CARRY OTHER BENEFIT PLANS TO RECEIVE THIS BENEFIT!

Wayne County has contracted with a counseling firm, which covers six (6) sessions of individual or couples counseling per year for each employee per issue. If you have a spouse who lives with you, they are also covered. Your children, depending on their age, may also be covered. You and/or your dependents may also qualify for sessions under the Medical Plan; however, please check your medical SPD as those benefits may be subject to copays.

What kind of problems could you bring to the EAP? Basically, anything that is bothering you. Some examples are:

- ☐ Problems at home that are making it difficult to do your job.
- ☐ Concerns about work that make it difficult to leave it at work.
- ☐ Not getting along with co-workers or supervisors.
- ☐ Anxiety or depression and not sure what to do about these feelings.
- ☐ Concerns about your use of drugs and/or alcohol.
- ☐ And the list can go on and on.

The EAP program also offers your employer with assistance for management and supervisory issues. These would be times when your employer may mandate that you come in and meet with the counselor/therapist to discuss problems such as attendance or difficulties in doing your job.

To make an appointment, call the below number and let them know you are a Wayne County employee and would like to make an appointment **for EAP Services**. They work very hard to make sure you are the only Wayne County employee in the waiting room, so you can go there confidentially. They will not even tell your employer you are seeing them, unless you give permission or are mandated to attend.

CONTACT INFORMATION IS AS FOLLOWS:

ComPsych GuidanceResources

Phone:	877-936-7327
TDD:	800-697-0353
Website:	www.guidanceresources.com
Web ID:	OUREAP

Call ComPsych® GuidanceResources® anytime for confidential assistance.

Call: **877.936.7327**
Go online: **guidanceresources.com**
TDD: **800.697.0353**
Your company Web ID: **OUREAP**

Personal issues, planning for life events or simply managing daily life can affect your work, health and family. ComPsych® GuidanceResources® provides support, resources and information for personal and work-life issues. GuidanceResources is company-sponsored, confidential and provided at no charge to you and your dependents. This flyer explains how GuidanceResources can help you and your family deal with everyday challenges.

Confidential Counseling

Someone to talk to.

This no-cost counseling service helps you address stress, relationship and other personal issues you and your family may face. It is staffed by GuidanceConsultants℠—highly trained master's and doctoral level clinicians who will listen to your concerns and quickly refer you to in-person counseling and other resources for:

- Stress, anxiety and depression
- Relationship/marital conflicts
- Problems with children
- Job pressures
- Grief and loss
- Substance abuse

Financial Information and Resources

Discover your best options.

Speak by phone with our Certified Public Accountants and Certified Financial Planners on a wide range of financial issues, including:

- Getting out of debt
- Credit card or loan problems
- Tax questions
- Retirement planning
- Estate planning
- Saving for college

Legal Support and Resources

Expert info when you need it.

Talk to our attorneys by phone. If you require representation, we'll refer you to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call about:

- Divorce and family law
- Debt and bankruptcy
- Landlord/tenant issues
- Real estate transactions
- Civil and criminal actions
- Contracts

Work-Life Solutions

Delegate your "to-do" list.

Our Work-Life specialists will do the research for you, providing qualified referrals and customized resources for:

- Child and elder care
- Moving and relocation
- Making major purchases
- College planning
- Pet care
- Home repair

GuidanceResources® Online

Knowledge at your fingertips.

GuidanceResources Online is your one stop for expert information on the issues that matter most to you... relationships, work, school, children, wellness, legal, financial, free time and more.

- Timely articles, HelpSheets℠, tutorials, streaming videos and self-assessments
- "Ask the Expert" personal responses to your questions
- Child care, elder care, attorney and financial planner searches

Just call or click to access your services.

WAYNE COUNTY OHIO

Annual Information

- Discounts Available to Employees
- Notice to Plan Participants
- Notice Regarding Prescriptions and Medicare
- Notice of Special Enrollment
- Women's Health and Cancer Rights Act
- Notice Regarding Wellness Program
- Health Insurance Marketplace Coverage Options
- Summary of Benefit Coverage

Wayne County Commissioners

Discounts Available To Employees

Some of these discounts overlap, so please look for your best deal. Below is a description of the discounts available:

ComPsych/Working Advantage

This is available to all full-time Wayne County and sub-group employees. ComPsych, our EAP provider, offers a variety of online discounts to hotels, theme parks and attractions, movies, shows and events, water parks, rental cars and more. You will need to visit the following web page and register, in order to receive discounts and savings: https://www.workingadvantage.com/GuidanceResources

Cleveland Playhouse Square

This is available to all Wayne County and sub-group employees. Purchase tickets before the general public and receive discounts to select shows at https://tickets.playhousesquare.org/G04. Click on the link under "How to Purchase Your Tickets" and use the promotion code WAYNECOUNTYOH.

Dunham Sports

This is available to all Wayne County and sub-group employees. Text "WAYNE" to 78557 or download the flyer from wayneohio.org/employee-discounts and show it at the register to receive a discount.

Akron RubberDucks

This is available to all Wayne County and sub-group employees. Each year in July employees have the opportunity to purchase discounted tickets to an Akron RubberDucks baseball game (specific date is announced each year). Also, one lucky person will be chosen to throw a ball from the pitcher's mound! Information will be emailed to your Appointing Authority or supervisor, so please check with them in May or June if they haven't forwarded an email to you regarding this fun event!

Visit https://www.wayneohio.org/employee-portal/employee-discounts/ in order to see additional discounts available to employees. Note that some discounts are also available to part-time employees and those not on the health plan.

Updated 1/1/2024

OFFICE OF THE
WAYNE COUNTY
COMMISSIONERS
Ron Amstutz ★ Jonathan Hofstetter ★ Sue A. Smail

NOTICE TO WAYNE COUNTY EMPLOYEE BENEFIT PLAN PARTICIPANTS

October 1, 2023

The Federal Health Insurance Portability and Accountability Act, in general, impose the following requirements and/or limitations on group health plans:

1. Limitations on pre-existing conditions exclusion periods (146.111).
2. Special enrollment periods for individuals (and dependents) losing other coverage (146.117).
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status (146.121).
4. Standards relating to benefits for mothers and newborns (Section 2704 of the PHS Act).
5. Parity in the application of certain limits to mental health benefits (Section 2705 of the PHS Act).
6. Required coverage for reconstructive surgery following mastectomies
7. Coverage of dependent students on a medically necessary leave of absence

The Federal Health Insurance Portability and Accountability Act gives the plan sponsor of a non-Federal governmental plan the right to exempt the plan in whole or in part from the requirements described above. As of January 1, 2014 we are no longer eligible to exempt our plan from items 1 thru 3 above.

The Wayne County Employee Benefit Plan has elected to exempt all of its Medical, Dental and Prescription plans from item numbers 4 thru 7 above. Wayne County currently provides, and plans to continue to provide, benefits as good, or better, than required for these categories; but in order to protect ourselves from future amendments of these provisions, we are electing to opt out of the requirement to provide these items. These exemptions have been sent to the Health Care Financing Administration (HCFA) for the Wayne County Employee Benefit Plans.

Recent legislation collectively known as Federal Health Care Reform may affect our ability to exempt some or parts of some of the above items. We are sending you this notice to let you know that where we still have authority to exempt the above items, we have exercised our right to do so.

THIS LETTER DOES NOT REQUIRE ANY ACTION ON YOUR PART. If you have any questions about this notice, please contact the following:

The Wayne County Benefit Plan
Attention: The Plan Administrator
428 West Liberty Street
Wooster, Ohio 44691

Important Notice from Wayne County Employee Benefit Plan About Your Prescription Drug Coverage and Medicare

10/1/2023

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Wayne County Employee Benefit Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Wayne County Employee Benefit Plan has determined that the prescription drug coverage offered by all of our plans are on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Wayne County Employee Benefit Plan coverage will not be affected. If you are a covered employee in one of our plans we will be primary in most cases to any Medicare coverage you elect.

If you do decide to join a Medicare drug plan and drop your current Wayne County Employee Benefit Plan coverage, be aware that you and your dependents may or may not be able to get this coverage back depending on the circumstances at that time.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with The Wayne County Employee Benefit Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact the Wayne County HR Director at (330) 287-5409. NOTE: You'll get this notice each year. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare if you are eligible for Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- ☐ Visit www.medicare.gov
- ☐ Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- ☐ Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember!

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Special Enrollment Notice

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides employees additional opportunities to enroll in a group health plan if they experience a loss of other coverage or certain life events.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, please contact your payroll person or Marcy Stoller, Benefits Specialist at 330-287-5410 or mstoller@wayneohio.org.

https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-c.pdf

Updated 10/7/2022

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please contact Misty White, Wellness Nurse at 330-287-5487 or wellnessnurse@wayneohio.org.

Updated 10/7/2022

Notice Regarding Wellness Program

The **Health First Wellness Incentive Program** is a voluntary wellness program available to all employees on the Wayne County Health Plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to earn points each year by participating in certain activities, and also complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for current lipid panel numbers, blood sugar number, and your current blood pressure reading. This is to determine your risk for high cholesterol, high blood pressure and diabetes. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of lower deductibles, lower coinsurance and lower copays. Although you are not required to earn points, complete the HRA, or participate in the biometric screening, only employees who do so will receive lower deductibles, lower coinsurance and lower copays.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as wellness programs to keep you healthy, periodic check-ins to stay on top of your health condition (such as high blood pressure), physicals or other services offered at the Employee Health Clinic by either the Wellness Nurse or the Nurse Practitioner. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although Wayne County and the Health First Wellness Incentive Program may use aggregate information it collects to design a program based on identified health risks in the workplace, the Employee Health Clinic and/or the Health First Wellness Incentive Program, including any of its employees, will never disclose any of your personal information either publicly or to Wayne County as the employer, except as necessary to respond to a request from you or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the Employee Health Clinic and/or the Health First Wellness Incentive Program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Health First Wellness Incentive Program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the Health First Wellness Incentive Program. Anyone who receives your information for purposes of providing you services as part of the Health First Wellness Incentive Program will abide by the same confidentiality requirements. The only individuals who will receive your personally identifiable health information are the Nurse Practitioner, the Wellness Nurse and the Receptionist, all who work within the Employee Health Clinic, in order to provide you with services under the Health First Wellness Incentive Program.

In addition, all medical information obtained through the Employee Health Clinic and/or the Health First Wellness Incentive Program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the Health First Wellness Incentive Program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the Health First Wellness Incentive Program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the Health First Wellness Incentive Program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Barb Winey, HR Director at 330-287-5409 or bwiney@wayneohio.org.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 9-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Wayne County Benefits Administrator 330-287-5410

.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

---

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Wayne County	34-6003005
5. Employer address	6. Employer phone number
428 W Liberty Street	330-287-5400

7. City	8. State	9. ZIP code
Wooster	OH	44691

10. Who can we contact about employee health coverage at this job?	
Wayne County Benefits Administrator	
11. Phone number (if different from above)	12. Email address
	commissioners@wayneohio.org

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☑ Some employees. Eligible employees are:

All employees who are paid an average of 30 hours per week or more and are employed full time. This applies to employees of Wayne County. Employees of different appointing authorities need to check with their supervisors for their eligibility for the benefit plan.

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

Please see our Medical Summary Plan Description for complete details on dependent coverage.

☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

THIS IS A SAMPLE! Please consult your Payroll Department to complete this page.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 368(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Summary of Benefit Coverage

Current Plan Year:

This is only a recap of Wayne County plan design: For further details about coverage and costs, please refer to the Summary Plan Description (SPD) or contact our HR Director at 330-287-5409.

IMPORTANT QUESTIONS	ANSWERS			WHY THIS MATTERS
	Low-Deductible With Incentive	**Low-Deductible Without Incentive**	**High-Deductible Consumer Driven**	
What is the overall deductible?	For each Calendar Year, In-network: Individual $500 / Family $1,000 Out-of-network: Individual $1,000 / Family $2,000	For each Calendar Year, In-network: Individual $1,000 / Family $2,000 Out-of-network: Individual $1,500 / Family $3,000	For each Calendar Year, In-network: Individual $1,800 / Family $3,600 Individual within Family $3,200 Out-of-network: Individual $1,800 / Family $3,600 Individual within Family $3,200	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes, in-network preventative charges are covered 100%	Yes, in-network preventative charges are covered 100%	Yes, in-network preventative charges are covered 100%	
Are there other deductibles for specific services?	No	No	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	In-network: Individual $1,500 / Family $3,000; Out-of-network: Individual $3,000 / Family $6,000	In-network: Individual $3,000 / Family $6,000; Out-of-network: Individual $4,500 / Family $9,000	In-network: Individual $5,000 / Family $10,000; Out-of-network: Individual $10,000 / Family $20,000	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for services	Premiums, copays, balance-billed charges, penalties for failure to obtain pre-authorization	Premiums, copays, balance-billed charges, penalties for failure to obtain pre-authorization	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

	and health care this plan doesn't cover	for services and health care this plan doesn't cover	for services and health care this plan doesn't cover	
IMPORTANT QUESTIONS	**ANSWERS**			**WHY THIS MATTERS**
	With Incentive	**Without Incentive**	**High Deductible**	
Will you pay less if you use a network provider?	Yes. For a list of in-network providers, see www.cigna.com or call 1-800-244-6224	Yes. For a list of in-network providers, see www.cigna.com or call 1-800-244-6224	Yes. For a list of in-network providers, see www.cigna.com or call 1-800-244-6224	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist	No. You don't need a referral to see a specialist	No. You don't need a referral to see a specialist	You can see the specialist you choose without permission from this plan
Are there services this plan doesn't cover?	Yes	Yes	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services

- ☐ **Copayments** are fixed dollar amounts (for example, $20) you pay for covered health care, usually when you receive the service.
- ☐ **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- ☐ The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- ☐ This plan may encourage you to use in-network providers by charging you lower deductibles, copayments, and coinsurance amounts.

Common Medical Event	**Services You May Need**	**Retail** (30-day supply)	**Mail** (90-day supply)	**Limitations & Exceptions**
If you need drugs to treat your illness or condition, more information about prescription drug coverage is available at www.cigna.com	Generic drugs	12 %	15% up to a $20 maximum	Some medications may not be covered, or you may pay more if you choose a brand name over a generic if available.
	Preferred brand drugs	30%	30% up to a $120 maximum	
	Non-preferred brand drugs	50%	50% up to a $180 maximum	*Note that this maximum amount does not include any DAW (Dispense as Written) penalty for filling a Non-Preferred brand that has a Generic available.*
	Specialty drugs	Under Prudent Rx Program, $0 copay for eligible specialty prescriptions. If you opt out of the program, 30% co-insurance charge up to your Maximum Out of Pocket for eligible specialty prescriptions,		
	Out-of-Pocket Maximum (OOP) On Low-Ded plan with incentive	$2,000 Maximum Out-of-Pocket per Individual for all drugs (Low-Ded Plan – this is separate from Medical OOP) $4,000 Maximum Out-of-Pocket per Family for all drugs (Low-Ded Plan – this is separate from Medical OOP)		
	Out-of-Pocket Maximum	$3,000 Maximum Out-of-Pocket per Individual for all drugs (Low-Ded Plan – this is separate from Medical OOP)		

	(OOP) On Low-Ded plan without incentive	$6,000 Maximum Out-of-Pocket per Family for all drugs (Low-Ded Plan – this is separate from Medical OOP) For those on the High Deductible Plan, prescription costs go towards the *Medical* Out-of-Pocket Maximum

Updated 10/7/2022

Common Medical Event	Services You May Need	Your Cost if you use an In-Network Provider			Your Cost if you use an Out-Of-Network Provider			Limitations & Exceptions
		With Incentive	Without Incentive	High Deductible	With Incentive	Without Incentive	High Deductible	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit, deductible waived	$40 copay per visit	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	Coverage is limited to 20 visits per calendar year for chiropractic care
	Specialist visit	$40 copay per visit, deductible waived	$80 copay per visit	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
	Preventive care/screening/immunization	No charge, deductible waived	No charge	No charge, deductible waived	40% coinsurance	40% coinsurance	35% coinsurance	Age and frequency schedules may apply
If you have a test	Diagnostic test (blood work)	$40 copay per visit	$80 copay per visit	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
	Imaging (CT/PET scan, MRI, x-ray)	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
	Physician/surgeon fees	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
If you need immediate medical attention	Emergency room services	$150 copay per visit	$300 copay per visit	15% coinsurance	$150 copay per visit	$300 copay per visit	35% coinsurance	No coverage for non-emergency use
	Emergency medical transportation	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
	Urgent care	$20 copay per visit	$40 copay per visit	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	Pre-authorization required for out-of-network care or $500 penalty may apply.
	Physician/surgeon fee	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
If you are pregnant	Prenatal and postnatal care	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None

	Delivery and all inpatient services	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None

Whenever you pay a co-insurance, you usually have to pay your deductible first before your co-insurance is calculated.

Updated 10/7/2022

Common Medical Event	Services You May Need	Your Cost if you use an In-Network Provider			Your Cost if you use an Out-Of-Network Provider			Limitations & Exceptions
		With Incentive	Without Incentive	High Deductible	With Incentive	Without Incentive	High Deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral Health or Substance Use Disorder Office Visits	$20 copay per visit, deductible waived	$40 copay per visit	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
	Mental/Behavioral Health or Substance Use Disorder Inpatient Services	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	Coverage is limited to 30 days per calendar year in-network and 10 days per calendar year out-of-network. Pre-authorization required for out-of-network care or $500 penalty may apply.
	Mental/Behavioral Health or Substance Use Disorder Outpatient Services	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	Coverage is limited to 50 visits per calendar year in-network and 20 visits per calendar year out-of-network.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	Coverage is limited to 30 visits per calendar year.
	Rehabilitation services	$40 copay per visit	$80 copay per visit	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	Coverage is limited to 30 visits for physical therapy and 20 visits each for occupational therapy and speech therapy.
	Habilitation services	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Services for Autism coverage is limited to 30 visits for physical therapy and 20 visits each for occupational and speech therapy.
	Skilled nursing care	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	Coverage is limited to 180 days per calendar year. Pre-authorization required for out-of-network care or $500 penalty may apply.
	Durable medical equipment	20% coinsurance	30% coinsurance	15% coinsurance	40% coinsurance	40% coinsurance	35% coinsurance	None
	Hospice service	No charge, deductible waived	No charge, deductible waived	15% coinsurance	No charge, deductible waived	No charge, deductible waived	35% coinsurance	Coverage is limited to 360 days per lifetime. Pre-authorization required for out-of-network care or $500 penalty may apply.

If your child needs dental or eye care	Eye exam							VSP, see Vision SPD
	Glasses							
	Dental check-up							Delta, see Dental SPD
Whenever you pay a co-insurance, you usually have to pay your deductible first before your co-insurance is calculated.								

Services Your Plan Does Not Cover

This isn't a complete list. Check your policy or plan document for other excluded services.

- ☐ Acupuncture
- ☐ Bariatric Surgery
- ☐ Cosmetic Surgery
- ☐ Dental Care (Adult)
- ☐ Dental Care (Child)
- ☐ Glasses (Child)
- ☐ Habilitation Services
- ☐ Long-Term Care
- ☐ Private-Duty Nursing
- ☐ Routine Eye Care (Adult)
- ☐ Routine Eye Care (Child)
- ☐ Routine Foot Care
- ☐ Weight Loss Programs

Other Covered Services

This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.

- ☐ Chiropractic Care (limited to 20 visits per calendar year)
- ☐ Hearing Aids (limited to $2,000 over a 3 year period)
- ☐ Infertility Treatment (diagnosis & treatment of underlying medical condition only)
- ☐ Non-Emergency Care when traveling outside the U.S.

Your Rights to Continue Coverage

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-244-6224. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights

- ☐ **Medical/Prescription:** If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Cigna at 1-800-244-6224, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), www.dol.gov/ebsa/healthreform; or Wayne County HR Director, 330-287-5409. Additionally, Cigna's website can give you steps to file an appeal. Information is at https://www.cigna.com/health-care-providers/coverage-and-claims/appeals-disputes/how-to-submit.
- ☐ **Dental:** If you receive notice of an Adverse Benefit Determination and you think that Delta Dental incorrectly denied all or part of your Claim, you or your Dentist may contact Delta Dental's Customer Service department and ask them to reconsider the Claim to make sure it was processed correctly. You may do this by calling the toll-free number, 800-524-0149, and speaking to a telephone advisor. For further and more detailed information on this process, please refer to the *Claims Appeal Procedure* on page 21 behind Tab 4.

Does this plan provide Minimum Essential Coverage?

- ✔ **Yes.**

Does this plan meet the Minimum Value Standards?

- ✔ **Yes.**

Coverage Examples

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans. Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be difference from these examples, and the cost of that care will also be different. See the next page for important information about these examples. **These are examples only and not reflective of our actual plan.**

Having a baby (9 months of in-network pre-natal care and a hospital delivery)				**Managing Type 2 diabetes** (in-network routine maintenance of a well-controlled condition)				**Simple Fracture** (in-network emergency room visit and follow up care)			
Plan's Overall Deductible	$500	$1,000	$1,800	**Plan's Overall Deductible**	$500	$1,000	$1,800	**Plan's Overall Deductible**	$500	$1,000	$1,800
Specialist Visit	$40 copay	$80 copay	85% covered*	**Primary Care Visit**	$20 copay	$40 copay	85% covered*	**Specialist Visit**	$40 copay	$80 copay	85% covered*
Hospital (facility) *After Deductible	80% covered*	70% covered*	85% covered*	**Hospital (facility)**	80% covered*	70% covered*	85% covered*	**Hospital (facility)**	80% covered*	70% covered*	85% covered*
Specialist office visits (prenatal care)				Primary care physician (office visits)	$500.00 (5)	$500.00 (5)	$500.00 (5)	Emergency Room Visit	$1,200.00	$1,200.00	$1,200.00
Childbirth/ delivery Professional Services	$1,857.15	$1,857.15	$1,857.15	Diagnostic Tests (blood work)	$1,200.00	$1,200.00	$1,200.00	Diagnostic Test (x-ray)	$500.00	$500.00	$500.00
Childbirth/ delivery Facility Services	$8,142.85	$8,142.85	$8,142.85	Prescription Drugs	$1,800.00	$1,800.00	$1,800.00	Durable medical equipment (crutches)	$500.00	$500.00	$500.00
Diagnostic Tests (ultrasounds and bloodwork)	$1,500.00	$1,500.00	$1,500.00	Durable medical equipment (glucose meter)	$2,100.00	$2,100.00	$2,100.00	Rehabilitation services (physical therapy)	$600.00 (6)	$600.00 (6)	$600.00 (6)
Specialist visit (anesthesia)	$1,180.00	$1,180.00	$1,180.00	Vaccines, other preventive	0	0	0				
Total owed to providers	**$12,680**	**$12,680**	**$12,680**	**Total owed to providers**	**$5,600**	**$5,600**	**$5,600**	**Total owed to providers**	**$2,800**	**$2,800**	**$2,800**
Patient pays:	Low-Ded **With Incentive**	Low-Ded **Without Incentive**	**High-Ded**	**Patient pays:**	Low-Ded **With Incentive**	Low-Ded **Without Incentive**	**High-Ded**	**Patient pays:**	Low-Ded **With Incentive**	Low-Ded **Without Incentive**	**High-Ded**
Deductibles	$500.00	$1,000.00	$1,800.00	Deductibles	$500.00	$1,000.00	$1,800.00	Deductibles	$500.00	$1,000.00	$1,800.00
Copays	$0.00	$0.00	n/a	Copays	$100.00	$200.00	n/a	Copays	$390.00	$780.00	N/A
Coinsurance	$1,000.00	$2,000.00	$1,632.00	Coinsurance	$900.00	$1,320.00	$570.00	Coinsurance	$100.00	$0.00	$150.00
Limits or exclusions (not covered)	n/a	n/a	n/a	Limits or exclusions (not covered)	n/a	n/a	n/a	Limits or exclusions (not covered)	n/a	n/a	n/a
Maximum out of pocket met?	YES	YES	NO	Maximum out of pocket met?	YES	NO	NO	Maximum out of pocket met?	NO	NO	NO
Total Patient pays	**$1,500**	**$3,000**	**$3,432**	**Total Patient pays**	**$1,500**	**$2,520**	**$2,370**	**Total Patient Pays**	**$990**	**$1,780**	**$1,950**
Total Plan pays	**$11,180**	**$9,700**	**$9,248**	**Total Plan pays**	**$4,400**	**$3,640**	**$3,230**	**Total Plan Pays**	**$1,810**	**$1,020**	**$850**

Updated 10/7/2022

Questions and Answers about the Coverage Examples

What are some of the assumptions behind the Coverage Examples?

- ☐ Costs don't include premiums
- ☐ Sample care costs are based on national averages supplies by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- ☐ The patient's condition was not an excluded or preexisting condition.
- ☐ All services and treatments started and ended in the same coverage period.
- ☐ There are no other medical expenses for any member covered under this plan.
- ☐ Out-of-pocket expenses are based only on treating the condition in the example.
- ☐ The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.