

**OHIO NORTHERN UNIVERSITY
EMPLOYEE BENEFIT PLAN**



OHIO NORTHERN UNIVERSITY

EFFECTIVE JANUARY 1, 2007

This booklet is a Summary Plan Description. It is intended to explain the benefits provided by the Ohio Northern University Employee Benefit Plan. It does not constitute the Plan. All rights and benefits are determined in accordance with the provisions of the Plan, and coverage is effective only if the covered person is eligible for coverage and becomes and remains covered in accordance with the terms of this Plan.

The benefits described in this Plan replace the coverage or benefits described in all booklets or amendments previously issued by Ohio Northern University that describe similar types of benefits.

To avoid dual references throughout this booklet, masculine pronouns such as *he*, *him*, and *his* will include the feminine gender as well for purpose of benefits and provisions of the plan.

Capitalization of the first letter of a word or phrase not normally capitalized according to the rules of standard punctuation (e.g., Surgery), with the exception of some job titles, company or agency names, certain types of coverage and references to specific sections of this Summary Plan Description, indicates a word or phrase that is defined in the “Definitions” section, or that refers to an item in the Schedule of Benefits.

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INTRODUCTION TO MANAGED CARE

This booklet explains in detail the benefits and other provisions of the Ohio Northern University Employee Benefit Plan as revised effective January 1, 2007.

Two deductible options are available for medical coverage and both options permit In-Network or Out-of-Network care.

NETWORK PPO (PREFERRED PROVIDER ORGANIZATION)

The Plan has contracted with a Network of preferred provider Hospitals and Physicians to provide care at discounted rates. The Plan provides incentives for you to use in-network providers through benefit differential in the Calendar Year Deductible, Out-of-Pocket maximums and benefit percentages. Consult the Network website or toll free telephone number shown on your medical identification card.

Covered retirees residing outside of the defined Network service area may choose an out-of-area option which will pay benefits at 75% and benefits will apply to the In-Network out-of-pocket maximum. (See the "Retirement" Section under "Employment Related Events Affecting Coverage.")

When urgent medical care is required while traveling on business or on vacation outside the defined Network area, the In-Network benefit may be payable upon review of a written request to the Claims Administrator.

PRE-CERTIFICATION AND UTILIZATION REVIEW

The Plan uses the services of Alternative Care Management Systems, Inc. (ACMS) to provide the required pre-certification and utilization review services to the Plan.

The Patient Services Center is the operations center of ACMS. It is staffed by nurses and other support personnel who work closely with Covered Persons and their Physicians in the delivery of healthcare services.

The Covered Person, a friend, a relative or the Covered Person's medical provider may contact the ACMS Patient Services Center. ACMS will also certify the length of the Hospital stay, as each day of confinement must be medically necessary. ACMS certification, however, is not a benefit determination and questions regarding benefit payment should be directed to the Claims Administrator.

This Plan requires notification to the ACMS Patient Services Center for:

- **Inpatient hospital admissions (Failure to do so will result in a benefit reduction of \$300 for that admission.)**
- **Outpatient treatment of mental illness, nervous disorders, alcoholism and drug dependency. (Failure to do so will result in a benefit reduction to 50%.)**

ACMS should also be contacted for:

- **Skilled nursing facility care**
- **Hospice**
- **Home health care.**

The toll-free telephone number for ACMS is: 1-877-304-0761

ACMS office hours are 8:00 a.m. to 5:00 p.m. Eastern Time, Monday through Friday. An answering system will take messages during the hours when ACMS is closed.

CASE MANAGEMENT

ACMS also performs Case Management services for the Plan. Case Management applies if the nature of a patient's condition is, or is expected to become catastrophic or chronic, or when the cost of treatment is expected to be significant.

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

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

DIABETES MANAGEMENT PROGRAM

Ohio Northern University offers a Diabetic Management Program to assist employees and their families in the management of this chronic condition. If a Covered Person participates in the Program, certain benefits related to the condition may be paid at an increased benefit percentage, or items normally not covered by the Plan may be covered if included as part of the Diabetic Management Program. Participation in the program is voluntary and the participant's privacy is protected at all times. **Additional information about the Program is available by contacting ACMS at 1-877-304-0761.**

CLAIMS ADMINISTRATION

The Plan's Claims Administrator is:

Employee Benefit Management Corp. (EBMC)
4789 Rings Road
Dublin, Ohio 43017-1599
1-877-304-0761 (Toll-Free, Outside Columbus)
Website: www.ebmconline.com

Claims should be submitted as directed on the Covered Person's Plan identification card. A Customer Service Representative is available at EBMC Monday through Friday during normal business hours. Claims information may also be obtained at EBMC's Website.

SCHEDULE OF BENEFITS

Effective January 1, 2007

(Eligible Employee and Dependents)

COMPREHENSIVE MEDICAL EXPENSE BENEFITS

ALL BENEFIT CONSIDERATION OF THE PLAN ARE SUBJECT TO THE USUAL, CUSTOMARY, AND REASONABLE (UCR) ALLOWANCE AND MEDICALLY NECESSARY PROVISIONS OF THE PLAN.

OVERALL LIFETIME MAXIMUM BENEFIT PER COVERED PERSON.....\$2,000,000
Alcoholism & Drug Dependency Care Lifetime Maximum Outpatient Benefit per Covered Person\$25,000

CALENDAR YEAR MAXIMUM BENEFITS PER COVERED PERSON

For Inpatient Mental Illness, Nervous Disorders, Alcoholism and Drug Dependency Care 30 Days
For Outpatient Mental Illness, Nervous Disorders, Alcoholism and Drug Dependency Care 50 visits
For Outpatient Physical/Occupational Therapy.....\$5,000

OPTION A

OPTION B

IN-
NETWORK

OUT-OF-
NETWORK

IN-
NETWORK

OUT-OF-
NETWORK

CALENDAR YEAR DEDUCTIBLE

Per Covered Person	\$400.....	\$500.....	Per Single \$1,100.....	\$1,500
Per Covered Family	\$800.....	1,000.....	Per Family \$2,200.....	\$3,000

Note: Under Plan B, an employee with single coverage will be subject to the Single deductible. If an employee has a spouse and/or children enrolled, all claims are subject to the Family deductible.

SCHEDULE OF BENEFITS - Continued

	<u>OPTION A</u>		<u>OPTION B</u>	
	<u>IN- NETWORK</u>	<u>OUT-OF- NETWORK</u>	<u>IN- NETWORK</u>	<u>OUT-OF- NETWORK</u>
MAXIMUM OUT-OF-POCKET PER CALENDAR YEAR (See "Notes" on Page 4)				
Includes the Calendar Year Deductible				
Per Covered Person.....	\$1,000	\$2,500	\$2,500	\$5,000
Per Covered Family	\$2,000	\$5,000	\$5,000	\$10,000

Note: The In-Network and Out-of-Network Calendar Year Deductibles and Out-of-Pocket Maximums will be combined.

HOSPITAL EXPENSE BENEFIT

Inpatient Expenses (Benefit reduction of \$300 will apply if ACMS is not notified as required.)

Medically Necessary Room, Board and Miscellaneous Expenses	90%	60%	90%	60%
Mental Health, Substance Abuse Limit per Calendar Year – 30 days				

Outpatient Expenses

Surgical Facilities	90%	60%	90%	60%
Pre-Admission Testing	90%	60%	90%	60%
Physical Therapy	90%	60%	90%	60%
All Other Covered Hospital Outpatient Expenses	90%	60%	90%	60%

EMERGENCY ROOM EXPENSE BENEFIT

Facility Expenses	\$50 Co-Pay	\$50 Co-Pay	90%	Same as
	per visit,	per visit,		In-Network
	then 100%	then 100%		
Physician Expenses	100%	Same as	90%	Same as
		In-Network		In- Network

SKILLED NURSING FACILITY EXPENSE BENEFIT	75%	Same as	75%	Same as
		In-Network		In Network

SCHEDULE OF BENEFITS - Continued

	<u>OPTION A</u>		<u>OPTION B</u>	
	<u>IN- NETWORK</u>	<u>OUT-OF- NETWORK</u>	<u>IN- NETWORK</u>	<u>OUT-OF- NETWORK</u>
HOSPICE CARE EXPENSE BENEFIT	75%	Same as In-Network	75%	Same as In Network
HOME HEALTH CARE EXPENSE BENEFIT	75%	Same as In-Network	75%	Same as In Network
Maximum Benefit of 120 Visits Per Calendar Year				
PHYSICIAN'S EXPENSE BENEFIT				
Inpatient and Outpatient Benefit				
Office Visits (For treatment of illness or injury)	\$15 Co-pay then 100%	60%	90%	60%
(Plan A Deductible Waived In-Network)				
Second Surgical Opinion (Deductible Waived).....	100%	100%	100%	100%
Allergy Injections In Office (Plan A Deductible Waived In-Network).....	100%	60%	90%	60%
Surgery	90%	60%	90%	60%
Anesthesia	90%	Same as In-Network	90%	Same as In Network
Hospital Inpatient Doctor Visits	90%	60%	90%	60%
Radiology/Pathology Interpretation.....	90%	Same as In-Network	90%	Same as In Network
DIAGNOSTIC EXPENSE BENEFIT				
Outpatient Diagnostic X-Ray, Laboratory, Medical Tests	90%	60%	90%	60%
Independent Laboratory Expenses	90%	Same as In-Network	90%	Same as In-Network
RADIATION THERAPY, CHEMOTHERAPY AND KIDNEY DIALYSIS EXPENSE BENEFIT				
Facility Expenses	90%	60%	90%	60%
Physician Expenses	90%	60%	90%	60%

SCHEDULE OF BENEFITS - Continued

	<u>OPTION A</u>		<u>OPTION B</u>	
	<u>IN-</u> <u>NETWORK</u>	<u>OUT-OF-</u> <u>NETWORK</u>	<u>IN-</u> <u>NETWORK</u>	<u>OUT-OF-</u> <u>NETWORK</u>
PREVENTIVE CARE EXPENSE BENEFIT				
(Deductible is waived for In-Network)				
Routine Care	100%	60%	100%	60%
Office Visit with Routine Care	\$15 co-payment	60%	100%	60%
(Combined Maximum Benefit of \$1,000 In-Network and \$500 Out-of-Network per Covered Person per Calendar Year)				
SMOKING CESSATION/WEIGHT LOSS EXPENSE BENEFIT				
100%.....100%				
(Calendar Year Deductible Waived)				
(\$500 Combined Lifetime Maximum per Covered Person)				
OUTPATIENT MENTAL ILLNESS, NERVOUS DISORDERS,				
ALCOHOLISM AND DRUG DEPENDENCY EXPENSE BENEFIT				
90%.....60%				
(Benefits paid at 50% UCR if ACMS is not notified as required)				
ALL OTHER COVERED MEDICAL EXPENSES				
75%.....Same as				
In Network In Network				

- NOTES:**
- 1) ACMS must be notified for all hospital admissions or hospital benefits will be reduced by \$300 for that period of confinement. For maternity management, ACMS notification is waived for a 48-hour normal or 96-hour Cesarean delivery but is encouraged as soon as possible after pregnancy is confirmed.
 - 2) Any hospital benefit reduction due to the failure to properly notify ACMS of the hospital confinement will not apply to the out-of-pocket maximum.
 - 3) Retirees under age 65 and their covered dependents who reside outside the PPO service area may choose to enroll in an out-of-area retiree plan under which benefits are paid at 75%, and subject to the in-network deductible and out-of-pocket .

PAYMENT WILL ONLY BE MADE FOR EXPENSES SUBMITTED WITHIN ONE YEAR FROM THE DATE SUCH EXPENSES WERE INCURRED UNLESS THERE ARE PROVABLE EXTENUATING CIRCUMSTANCES.

PRESCRIPTION DRUG CARD BENEFITS

OPTION B

For PLAN B participants the Health Plan card serves as a discount card for the purpose of purchasing necessary prescription drugs. The Covered Person is required to pay the full discounted cost at the time of purchase and submit the receipt to the Health Plan for reimbursement, subject to the Calendar Year Deductible and at the benefit percentage for “All Other Covered Medical Expenses.”

OPTION A

CALENDAR YEAR DEDUCTIBLE

Per Covered Person	\$100
Maximum per Covered Family	\$200

CO-PAYMENTS

RETAIL PHARMACY – Maximum 90-Day Supply

Co-payment per Generic Prescription.....	10%
Co-payment per Preferred Brand Prescription.....	30% (With a \$15 Minimum)
Co-payment per Brand Name Prescription.....	40% (With a \$30 Minimum)

MAIL ORDER PHARMACY – Maximum 90-Day Supply

Co-payment per Generic Prescription.....	5%
Co-payment per Preferred Brand Prescription.....	25% (With a \$15 Minimum)
Co-payment per Brand Name Prescription.....	35% (With a \$30 Minimum)

NOTE: Certain drugs that previously required a prescription but are now available over-the-counter will be considered if a prescription is submitted from the physician. Benefits paid under the Prescription Drug Benefits section of the Plan will apply to the Overall Lifetime Maximum Benefits but not to the deductible or to the Out of-Pocket Maximum under the Comprehensive Medical Expense Benefits. If the cost of the drug is less than the co-payment, the actual cost of the drug will apply. A minimum fee to cover shipping costs may apply to mail order drugs.

VISION BENEFITS
(Eligible Employees and Dependents)

<u>VSP</u>	<u>Non-VSP</u>
<u>Member Doctor</u>	<u>Member Doctor</u>

COVERED SERVICE:

Eye Exam, Limited to one every 12 months.....	\$10 Co-pay,.....	100% up then 100% to \$35
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Note: An urgent care visit to a participating VSP provider will be covered at 100% less a \$5.00 co-payment in addition to the annual routine examination. Urgent care visits are covered for accidental injury or illness, such as pink eye.

Lenses and Frames Limited to one set every 24 months	\$25 Co-pay,.....	See Below then 100%
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AFTER THE ABOVE CO-PAYMENT IS MET, THE FOLLOWING BENEFITS APPLY:

LENSES

Single Vision Lenses.....	100%	100% to \$25
Bifocal Lenses	100%	100% to \$40
Trifocal Lenses.....	100%	100% to \$55
Lenticular	100%	100% to \$80

FRAMES (<i>One per 12-Month Period</i>)	100% to Plan Allowance.....	100% to \$45
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CONTACT LENSES, EVALUATION AND FITTING

(Instead of Frames and Lenses)

Medically Necessary (<i>Per 12-Month Period</i>).....	100%	100% to \$210
Elective (<i>Per 12-Month Period</i>).....	100% to \$130	100% to \$105 plus 15% discount off professional services

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SECTION A

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CONDITIONS OF COVERAGE

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ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

ELIGIBLE EMPLOYEE

All persons regularly employed on a full-time basis for the University are eligible to participate in the Plan on the first day of full-time employment if qualified, and requested by the employee. Regularly employed on a full-time basis in an Academic setting means those persons teaching nine or more credit hours per academic quarter in what is expected to be a continuing position, or teaching nine or more credit hours on a visiting basis for at least one year. In an Administrative or Staff position, regularly employed full-time means those persons employed for 30 hours or more in what is expected to be a continuing full-time basis. In rare and extraordinary situations as determined and agreed upon between the Office of Academic Affairs and Office of Financial Affairs, and further identified by section 2.30 of the faculty handbook, employees may share a full-time faculty position. Spouses sharing a full-time position may qualify for medical benefits under the Plan. Employees sharing a full-time position with a person other than their spouse will not qualify for coverage under this Plan.

New employees who are enrolled will be covered on the date they satisfy eligibility requirements, provided they are actively at work on that date.

An employee who is not actively at work on his effective date of coverage will not be covered until the day he returns to active employment. An employee who is not actively at work because of medical disability or other health conditions on his effective date of coverage, however, will **not** be subject to the actively at work requirements.

If an employee is hospital confined on the effective date of any revision in Plan benefits, all charges incurred during that confinement will be considered at the level of benefits in effect on the date his hospital confinement commenced. If the employee is not actively at work due to medical disability or other health conditions on the effective date of the revision in benefits but is **not** hospital confined, charges will be considered at the level of benefits in effect on the date charges were incurred.

ELIGIBLE DEPENDENT

An eligible dependent is the eligible employee's legal spouse and all children of the eligible employee to age 19, provided the children are unmarried, dependent upon the eligible employee for support and maintenance, and not employed full-time.

The term "children" shall include:

- a) Natural children and legally adopted children;
- b) Children for whom the covered employee has retained the legal duty for total or partial support pending final adoption proceedings;
Note: Any Pre-existing Conditions Limitation in the Plan will be waived for any child in the process of adoption;
- c) Step-children living with the employee in a parent/child relationship;

Note: Stepchildren enrolled prior to January 1, 2007 will not be subject to the residency requirement.

- d) Other children for whom the eligible employee has legal guardianship who are living with the eligible employee in a regular parent-child relationship; and
- e) Any child of an eligible employee covered under the Plan who is determined to be an eligible dependent under a qualified medical child support order (QMCSO) or a national medical support notice (NMSN), as defined herein.

In addition to the above, children will be considered as eligible dependents from age 19 to the end of the month in which the child becomes age 25 provided the children are attending on a full-time basis an accredited high school, college, university, or other institution offering post high school education, are unmarried, not employed on a full-time basis, and are dependent upon the eligible employee for support and maintenance. Upon turning age 24, a dependent student must satisfy the IRC Section 152 definition of dependent (other than the gross income test) to continue coverage under this plan. Full-time student status will be determined based on the standards of the institution attended. Eligibility will cease at the end of the month in which the dependent graduates or is no longer a Full-Time Student.

A child who is physically or mentally incapable of self-support upon attaining the age limit may be considered an eligible dependent while remaining incapacitated, unmarried, unemployed, residing with the employee, and continuously covered under the Plan or a previous employer's group health plan. To continue a child under this provision, proof of incapacity must be submitted to the Claims Administrator at least 30 days after the child's attainment of the age limit. If approved, proof of continuing incapacity may be required periodically.

Newborn children are eligible for coverage under the Plan from birth (including routine nursery care and pediatric examinations while hospital-confined) provided that dependent coverage is in effect at the time of birth or elected within 30 days following the birth of the child.

The term "eligible dependent" shall not include anyone who is covered as an eligible employee. Also, if the University employs both parents, children will be covered only as dependents of one parent.

EFFECTIVE DATE OF COVERAGE FOR DEPENDENTS

An eligible dependent who is enrolled after the effective date of this Plan will become covered on the same date as the eligible employee or the date such dependent is acquired, whichever is later.

If the eligible dependent is hospital-confined on the effective date of a revision in benefits, all charges incurred during that confinement will be considered at the level of benefits in effect on the date his hospital confinement commenced. If on the date of any revision in benefits the eligible dependent is **not** hospital confined, charges will be considered at the level of benefits in effect on the date charges were incurred.

ENROLLMENT REQUIREMENTS

Coverage does not become effective for an employee and/or his dependents who become eligible for coverage on or after the effective date of this Plan until the employee completes an Enrollment Form agreeing to any required contributions. If the employee enrolls his eligible dependents within 30 days after they first become eligible, coverage for any additional dependents acquired later (i.e. a newborn or adopted child or a new spouse) will become effective on the date they qualify as eligible dependents. The employee, however, must notify the Office of Human Resources of any new dependents and complete a new Enrollment Form. Additional information verifying eligibility may be required.

OPEN ENROLLMENT

In December of each year, an Open Enrollment Period for the following Calendar Year will allow all covered employees who failed to enroll in the Plan during their initial eligibility period to elect coverage under the Plan. The effective Date of new coverage will be January 1, provided the Enrollment Forms for Open Enrollment are submitted to the Company on or before the stated deadline. No enrollment will be allowed at any other time during the year, except as provided under “Special Enrollment Periods” below.

An employee may change from Option A to B or Option B to A only during the Annual Open Enrollment or at the time a Change in Status as outlined under the Pre-Tax feature occurs.

SPECIAL ENROLLMENT

An eligible employee who declined coverage during the initial 30 day eligibility period may enroll for coverage during a **Special Enrollment Period** if the following conditions are met:

- a) The eligible employee (and/or dependent) loses coverage under another group health plan or other health insurance coverage which was in force at the time this coverage was initially declined and was the reason for declination.
- b) The loss of coverage is due to one (1) of the following events:
 - i) Loss of eligibility for coverage as a result of cessation of employer contributions, legal separation, divorce, or due to a spouse’s death, termination of employment, or reduction in the number of hours employed. Loss of eligibility does not include any loss due to failure of the individual to pay premiums on a timely basis or termination for cause; or
 - ii) COBRA continuation coverage has been exhausted.

A Special Enrollment Period is also offered to any eligible employee (and/or dependent) who previously declined coverage for any reason who later acquires an eligible dependent (or additional eligible dependent) due to:

- Marriage
- Birth of a Child
- Adoption or placement for adoption

In the case of enrollment during a Special Enrollment Period, the employee must request coverage as outlined in this section within 30 days of the date COBRA continuation coverage is exhausted, the other coverage is terminated due to loss of eligibility, or of acquiring an eligible dependent. The effective date of coverage obtained under a Special Enrollment Period will be the first of the month following the date the completed request for enrollment is received by the Plan Administrator, except in the case of birth, adoption, or placement for adoption the effective date will be the date of birth, adoption, or placement for adoption.

Individuals obtaining coverage under a Special Enrollment Period will not be considered late enrollees, but will be subject to the Pre-Existing Conditions Limitation contained in the Plan applicable to individuals enrolling within the first 30 days of eligibility. Certificates of Prior Health Coverage, if presented, will be applied to reduce the Plan's Pre-Existing Conditions Limitation.

The Plan will recognize a qualified medical child support order (QMCSO) or a national medical support notice (NMSN), as defined, for purposes of providing coverage to dependent children. Such order must be sent to the Plan Administrator who will notify the eligible employee named in the order and each alternate recipient (a child of an eligible employee who is recognized in the QMCSO or NMSN as having the right to enroll in the Plan) that a medical child support order (MCSO) has been received and the Plan procedures for determining if it is a "qualified" MCSO. The Plan Administrator must notify each person specified in the MCSO as to their eligibility for coverage and must allow the alternate recipient to designate a representative to receive Plan communications.

PRE-EXISTING CONDITIONS LIMITATION

Covered persons shall **not** be entitled to benefits for expenses incurred as the result of any injury or illness for which the covered person has consulted with a physician, taken medication or received any medical care or services during the 6 month period immediately prior to becoming covered under the Plan until the expiration of:

1. A period of 12 consecutive months from the covered person's Enrollment Date in the Plan; or
2. A period of 18 consecutive months from the covered person's Enrollment Date in the Plan if enrollment is more than 30 days after the individual was first eligible as described for the Annual Enrollment under "Enrollment Requirements."

This provision does not apply to a newborn child enrolled within 30 days of his birth, or to an adopted child under age 18 who is enrolled within 30 days of his adoption or placement for adoption, or to expenses due to pregnancy which would otherwise have been eligible for benefits under the Plan.

Any period of time during which Creditable Coverage, as defined, was in effect will carry over to offset or reduce the Pre-Existing Conditions Limitation of 12 or 18 months, as applicable, as long as no break in coverage of 63 days or more has occurred. Any waiting period for coverage is not considered a break in coverage. Certification of Creditable Coverage must be supplied indicating the exact time period such coverage was in effect. This certification is supplied by the employer, insurance company or other organization under which the Creditable Coverage occurred (see Definitions Section, Creditable Coverage under General Provisions). The Pre-Existing Conditions Limitation is reduced by one day for each day of prior Creditable Coverage certified. The newly enrolled individual will be notified in writing of the number of days remaining, if any, in the Pre-Existing Conditions Limitation after prior Creditable Coverage has been deducted.

Eligible individuals have the right to appeal the decision relative to the application of Creditable Coverage and supply additional evidence of such prior coverage.

EMPLOYMENT RELATED EVENTS AFFECTING COVERAGE

Layoff

Coverage will terminate on the last day of the month in which the layoff begins. An Eligible employee returning from layoff within six months of layoff shall be covered on the day he returns to active full-time employment. The Pre-Existing Conditions Limitation will be waived. "COBRA Continuation Coverage" outlines continued coverage provisions.

Retirement

Coverage for retired eligible employees will continue according to the retirement portion outlined in the Employee Handbook.

Coverage for eligible retirees or their eligible dependents under age sixty-five (65) will continue under the same Plan benefits as for an active employee, except:

Covered retirees and their covered dependents under age 65 who reside outside of the PPO service area may elect to have medical benefits paid at 75% after the Plan A deductible. The Plan A In-Network out-of-pocket limit will apply. Second surgical opinions will be paid at 100% with the deductible waived. All other provisions and limitations outlined herein will apply.

On the first day of the month in which the eligible retiree or dependent spouse reaches age 65, an Employer-sponsored Medicare Supplement plan will be offered.

Death of the Employee

Coverage for enrolled dependents of a deceased covered employee who has completed 10 or more years of service with the University will continue, subject to any required contributions, but not beyond the earlier of:

- a) The date of remarriage of the surviving spouse;
- b) The date the dependent ceases to qualify as a dependent for any reason; or
- c) The date another group health plan or Medicare becomes available to the surviving spouse.

Non-FMLA Leave of Absence

Coverage under this Plan will continue for a maximum of one year from the date the covered employee's University-approved personal leave of absence begins, subject to payment of any required contributions. Employees on a University-approved sabbatical may have coverage continued beyond the one-year period. This provision does not apply to any leave requested under the terms of the Family and Medical Leave Act of 1993 (FMLA) as outlined below. Additional coverage is available under the section entitled "COBRA Continuation Coverage."

Military Leave

If a covered employee is on a military leave of absence, coverage will continue for a maximum of 31 days from the date leave began, subject to payment of required employee contributions. Additionally, under the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA), as amended by the Veterans Benefit Improvement Act of 2004 (VBIA), an eligible employee may elect to continue coverage for himself and his enrolled dependents for a period up to a maximum of 24 months.

Coverage **is** reinstated effective on the date the employee returns to work without application of the Pre-Existing Conditions Limitation, other than those that would have applied if there had been no absence for uniformed services. Additional information regarding an employee's rights and obligations under USERRA is available from the employer. These rights apply only to employees (and their dependents) who were covered under the Plan before leaving for military service.

Advance notice of military leave should be provided to the Company. General Limitations may be imposed for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during military service

The section entitled "COBRA Continuation Coverage" outlines alternative continuation coverage.

FMLA Leave of Absence

Coverage may continue during an unpaid FMLA leave of absence for a maximum of 12 weeks during any 12-month period under the Group Health Plan, subject to payment of any required contributions. The section entitled "COBRA Continuation Coverage" outlines continued coverage provisions.

INDIVIDUAL TERMINATION OF COVERAGE

The coverage of any covered person under the Plan shall terminate the earliest of the following dates:

1. The date of termination of the Plan, the date certain benefits terminate, or the date the employee is no longer in an eligible class of employees;
2. The date a covered person becomes a full-time member of the Armed Forces of any country, except as specified for Military Leave under "Employment related Events Affective Coverage";
3. The first day of the month in which a covered employee fails to make any required contribution;
4. The date an **active** covered employee or his eligible covered dependent spouse elects Medicare as the primary plan of benefits;
5. The last day of the month in which a covered employee's employment terminates, except as provided under the previous section entitled "employment Related Events Affecting Coverage" and as outlined under "COBRA Continuation Coverage";
6. With respect to a covered dependent, the date coverage terminates for the covered employee or the date such dependent no longer meets the qualifications of an eligible dependent, except as outlined under "COBRA Continuation Coverage".
7. The date the Covered Person has exhausted the Overall Maximum Lifetime Benefit of the Plan

COBRA CONTINUATION COVERAGE (Consolidated Omnibus Budget Reconciliation Act)

EMPLOYEE QUALIFYING EVENTS

A covered employee and/or any covered dependent may elect COBRA Continuation Coverage under the Plan at his own expense for up to 18 months if coverage is lost due to one of the following qualifying events:

- 1) Voluntary or involuntary termination of employment of the covered employee (other than for gross misconduct)
- 2) A reduction in work hours for the covered employee

DEPENDENT QUALIFYING EVENTS

A covered dependent may elect COBRA Continuation Coverage under the Plan at his own expense for up to a maximum of 36 months if coverage is lost due to one of the following qualifying events:

- 1) The death of the covered employee
- 2) Loss of eligibility as a covered dependent as defined in the Plan
- 3) Divorce or legal separation of the covered employee
- 4) The covered employee becoming entitled to primary Medicare benefits
- 5) A filing for reorganization under Chapter 11 of the Bankruptcy Code by the Company in the case of a surviving spouse and/or dependent child(ren) of a deceased retired employee

The covered employee or dependent is responsible for notifying the Company within 60 days of the events outlined in items 2) and 3) above. The notification must be in writing and include the name and address of the person affected as well as the date of the event. Failure to do so will result in the loss of the covered dependent's right to elect COBRA Continuation Coverage.

MEDICARE'S EFFECT ON COBRA

If the employee is enrolled for Medicare benefits at the time coverage terminates due to an Employee Qualifying Event listed above, the period of continuation for covered dependents will be the longer of

- a. 18 months from the date coverage terminates due to the Qualifying Event; or
- b. 36 months from the date the Employee became enrolled for Medicare benefits.

MULTIPLE QUALIFYING EVENTS

Subsequent Qualifying Events occurring while the COBRA continuation is in effect may entitle dependents who are Qualified Beneficiaries to additional periods of coverage, but the total period of COBRA continuation coverage for all Qualifying Events will not exceed 36 months from the date of the original Qualifying Event.

COBRA RIGHTS AND OBLIGATIONS

COBRA Continuation Coverage must be elected within 60 days from the later of the date coverage terminates or the date written notice of the right to elect COBRA Continuation Coverage is sent. Failure to elect within this time frame will result in the loss of the Covered Person's right of COBRA Continuation Coverage. Payment for the cost of COBRA Continuation Coverage is due by the first of the month for each month of coverage, and coverage will cease if the monthly payment is not received within 30 days of the date it was due. Payment for the full cost of COBRA Continuation Coverage for the period from when coverage was lost through the date of election must be made within 45 days after the election.

A Qualified Beneficiary may waive COBRA continuation coverage during the 60-day election period. This waiver of coverage may be revoked at any time before the end of the election period. In this case, coverage will be effective on the date the waiver revocation notice is received by the COBRA Administrator. Coverage will not be provided retroactively.

COBRA Continuation Coverage will be provided for each month as long as payment for that coverage period is made before the end of the grace period for that payment. However, if a monthly payment is paid later than the first day of the month, but before the end of the grace period for the coverage period, coverage under the Plan may be suspended and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claims submitted while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

If the Company makes revisions in coverage after a Covered Person has elected COBRA, any revisions for active employees will also apply to COBRA-qualified beneficiaries.

Special rules apply to a loss of retiree health coverage resulting from the Company's Chapter 11 bankruptcy proceedings that commence within one year before or after the date the proceedings begin.

A child who is born to or placed for adoption with the covered employee during a period of COBRA Continuation Coverage will be eligible to become covered as a dependent. In accordance with the terms of the Plan and federal law requirements, these new dependents may be added to COBRA Continuation Coverage upon proper notification to the Company of the birth or adoption.

TRADE ACT OF 2002

Special COBRA rights apply to employees who have been terminated or experience a reduction of hours as a result of import competition or shifts of production to other countries. These employees may qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 2002. These employees are entitled to a second opportunity to elect COBRA Continuation Coverage for themselves and certain family members (if they did not elect COBRA Continuation Coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after their Group Health Plan coverage ended. The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance. Under the new tax provisions, eligible individuals can either take a tax credit or receive advanced payment of 65% of premiums paid for qualified health insurance, including COBRA Continuation Coverage. Employees who qualify, or may qualify, for assistance under the Trade Act of 2002, should contact their COBRA Administrator for additional information. They must contact their COBRA Administrator promptly after qualifying for assistance under the Trade Act of 2002 or they will lose their special COBRA rights.

Any questions about the Trade Act of 2002 may be directed to the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282, or the website can be accessed at www.doleta.gov/tradeact.

COBRA DISABILITY CONTINUATION

Covered employees and dependents entitled to elect COBRA Continuation Coverage due to an employee's termination of employment or reduction in hours may extend their coverage from 18 to 29 months. The covered employee or dependent must be disabled (as defined under Title II or Title XVI of the Social Security Act) at the time of termination or reduction in hours or within the first 60 days of COBRA Continuation Coverage. The covered employee or dependent must notify the Company (in writing) within 60 days of the Social Security disability determination (or, if later, within the first 60 days of COBRA Continuation Coverage) and before the end of the normal 18-month coverage period. Failure to provide notice within this time frame will result in the loss of the 11-month extension of COBRA Continuation Coverage. Beginning with the 19th month, the cost of the COBRA Continuation Coverage may increase up to 50%.

The covered employee or dependent is also responsible for notifying the Company within 30 days after a final determination has been made by Social Security that the Covered Person is no longer disabled. COBRA Continuation Coverage may be terminated on the first day of the month that is more than 30 days after the final determination that the Covered Person is no longer disabled or on the date the individual becomes entitled to Medicare benefits, if sooner.

TERMINATION OF COBRA COVERAGE

Any COBRA Continuation Coverage made available above will cease if:

- The Company no longer provides group health coverage to any of its employees.
- After payment has begun, a covered employee or dependent fails to make the full payment when due or within the 30-day grace period allowed by law.
- The covered employee or dependent becomes entitled to Medicare after COBRA Continuation Coverage has been elected. COBRA Continuation Coverage may be elected if Medicare coverage was in effect for the Covered Person prior to the COBRA qualifying event.
- The covered employee or dependent becomes covered (as an employee or otherwise) under another Group Health Plan after COBRA Continuation Coverage has been elected, unless that plan contains any exclusion or limitation in regard to a Pre-Existing Condition that is not waived by reason of prior Creditable Coverage.

COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or beneficiary not receiving COBRA Continuation Coverage (such as fraud).

PLAN CONTACT INFORMATION

Contact the University for additional details concerning COBRA Continuation Coverage. In order to protect a family's rights, the covered person should keep the Company informed of any changes in the addresses of family members and/or any new dependents, and should retain a copy of any notices sent to the Company.

For more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting Group Health Plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

PRE-TAX ELECTION FEATURE

Employee Contributions

Unless they elect otherwise, all covered employees will have their share of the cost of coverage paid on a pre-tax basis. This means the employee's share of the cost will be deducted from his pay before his taxable wages are determined. Therefore, total wages remain the same, but the amount of wages that is taxed is a lower amount. The use of pre-tax dollars to pay for coverage will reduce federal and state income taxes and increase an employee's spendable income.

The amount of the pre-tax election is not subject to FICA taxes and may have a very slight negative effect on the Social Security benefit payable in the event of a covered employee's retirement, disability or death. In addition, many municipalities do not recognize pre-tax elections and impose their city income taxes on gross earnings.

Once a covered employee's pre-tax election becomes effective, it remains in effect until the next re-enrollment period. No change in election is permitted prior to that time except in cases of significant cost or coverage changes to the employee, separation from service by the employee or certain change-in-status events. Change-in-status events include:

- 1) Marriage, divorce, legal separation or annulment of the employee's marriage
- 2) Death of the employee's spouse or a child
- 3) Birth, adoption or placement for adoption of a child of the employee, including the commencement or termination of an adoption proceeding
- 4) Commencement or termination of employment by the employee, the employee's spouse or a dependent
- 5) A reduction or increase in hours by the employee, spouse or dependent, including a switch from full-time to part-time employment, a strike or lockout, or commencement or return from an unpaid leave of absence
- 6) Dependent satisfies (or ceases to satisfy) dependent eligibility requirements

- 7) A change in the place of residence or work of the employee, spouse or dependent that affects the employee's eligibility for coverage
- 8) Significant change in the health coverage of the employee or spouse attributable to the spouse's employment
- 9) A judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a Qualified Medical Child Support Order as defined by ERISA)
- 10) The entitlement or loss of entitlement by the employee, spouse or dependent to Medicare or Medicaid
- 11) Increase or decrease during the Plan year in the cost of the healthcare program. The Plan will automatically make a corresponding change in the salary reduction amount. If the cost of the healthcare Plan reduces significantly, the employee is allowed to begin participation in the Pre-Tax Election option. If the cost of the healthcare Plan increases significantly, the employee is allowed to revoke his pre-tax election.
- 12) Significant curtailment without loss of employee, spouse or dependent's coverage. "Significant curtailment" means a significant increase in the deductible, co-payments or out-of-pocket limit of the Group Health Plan. If there is a significant curtailment with loss of employee, spouse or dependent's coverage, the employee may revoke his election. If the Plan adds a new coverage option or if an existing benefit package option is significantly improved, the Plan may permit a covered employee to revoke his election and, instead, make a pre-tax election on a prospective basis to fund for coverage under the new or improved benefit package option.
- 13) An election change that is due to, and corresponds with, a change made under another employer's cafeteria plan. The other cafeteria plan must permit Participants to make an election change that would be permitted under special enrollment rights; change in status; judgment, decree or order; entitlement to Medicare or Medicaid; significant cost or coverage changes; or special requirements related to the Family and Medical Leave Act (FMLA).
- 14) Loss of coverage under any group health coverage sponsored by a government or educational institution

AN ELECTION CHANGE DUE TO A CHANGE IN STATUS MUST BE MADE WITHIN 30 DAYS OF THE DATE OF THE CHANGE IN STATUS. ACCORDING TO RULES ESTABLISHED BY THE INTERNAL REVENUE SERVICE, THE ELECTION CHANGE MUST BE CONSISTENT WITH THE CHANGE IN STATUS.

In the event of separation from service and subsequent re-employment during the same Pre-Tax Election Plan year, if the employee should be rehired within 30 days of his termination, he would be able to make a new election if the facts and circumstances justified the change. If the employee is rehired more than 30 days after termination, he may make a new election regardless of the circumstances.

The regulations also permit an employee to increase his pre-tax contributions for coverage under his current employer's health plan if a qualifying event as defined under the Consolidated Omnibus Budget Reconciliation Act (COBRA) occurs with respect to the employee, the employee's spouse or a dependent. As a result, the employee could increase pre-tax contributions in mid-year to pay his cost of COBRA Continuation Coverage. The right to increase pre-tax contributions does not apply to COBRA coverage under another employer's plan.

The regulations also confirm that an employee may change his pre-tax election for health coverage to the extent the election change corresponds and is consistent with the special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA). If an employee has a right to enroll in an employer's Group Health Plan or to add coverage for a family member under HIPAA, the employee may make a confirming election under this Pre-Tax Election option.

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SECTION B

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COMPREHENSIVE MEDICAL EXPENSE BENEFITS

If a covered person incurs covered medical expenses as a result of non-occupational injury or illness which are necessary medical services, the Plan will consider charges up to the Usual, Customary, and Reasonable (UCR) Allowance and pay benefits after the deductible or per-visit co-payment at the benefit percentages specified in the Schedule of Benefits for such necessary medical services received. The benefits payable shall not exceed the overall lifetime maximum benefit and are subject to all limitations and conditions of the Plan.

The Claims Administrator may, at its discretion, designate as additional covered expenses the costs of alternative care including home care, therapy, nursing/housekeeping assistance, medical equipment and supplies when recommended by the health care management company and approved by the Plan Sponsor.

MEDICAL AUDIT

All covered persons should review all invoices for medical supplies and/or services rendered. If an employee discovers an error between the charges made and the benefits paid or to be paid that result in a savings of \$20 or more, the employee will be rewarded as follows:

- a) 50% of monies saved; and
- b) A maximum award of \$1,000.

The award will be made after the employee obtains a corrected billing from the provider of services and/or supplies, or after the employee obtains a refund of incorrect charges already paid to the provider. Any refund from a provider must be made payable to "Ohio Northern University Employee Benefit Trust."

NOTE: Any savings must be initiated, negotiated and culminated by the covered employee before the University can make any reward.

OVERALL LIFETIME MAXIMUM BENEFIT

The Overall Lifetime Maximum benefit under this Plan per Covered Person is listed in the Schedule of Benefits. This maximum includes, and is not in addition to, any limits imposed on specific treatment. Any present or future increase in this Overall Lifetime Maximum Benefit is not available to any Covered Person who previously has exhausted the Overall Lifetime Maximum Benefit.

CALENDAR YEAR DEDUCTIBLE

All covered medical expenses are subject to the calendar year deductible amounts specified in the Schedule of Benefits unless specifically waived. Before benefits are payable for eligible expenses, the covered person must satisfy the applicable deductible. Covered medical expenses used to satisfy the deductible are not reimbursable by the Plan. Any benefit reduction incurred by a covered person due to failure to comply with ACMS notification

requirements will not apply to satisfaction of the Calendar Year Deductible or to the out-of-pocket maximum specified in the Schedule of Benefits.

Family Deductible

Plan A

All amounts applied to a covered persons' deductible will also apply to the family deductible. However, the family deductible will not be satisfied until one family member has met his individual deductible.

Plan B

Any person enrolled with spouse and/or children coverage will be subject to the family deductible. Benefit payments will not begin until the family deductible has been satisfied. The family deductible can be met by one or more family members.

PER VISIT CO-PAYMENT

The Plan may impose an initial per visit Co-payment each time a Covered Person incurs charges for certain types of medical services. The amount of this per-visit-co-payment is shown in the Schedule of Benefits when it is applicable. The per-visit-co-payment is not applied to the Calendar Year Deductible nor to the Out-of-Pocket Maximum.

BENEFIT PERCENTAGE

After satisfaction of the individual or family Calendar Year Deductible or any per-visit-co-payment, additional covered expenses are payable at the benefit percentages shown in the Schedule of Benefits. The percentage of the covered charge that is the Covered Person's responsibility is also called a co-payment.

OUT-OF-POCKET MAXIMUM

If the maximum out-of-pocket amount (per Covered Person or Family) shown in the Schedule of Benefits is met during any one calendar year due to the Calendar Year Deductible and benefit percentages outlined herein, the Plan will pay 100% of additional eligible expenses incurred during the remainder of that Calendar Year.

Amounts applied to the In-Network out-of-pocket maximum will also apply to the Out-of-Network out-of-pocket maximum, and vice versa.

The Out-of-Pocket Maximum will not apply to:

- Any benefit reduction for failure to comply with ACMS certification requirements;
- Any per-visit Co-Payment as shown in the Schedule of Benefits.

HOSPITAL EXPENSE BENEFITS

INPATIENT HOSPITAL EXPENSE BENEFITS

Hospital benefits will be reduced by \$300 for any one period of confinement if ACMS is not notified as follows for each hospital admission, except as specified below for maternity management:

Non-Emergency Admission	Seven days advance notice;
Emergency Admission-	Forty-eight hours or two business days following admission;
Maternity Management.....	As soon as possible after pregnancy is confirmed (Notice waived for 48-hour Normal and 96-hour Cesarean delivery stays.)

The toll-free telephone number for ACMS is: 1-877-304-0761

ACMS office hours are 8:00 a.m. to 5:00 p.m. Eastern Time Monday through Friday. An answering system will take messages during the hours when ACMS is closed.

When hospitalization of a covered person is authorized and recommended by a physician for the medically necessary treatment of a non-occupational injury or illness, the Plan will pay benefits at the percentages specified in the Schedule of Benefits for hospital charges during the calendar year for medically necessary room and board (including routine nursery care for newborns) and miscellaneous expenses. "Miscellaneous expenses" means necessary services, medicines and supplies for diagnosis and treatment, including anesthesia materials, radiology and pathology, but excluding charges of a private-duty nurse or Physician.

If a covered person is admitted to a hospital for dental care, and such admission is certified as medically necessary by the physician in charge of the care of the covered person, benefits for inpatient or outpatient hospital charges only are payable.

Benefits for inpatient treatment of mental illness, nervous disorders, alcoholism and drug dependency are payable as any other illness limited to 30 days per calendar year. Alcoholism and drug dependency care is also limited to the lifetime maximum benefit shown in the Schedule of Benefits per covered person. ACMS may recommend either a Day Treatment Program, Partial Hospitalization, or Intensive Outpatient Treatment Program, as defined, either instead of or in addition to an inpatient confinement for treatment of mental illness, nervous disorders, alcoholism or drug dependency, and benefits shall be payable at the same benefit percentage and subject to the same 30 day limit as inpatient confinement.

Newborns' and Mothers' Health Protection Act of 1996

The Plan will not restrict benefits or require authorization for any Hospital stay in connection with childbirth of 48 hours or less following a normal vaginal delivery, or of 96 hours or less following a cesarean section. This applies to Hospital Inpatient expenses for both the mother and the newborn child. The mother may leave the Hospital sooner than these periods if she and her attending Physician agree to an earlier release. For Maternity Management purposes, the Plan encourages all Participants to notify ACMS of their pregnancy as soon as possible after a pregnancy is confirmed or as soon as coverage becomes effective if a new Participant is pregnant on her Effective Date. This notification to ACMS will not affect reimbursement levels for the minimum length of Hospital stay.

However, any hospital stay for delivery for child(ren) exceeding the time periods stated above, any stay for complications during a pregnancy, and any post-hospital home health nursing visits after delivery do require ACMS notification **or hospital benefits for such charges will be reduced by \$300 per period of confinement.**

OUTPATIENT HOSPITAL EXPENSE BENEFITS

The Plan will pay benefits at the benefit percentages outlined in the Schedule of Benefits for other outpatient hospital services in connection with:

- a) Use of facilities and supplies when surgery is performed in the outpatient department of a hospital or at a freestanding surgical or emergency care facility;
- b) Pre-admission testing within seven days prior to hospital confinement (and related to the scheduled surgery) which would have been required and covered during a hospital confinement;
- c) Physical therapy;
- d) All Other Covered Hospital Outpatient Expenses.

EMERGENCY ROOM EXPENSE BENEFIT

When a Covered Person uses the services of a Hospital emergency room for treatment of an Illness or Injury, facility and Physician charges will be paid at the appropriate benefit percentage or after a per visit co-payment as shown in the Schedule of Benefits. The per-visit co-payment does not apply to the Calendar Year Deductible nor to the out-of-pocket maximum.

SKILLED NURSING FACILITY EXPENSE BENEFITS

The ACMS Patient Services Center should be notified prior to admission to a Skilled Nursing Facility. The toll-free telephone number for ACMS is:

1-877-304-0761

ACMS office hours are 8:00 a.m. to 5:00 p.m. Eastern Time Monday through Friday. An answering system will take messages during the hours when ACMS is closed.

If a covered person is transferred from a hospital immediately following a confinement and/or documented certification of medical necessity is made by the attending physician, the Plan will pay benefits at the benefit percentages outlined in the Schedule of Benefits for daily room and board and covered miscellaneous expenses.

The Covered Person's share of the co-payment percentage will count toward the out-of-pocket maximum. No skilled nursing facility benefits are payable for personal care or personal care items.

HOSPICE CARE EXPENSE BENEFITS

The ACMS Patient Services Center should be notified prior to admission to a Hospice Care Program. The toll-free telephone number for ACMS is:

1-877-304-0761

ACMS office hours are 8:00 a.m. to 5:00 p.m. Eastern Time Monday through Friday. An answering system will take messages during the hours when ACMS is closed.

If a covered person incurs charges made by a licensed Hospice Care Program either as an inpatient or outpatient, the Plan will pay benefits at the benefit percentages shown for hospice care in the Schedule of Benefits. Such treatment must be recommended by the attending physician and is normally rendered within six months of the terminally ill covered person's entry or re-entry (after a remission period) into the hospice care program.

Hospice services consist of:

- Inpatient charges at a Hospice if medically necessary
- Services of Physicians
- Part-time nursing care and home health aide services
- Necessary medical supplies, drugs and medicines
- Laboratory services, radiotherapy, oxygen and oxygen equipment
- Emotional support services and bereavement counseling furnished within six months after the patient's death
- Physical, occupational, speech, respiratory and chemical therapy

No hospice benefits are payable for:

- Services or supplies rendered during any period in which the covered person is not under the regular care of a physician;
- Services or supplies that might be considered as a covered expense under other sections of the Plan;
- Charges incurred during a remission period when the covered person is discharged from the hospice care program;
- Charges for services provided by the covered person, spouse, child, brother, sister or parent of the covered person; and
- Charges for, pastoral, financial or legal counseling.

HOME HEALTH CARE EXPENSE BENEFITS

The ACMS Patient Services Center should be notified prior to receiving Home Health Care services. The toll-free telephone number for ACMS is:

1-877-304-0761

ACMS office hours are 8:00 a.m. to 5:00 p.m. Eastern Time Monday through Friday. An answering system will take messages during the hours when ACMS is closed.

If a covered person incurs charges for services rendered by a Home Health Care Agency for treatment due to an injury or illness, the Plan will consider charges up to the Usual, Customary, and reasonable (UCR) Allowance and pay benefits at the benefit percentages for home health care for the maximum number of visits per calendar year shown in the Schedule of Benefits. The attending physician must recommend home health care, and ACMS should be notified prior to treatment.

Home health care services must be established and approved in writing by the attending physician following a hospital confinement and/or the attending physician must make documented certification of medical necessity. A visit occurs each time an employee of a Home Health Care Agency visits the patient. Each four hours or less of home health care services will be considered one home health care visit.

Home Health Care Services consist of:

- Care by or under the supervision of a registered nurse (R.N.) or licensed practical nurse (L.P.N.);
- Part-time or intermittent home health aide services primarily for the care of the covered person as long as the covered person is receiving either skilled nursing care, physical, occupational or speech therapy; and
- Physical, occupational or speech therapy provided in the covered person's home by the Home Health Care Agency.

Any charges for home health care visits exceeding the Calendar Year maximum number of visits shown in the Schedule of Benefits are not covered expenses and shall not apply to the out-of-pocket maximum or to the section of the Plan entitled "All Other Covered Medical Expenses."

No Home Health Care benefits are payable for:

- Services performed by a member of the covered person's family or a person residing in the covered person's home;
- Transportation services; and
- Services or supplies rendered during any period in which the covered person is not under the regular care of a physician.

PHYSICIAN'S EXPENSE BENEFITS

If a covered person incurs eligible expenses as the result of a non-occupational Injury or Illness while hospital confined or as an outpatient for the medical services listed below, the Plan will pay benefits at the benefit percentages shown in the Schedule of Benefits for such services. The calendar year deductible applies to all inpatient and outpatient Physician's Expense Benefits except Plan A In-Network Non-Surgical Office Visits and allergy injections. The Calendar Year Deductible is also waived for Second Surgical Opinions, whether in-network or not. The Covered Person's share of the percentage co-payments will count towards the Out-of-Pocket Maximum. The Covered Person's In-Network per visit co-payment for non-surgical office visits do not count toward the Out-of-Pocket Maximum.

Non-Surgical Office Visits

Physician's office visit charges, including allergy injections, testing and treatment, are payable as shown in the Schedule of Benefits. X-ray and laboratory tests performed during the office visit and billed by the doctor's office will be included in this benefit.

Second Surgical Opinion -(Calendar Year Deductible Waived)

If a surgeon recommends non-emergency surgery, the covered person may obtain a second professional opinion by another surgeon who is not in practice with and has no business relationship with the attending surgeon. The Plan will pay benefits at the co-payment percentages shown in the Schedule of Benefits for a Second Surgical Opinion.

The Plan will pay for the consultation and any necessary tests provided the Second Surgical Opinion is performed in the physician's office, clinic or the outpatient department of the hospital for the purpose of determining the necessity for a specific surgical procedure recommended by the surgeon. The Plan will also pay for one (1) additional consultation by a third surgeon when the first two opinions vary.

ACMS may be contacted for advice on the necessity of obtaining a Second Surgical Opinion for a specific surgical procedure. No benefits are payable under this provision for:

- a) The initial visit with the attending physician or surgeon at which time surgery is recommended; or
- b) Any pre-surgical visit with the surgeon who ultimately performs the surgical procedure.

Surgery and Assistant Surgeon Charges

Surgical benefits are payable as shown in the Schedule of Benefits and include operative and cutting procedures when performed by a Physician acting within the scope of his license who is not an employee of the Hospital where the surgery is performed. Vasectomy and tubal ligation—but not reversals of sterilization—and certain oral surgical procedures will also be covered, including:

- Surgical removal of impacted teeth
- Repair of Injury to teeth within 12 months of the accident
- Excision of tumors and cysts of the mouth and oral cavity

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

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

Women's Health and Cancer Rights Act of 1998

Medical and surgical services for mastectomy, as well as subsequent reconstruction in connection with a mastectomy, will be covered under the Plan as follows:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce symmetrical appearance
- Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient

Anesthesia

Anesthesia benefits are payable as shown in the Schedule of Benefits for the physician's charges for administration of general anesthesia in connection with a covered surgical procedure. Anesthesia services must be ordered by the attending physician or surgeon and administered by a physician, surgeon, or Nurse Anesthetist who is neither the operating surgeon nor his surgical assistant who is not an employee of the hospital.

Hospital In-patient Doctor Visits

Physician's hospital visit benefits are payable as shown in the Schedule of Benefits for physician's charges while the Covered Person is hospitalized. Hospital visits must be rendered by a physician other than the operating surgeon or his assistant.

The applicable per-visit co-payment will not apply to the Calendar Year Deductible nor count toward the satisfaction of the out-of-pocket maximum.

Radiology/Pathology Interpretation

Plan benefits are payable as shown in the Schedule of Benefits for the physician's charges for interpretation of radiology and pathology tests.

DIAGNOSTIC X-RAY, LABORATORY AND MEDICAL TEST EXPENSE BENEFITS

If a covered person incurs outpatient charges at the hospital or at an independent laboratory for X-ray, laboratory and medical tests performed for the purpose of diagnosing a non-occupational Injury or Illness, the Plan will pay benefits at the benefit percentages outlined in the Schedule of Benefits for such services.

For x-ray and laboratory tests performed during an office visit and billed by the Network physician, refer to the section entitled "Physician's Expense Benefit."

No benefits are payable under this section of the Plan for:

- Dental X-rays, except as the result of an Injury or surgical removal of impacted teeth
- Any examination which is payable under the "Hospital Benefit" section of the Plan

RADIATION THERAPY, CHEMOTHERAPY AND KIDNEY DIALYSIS EXPENSE BENEFIT

Radiation, radium, X-ray therapy, and chemotherapy benefits are payable as shown in the Schedule of Benefits for the facility and physician's charges for treatment through the use of roentgen rays, radium rays, the rays of other radioactive substances, or through chemotherapy.

Kidney dialysis benefits are payable as shown in the Schedule of Benefits for the facility and physician's charges for necessary kidney dialysis services performed by a physician who is not an employee of the hospital.

PREVENTIVE CARE EXPENSE BENEFITS
(Calendar Year Deductible Waived For In-Network)

The Plan will pay benefits for all routine preventive care as shown in the Schedule of Benefits. Covered services include, but are not limited to:

- routine physical exams,
- Pap smears
- Mammograms
- prostate exams and PSA testing
- colonoscopy
- sigmoidoscopy
- bone density tests, and
- any other routine testing or screenings recommended by the attending physician.

The calendar year deductible is waived for In-Network preventive care expenses. However, all per visit co-payments and percentage co-payments apply. The per-visit co-payment of Plan A does not count toward the satisfaction of the Out-of-Pocket Maximum.

No benefits are payable beyond the Calendar Year Maximum Benefit specified in the Schedule of Benefits. Any benefits paid out-of-network will also apply toward the maximum in-network benefit and vice versa.

SMOKING CESSATION/WEIGHT LOSS EXPENSE BENEFIT
(Calendar Year Deductible Waived)

The Plan will pay benefits for the treatment of weight loss and/or smoking cessation as shown in the Schedule of Benefits, not to exceed a lifetime maximum benefit of per Covered Person as shown in the Schedule of benefit. All treatment must be recommended and supervised by a licensed medical professional, and may include prescription drugs.

The calendar year deductible is waived for treatment of smoking cessation and weight loss.

OUTPATIENT MENTAL ILLNESS, NERVOUS DISORDERS, ALCOHOLISM AND DRUG DEPENDENCY EXPENSE BENEFITS

The ACMS Patient Services Center must be notified prior to outpatient treatment of mental illness, nervous disorders, alcoholism, or drug dependency. Failure to comply will result in a reduction of the benefit percentage to 50%.

The toll-free telephone number for ACMS is:

1-877-304-0761

ACMS office hours are 8:00 a.m. to 5:00 p.m. Eastern Time Monday through Friday. An answering system will take messages during the hours when ACMS is closed.

If a covered person incurs charges for outpatient treatment of mental illness, nervous disorder, alcoholism and/or drug dependency, including services in a Community Mental Health Facility, an Alcoholism Treatment Facility, or a Hospital, as defined, the Plan will pay benefits as outlined in the Schedule of Benefits up to the maximum number of visits per Calendar Year as specified.

Covered services include:

- Professional services performed by an employee of, and billed by, the facility.
- Psychological testing when administered by a licensed psychologist;
- Prescription drugs, biologicals and solutions dispensed and administered by the facility in connection with the condition being treated;
- Electroshock therapy, including anesthesia when administered by a physician;
- Individual, group or family counseling; and
- Supplies and use of equipment for detoxification and/or rehabilitation.

The Calendar Year Deductible applies to treatment of mental illness, nervous disorder and alcoholism and drug dependency. Any percentage co-payments apply to the out-of-pocket maximum. However, any penalty reduction for failure to notify ACMS as required by the Plan will not apply toward satisfaction of the out-of-pocket maximum.

No benefits are payable under this section of the Plan for:

1. Services of the attending physician or other medical services except as specified;
2. Mental health services beyond the period necessary for evaluation and diagnosis of mental deficiency or retardation; and
3. Diversional therapy or marriage counseling.

ORGAN AND/OR TISSUE TRANSPLANTS EXPENSE BENEFITS

ACMS must be notified prior to receiving services for an Organ and/or Tissue Transplant or any inpatient hospital benefits will be reduced by \$300 per period of confinement. The toll-free telephone number for ACMS is:

1-877-304-0761

ACMS office hours are 8:00 a.m. to 5:00 p.m. Eastern Time Monday through Friday. An answering system will take messages during the hours when ACMS is closed.

The Plan will consider charges up to the Usual, Customary, and Reasonable (UCR) Allowance and pay benefits after satisfaction of the Calendar Year Deductible and at the appropriate benefit percentages for the services provided as shown in the Schedule of Benefits for services and supplies provided in connection with organ and/or tissue transplant procedures, including bone marrow/stem cell transplants as outlined below:

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

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

Donor Costs —

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

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

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

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

- 1) Total travel and lodging benefits will not exceed \$10,000 per transplant.

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

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

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

SPECIAL TRANSPLANT BENEFIT

In addition to any standard transplant benefit set forth in this booklet, a Special Transplant Benefit may be available when a Covered Person participates in the Special Transplant Program. The Special Transplant Benefit provides enhanced transplant benefits and participation in the Program is voluntary. Additional information regarding the Special Transplant Program may be obtained through ACMS.

The Special Transplant Benefit provides the following benefits in addition to any transplant benefits available under this plan:

1. Access to Centers of Excellence Transplant Facilities throughout the United States;
2. Waiver of the Covered Person's deductible and co-payments up to \$1,500 during the year in which the transplant occurs.

The Special Transplant Benefit is only available when a Covered Person participates in the Special Transplant Program and satisfies all of the following requirements:

1. Notification of the transplant procedure must be provided to ACMS in accordance with its guidelines;
2. ACMS will call the Special Transplant Program at 1-888-4ORGANS as soon as the Covered Person is identified as a potential transplant candidate to notify the Special Transplant Program of the impending transplant; and
3. All transplant services must be rendered at a Centers of Excellence Transplant Facility which participates in this Program for the specific organ or tissue transplant required. A current list of participating Centers of Excellence facilities for each type of transplant is available from ACMS.

ALL OTHER COVERED MEDICAL EXPENSES

The Plan will consider charges up to the Usual, Customary, and Reasonable Allowance for the following types of necessary medical services, supplies and treatments that have not been considered under other provisions of the Plan. The Plan will pay benefits at the benefit percentages shown in the Schedule of Benefit after the Calendar Year Deductible has been satisfied.

1. **Ambulance.** Necessary professional ambulance service to and from the nearest hospital qualified to provide treatment of an illness or injury;
2. **Blood.** Blood, blood plasma, blood derivatives, and blood transfusions;
3. **Dental.** Dental services for:
 - a) Accidental injury to sound natural teeth (within 12 months of the injury);
 - b) Removal of impacted wisdom teeth whether partially or completely covered by bone or soft tissue;
 - c) Operative and cutting procedures of the mandible and maxilla;
 - d) Excision of radicular or dentigerous cyst;
 - e) Dental root resection (apicoectomy);
 - f) Alveolectomy (area covering at least six consecutive tooth sockets) only when performed as an independent procedure (not at the time of extraction of teeth); and
 - g) Gingivectomy or osseous surgery
4. **Durable Medical Equipment.** Rental, not to exceed the purchase price, (or purchase at the Plan's option subject to pre-approval by the Claims Administrator) of a hospital bed, wheelchair or other durable medical equipment required for therapeutic use;

Note: ACMS notification is encouraged at 1-877-304-0761 prior to rental or purchase of durable medical equipment exceeding \$400.
5. **Medial Supplies.** Orthopedic braces, crutches, casts, and other necessary medical supplies including their replacements, repair or adjustment when medically necessary;
6. **Midwife.** Charges incurred by a licensed midwife or midwife in an approved facility licensed by the appropriate state health department;
7. **Nursing care.** Services of a registered nurse (R.N.) or licensed practical nurse (L.P.N.), if not a member of the covered person's immediate family or residing in the covered person's home, limited to a maximum benefit of \$100 per day;
8. **Occupational Therapy.** Services of a licensed occupational therapist if prescribed by the attending physician, either inpatient or outpatient, limited on an outpatient basis to a maximum benefit per Calendar Year as specified in the Schedule of Benefits;
9. **Oxygen.** Oxygen and rental of equipment for its administration;

10. **Physician Services.** Charges made by legally qualified physicians for diagnosis and treatment, including the medically necessary treatment provided by a licensed chiropractor, except as otherwise specified herein;

11. **Physical Therapist.** Services of a licensed physical therapist if prescribed by the attending physician;

12. **Prescription Drugs.**

PLAN A ONLY:

Drugs obtainable only upon the written prescription of a licensed physician and which are not available through the Prescription Drug Program of the Plan;

Note: All other drugs must be obtained under the Prescription Drug Card Benefits section of this Plan.

PLAN B ONLY:

Drugs and medicines obtainable only upon the written prescription of a licensed physician;

13. **Prosthetic Appliances.** Prosthetic appliances (except corrective shoes) such as artificial limbs and eyes, including their replacement, repair, or adjustment when medically necessary;

14. **Speech Therapy.** Speech therapy rendered by a licensed, certified speech therapist (C.S.T.) will be considered as shown in the Schedule of Benefits. Restorative or rehabilitative speech therapy must be for speech loss or impairment due to an Illness or Injury or due to surgery performed as the result of an Illness or Injury. Speech therapy services provided due to developmental delays are not covered by the Plan; however, such services may be available through state programs. This Plan will not duplicate speech therapy services provided by the public schools or other agencies. Because not all speech therapy is covered, it is recommended that a treatment plan be submitted to ACMS for review after the first visit.

SECTION C

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PRESCRIPTION DRUG PROGRAM

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PRESCRIPTION DRUG PROGRAM

If a covered person requires prescription drugs prescribed by the attending physician, the Plan will provide two separate options for payment of covered charges. At a participating Network pharmacy, the covered person may present his prescription drug card and pay a co-payment per prescription order. For maintenance drugs, the prescription order may be submitted by mail to the mail order prescription drug company with a check for the co-payment. The co-payment required will not apply to Comprehensive Medical Expense Benefits. The Schedule of Benefits outlines the applicable co-payment amounts.

Benefits paid under the Prescription Drug Program will apply to the Maximum Lifetime Benefit Per Covered Person shown in the Schedule of Benefits under Comprehensive Medical Expense Benefits.

COVERED DRUGS

Covered drugs include legend drugs, compounded medications when at least one ingredient is a legend drug, and injectable insulin and Imitrex. "Legend drugs" are those which Federal Law requires to bear the legend "Caution: Federal Law prohibits dispensing without a prescription". Pre-natal vitamins and oral contraceptives will be covered items. Retin-A will be covered for covered persons through the age of 24. Impotency medications will be covered only with a letter of medical necessity. Any questions regarding the network pharmacy program can be answered by calling the telephone number shown on the Identification Card.

OPTION 1 - PHARMACY NETWORK

Prescriptions for up to a 90-day supply may be filled at any pharmacy that accepts the prescription drug card and the Plan will pay the full cost after the covered person pays the co-payment shown in the Schedule of Benefits. The covered person should present his prescription drug card to the participating pharmacy and pay the required co-payment at time of purchase.

OPTION 2 - MAIL ORDER MAINTENANCE PROGRAM

If a covered person incurs expenses for maintenance medicines obtainable upon the written prescription of a licensed physician, the Plan will pay the full cost after the covered person pays the co-payment for a generic or a brand-name prescription order shown in the Schedule of Benefits.

The mail order program fills prescriptions from a 30-day minimum supply up to a 90-day maximum supply of medication, and provides for automatic substitution of FDA-approved generic drugs unless otherwise specified by the attending physician. The co-payment is required of the covered person when a prescription is mailed in. The filled prescriptions may be sent to the home or to the office, and delivery is usually achieved within five to ten days.

The mail order program is designed for maintenance drugs taken on a regular basis, and for which a prescription exceeding 30 days has been written. All refills should be mailed after it has been determined that the drug is to be taken on a continuing basis. A refill order slip will be enclosed with each order. This slip should be submitted when a 10 to 14-day supply of medication remains.

For covered persons currently using prescribed maintenance drugs, the physician should be contacted for a new prescription to be sent to the mail order program. It should be explained that the prescription would be submitted to a new mail order pharmacy.

The mailing envelope for prescriptions is available in the Company. All refill orders plus a check should be submitted in the mailing envelope after it has been determined that the drug is to be taken on a continuing basis.

NOTE: *Prescription drugs may not be purchased through the pharmacy card program or the mail order program for any covered dependents who have primary coverage through another group health care plan.*

LIMITATIONS UNDER NETWORK PHARMACY AND MAIL ORDER PROGRAM

No prescription benefits shall be payable for:

1. **Active Treatment.** Prescriptions that are not necessary for the treatment of an Illness or Injury unless specifically outlined herein (Example: diet pills, vitamins, laxatives, Norplant, Rogaine, etc.)
2. **Administration.** Charges for administration or injection of any drug
3. **Apparatus.** Medical apparatus and equipment
4. **Compounded Prescriptions.** Compounded prescriptions unless at least one ingredient is in prescription strength
5. **Cosmetic.** Drugs prescribed for cosmetic purposes except as specifically provided
6. **DESI.** DESI Drugs (Drugs determined by the Food and Drug Administration as lacking substantial evidence of effectiveness)
7. **Devices.** Charges for therapeutic devices or appliances such as support garments or other non-medical substances, regardless of the intended use
8. **Fertility Drugs.** Fertility drugs
9. **Immunization Agents.** Immunization agents, biological sera, blood or blood plasma
10. **Investigational.** Investigational or experimental drugs or drugs intended for non-medical use
11. **Non-network.** Any prescription drugs purchased at non-network pharmacies
12. **Over the Counter. (OTC)** Items that can be purchased legally without a prescription
13. **Smoking Cessation.** Smoking cessation products. (see Medical Benefits for Smoking Cessation Benefit.)
14. **Time Limit.** Any prescription refill dispensed later than one year after the original prescription

SECTION D

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VISION SERVICE PLAN (VSP)

VISION EXPENSE BENEFITS

EXAMINATION AND MATERIALS

When an examination and/or materials are received from a VSP member doctor, the Covered Person will have no out-of-pocket expense other than the co-payment shown in the Schedule of Benefits, unless optional items are selected that the Plan does not cover. Polycarbonate lenses and anti-reflective and scratch resistant coatings are covered items. Optional items not covered by the Plan include but are not limited to, oversize lenses (61 mm or larger), progressive lenses, tinted or photochromic lenses, coated lenses, no-line multi-focal lenses or a frame which exceeds the Plan allowance.

Services obtained through non-VSP member doctors are subject to the same co-payments and limitations as services through VSP member doctors. See the Schedule of Benefits for reimbursement maximums.

FRAMES

VSP's frame benefit fully covers more than 13,000 of the frames currently available. Due to this large selection and the fact that buying habits and tastes differ from one region to the next, frame inventories may vary from office to office. When deciding on a frame, Covered Persons can choose a frame up to the value stated in the Schedule of Benefits. Covered persons will receive a 20% discount on frames over their frame allowance.

CONTACT LENSES

Contact lenses may be selected in place of lenses and frames. The lens allowances shown in the Schedule of Benefits are for two lenses; if only one lens is needed, the allowance will be one half of the pair allowance. Annual supplies of many of the most popular contact lenses are available to Covered Persons at competitive prices (at a VSP provider).

VSP will determine when contact lenses are "medically necessary". Otherwise, the "elective" allowance shown in the Schedule of Benefits will prevail.

PRIMARY EYE CARE

When a VSP participating doctor is visited for health-related problems of the eyes, the plan will cover 100% of the (non-surgical) expense after a \$5.00 co-pay per visit.

VISION BENEFIT LIMITATIONS

No vision benefits will be payable for the following expenses:

- Medical or surgical treatment of the eyes (may be covered under the medical plan)
- Orthoptics or vision training and any employment-related testing
- Plano lenses
- Two pairs of glasses instead of bifocals

Please see General Limitations for additional limitations.

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GENERAL LIMITATIONS

No benefits shall be payable under the Plan with respect to:

1. **Abortion.** Any charges for elective abortion unless the life of the mother is in danger;
2. **Alternative Treatment.** For charges in connection with acupuncture, acupressure, or hypnosis.
3. **Artificial Impregnation.** Any charges related to artificial impregnation (including artificial insemination and in vitro procedures);
4. **Civil Insurrection.** Any charges incurred as the result of injury or illness caused by participation in civil insurrection or riot unless due to a medical condition or domestic violence;
5. **Court Ordered.** Any charges for court-ordered care to avoid a fine or incarceration unless medically necessary;
6. **Cosmetic.** Any charges for cosmetic surgery except:
 - a) As the result of an accidental injury or illness;
 - b) Surgery to correct a covered child's congenital defect; and
 - c) As the result of removal of tissue due to a cyst, tumor or carcinoma and as specifically provided for mastectomy;
7. **Custodial Care.** Any charges for education, training, custodial or domiciliary care, rest cures or nursing homes, or for personal hygiene or convenience items;
8. **Dental Care.** Any charges for dental treatment except treatment due to an accidental injury to sound natural teeth and as specifically provided herein (see "All Other Covered Medical Expenses");
9. **Education.** Any charges in connection with any treatment, therapy, teaching technique or program for remedial education or habilitative training which is principally intended to overcome, compensate for or improve any non-organic learning impairment;
10. **Experimental.** For, or in connection with, Experimental, Investigational or Unproven drugs, procedures or treatment as defined
11. **Family.** Any charges for services of any person who is a member of the covered person's immediate family or who resides in his home;
12. **Foot Care.** Any charges for services or supplies for removal of corns, calluses or clavus, or trimming of nails;
13. **Government Benefits.** Any service or supply for care or treatment provided or furnished by the United States Government, or any service or supply for care or treatment provided or furnished by any state or local government when without this coverage the employee would not be required to make payment, except:

- a) Treatment rendered United States veterans for non-service related injury or illness in Veterans Administration hospitals;
 - b) Inpatient hospital charges for treatment rendered to military retirees and their eligible dependents while confined in a military hospital;
 - c) Inpatient psychiatric care provided by a state hospital;
14. **Illegal Occupation.** Any charges incurred for injury or illness resulting from or sustained as a result of being engaged in an illegal occupation and commission or attempted commission of an assault or felonious act unless due to a medical condition or domestic violence;
15. **Infertility.** Any charges for procedures or drugs for the treatment of infertility, although the initial tests to determine the diagnosis of infertility are covered;
16. **Mental Illness/Substance Abuse.** Any charges for treatment of mental illness or nervous disorders, alcoholism or drug dependency except as specified in the Plan;
17. **No Legal Obligation.** Any charges which the covered person has no legal obligation to pay or which would have not been made in the absence of coverage under this Plan;
18. **Not Medically Necessary.** For services or supplies not deemed medically necessary for the active treatment of an illness, except as specifically provided herein;
19. **Not Prescribed.** Any charges for services or supplies which are not necessary for the active treatment of an illness or injury or which are not prescribed or recommended by a physician acting within the scope of his license, except as otherwise specified herein;
20. **Nutritional Therapy.** Nutritional supplements and therapies are not covered except for enteral and parenteral nutrition therapies when medically necessary. Medical necessity is determined on a case by case basis and the treatment plan and a detailed explanation of the medical necessity must be submitted to the ACMS for review and approval. Not covered are:
- a) Enteral tube feedings for individuals who are capable of adequate oral intake.
 - b) Food supplements, specialized infant formula, vitamins and/or minerals taken orally
 - c) Parenteral nutrition for individuals with a functioning gastrointestinal tract whose need for parenteral nutrition is only due to
 - swallowing disorder
 - Temporary defect in gastric emptying
 - psychological disorder
 - hemodialysis
 - Disorders inducing anorexia such as cancer
 - Peritoneal dialysis (intraperitoneal amino acid (IPAA) supplementation for individual on peritoneal dialysis may be considered if certain criteria are met.)
21. **Self-Inflicted.** Any charges incurred due to intentionally self-inflicted injury and any attempts to commit suicide or complications arising out of the attempt(s) unless due to a medical condition or domestic violence;
22. **Sexual Dysfunction.** Any charges for treatment or surgery to change gender or to improve or restore sexual function;

23. **TMJ.** For treatment of Temporomandibular Joint dysfunction, except as specifically outlined in the Plan;
24. **UCR** Any charges in excess of Usual, Customary, and Reasonable Allowance. (see "Definitions")
25. **Vision/Hearing.** Any charges for refractions, eyeglasses or contact lenses (except for the first pair following cataract surgery and as provided in the VSP program), radial keratotomy or any similar refractive procedure, hearing aids, or examinations for the prescription or fitting thereof;
26. **War.** Any charges incurred due to injury or illness resulting from duty as a member of the Armed Forces of any state or country, war or act of war, declared or undeclared, or nuclear explosion or accident;
27. **Weight Loss.** Weight loss by diet control, medicine, or exercise. Surgical treatment of morbid obesity is not be covered unless a patient meets ALL of the following criteria:
 - a) The patient has had a diagnosis of morbid obesity for at least five years.
 - b) The patient has a body maximum index (BMI) greater than or equal to 40 or a BMI greater than 35 with any of the following severe co-morbidities:
 - Coronary heart disease
 - Type 2 diabetes mellitus
 - Hypertension
 - Sleep apnea
 - c) The patient is between the ages of 18 and 55.
 - d) The patient has been on a medically supervised weight loss and exercise program for 12 consecutive months prior to the surgery date, and occurring within three years of the proposed surgery date. Medical supervision must occur under an M.D., D.O., N.P. or R.D. To review the medical necessity of the obesity surgery, all of the following documentation must be submitted for review:
 - Description of the supervised dietary program
 - Patient response to dietary program
 - Documentation of the patient participating in an exercise program
 - e) Evaluation by a licensed psychologist or psychiatrist documenting the absence of significant psychopathology that can limit a patient's ability to comply with the pre- and post-operative regimen.
 - f) Documentation that the patient is willing to comply with all pre- and post-operative treatment plans.

The following surgical procedures are considered investigational and are not covered under the Plan:

- Loop gastric bypass
- Gastroplasty (stomach stapling)
- Duodenal switch operation

- Biliopancreatic bypass (Scopinaro procedure)
- Mini gastric bypass

The Plan also excludes any reduction or removal of excess skin as a result of weight reduction (e.g. liposuction, panniculectomy, thigh/breast/arm reduction, etc.), regardless of the condition of the skin.

28. **Workers Compensation.** Any charges incurred for illness or injury which entitles the covered person to any benefits under a Workers' Compensation Act or similar legislation; or which are due to any occupation or employment for wage or profit except if Workers Compensation coverage was not available to the Covered Person; and
29. **Workplace Clinic.** Any charges for services and supplies provided through a medical department, clinic or other facility provided by or maintained by the covered person's employer, or a medical clinic or similar facility for which services or supplies are or should be available without charge to the covered person.

COORDINATION OF BENEFITS WITH GROUP PLANS AND MEDICARE

EXPLANATION OF COORDINATION

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

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

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

PRIMARY PLAN

Regardless of the rules set forth in other plans covering persons covered under this Plan, benefits shall be determined according to the following rules which establish the order of payment and the Primary Plan in the following order:

- a) The plan not having any Coordination of Benefits provision or Non-Duplication Coverage Exclusion will always be the Primary Plan; or
- b) The plan covering the person as an employee, rather than the Plan covering the person as a dependent; or

- c) The plan covering the person as an active employee will always be the Primary Plan while the Plan that covers the covered employee who is laid-off or retired will be secondary; this shall also apply to the covered dependents of such employee; or
- d) If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, member subscriber or retiree (or as that person's dependent) will be the Primary Plan and the continuation coverage will be secondary; or
- e) The Primary Plan with regard to a dependent child shall be the Plan covering the person as a dependent child of the employee (Parent), whose birthday occurs earlier in the calendar year. If both parents have the same birthday, the Primary Plan is the plan that has covered the parent for the longer period of time. However, determination of the Primary Plan with respect to a dependent child according to the employee's birthday method will defer to the other Plan in force when the other Plan does not follow the birthday method. The following exception for dependent children of separated or divorced parents shall apply:
 - I) If parents are divorced or separated and there is a court decree which establishes financial responsibility for medical, dental, or other health care expenses for the child, the Plan covering the child of the parent who has that responsibility will be primary;
 - II) If there is no such court decree, the Plan that covers the child as a dependent of the parent with custody will be primary;
 - III) If there is no court decree and the parent with custody has remarried, the order of benefits will be:
 - 1) The Plan of the parent with custody;
 - 2) The Plan of the spouse of the parent with custody;
 - 3) The Plan of the parent without custody.

When the above rules do not apply, the Plan that has covered the person (patient) for the longer period of time will be primary.

ALLOWABLE EXPENSES

"Allowable Expenses" shall mean any necessary usual, customary and reasonable expenses incurred while eligible for benefits under the Plan, part or all of which would be covered under any of the Plans, but not including any expenses contained in the list of General Limitations. "Plan" shall mean any Plan providing benefits or services for or by reason of medical or dental care or treatment that is provided by group insurance, Medicare, no-fault auto insurance or any other employer or government-sponsored programs.

With regard to any covered person eligible to elect Medicare, except those described in the next paragraph, Medicare benefits will be considered as having been paid whether or not the

covered person has applied for Medicare coverage or submitted a claim for Medicare benefits. It is the covered person's responsibility to apply for and maintain both Part A and Part B Medicare coverage.

With regard to an **actively at work** eligible employee age sixty-five (65) or older, or an eligible covered dependent spouse of an active eligible employee who is within the same age bracket, either of whom has elected in writing to be covered under this Plan, the benefits of this Plan will be primary.

This Plan shall also be primary for military retirees and their eligible dependents for inpatient hospital charges in military medical hospitals as required by law and in accordance with this Plan. The Claims Administrator shall have the right to request and release any information that is necessary in order to determine the primary plan.

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

FACILITY OF PAYMENT

Benefits may be paid directly to the providers of services if a valid assignment of benefits is executed.

If, in the opinion of the Claims Administrator, a valid release cannot be rendered for the payment of any benefit payable under this Plan, the Claims Administrator may, at his option, make such payment to the individual or individuals as are, in the Claims Administrator's opinion, equitably entitled thereto. In the event of the death of the covered person prior to such time as all benefit payments due him/her have been made, the Claims Administrator may, at his sole discretion and option, honor benefit assignments, if any, made prior to the death of such covered person.

Any payment made by the Claims Administrator in accordance with the above provisions shall full discharge the Plan to the extent of such payment.

RECOVERY RIGHTS

INTRODUCTION

The Plan has the right to recover in full the medical benefits (and disability benefits if provided by the Plan) paid for injuries caused by the act or omission of any party. The Plan's right of recovery, as explained below, may be from the Covered Person, the third party, any liability or other insurance covering the third party, the Covered Person's own uninsured motorist benefits, underinsured motorist benefits or any medical pay or no-fault benefits which are paid or payable to the Covered Person from any source whatsoever. The Plan's right to any

monies recovered (through either reimbursement or subrogation) takes priority over any other party's right (including that of the Covered Person) to monies recovered, regardless of whether the amount recovered constitutes a partial or full recovery of the benefits paid by the Plan.

RIGHT OF REIMBURSEMENT

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

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

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

SUBROGATION

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

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

IN GENERAL

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

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

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

AMENDMENT, MODIFICATION OR TERMINATION

The Trustees of this Plan reserve the right to amend, modify, or terminate any or all of the provisions of this Plan (including retroactively if necessary or appropriate to meet ERISA or other statutory requirements) at any time. Amendment, modification, or termination, however, shall not adversely affect the right of a covered person to receive reimbursement for medical expenses incurred prior to the date of such amendment, modification or termination, nor shall it permit the use or application of the Trust funds for the benefit of anyone other than persons covered or formerly covered under this Plan.

DEFINITIONS

ADVERSE BENEFIT DETERMINATION

An adverse benefit determination means any denial or failure to make payment, in whole or in part, in response to a claim properly submitted to the Claims Administrator, including determination of a person's eligibility to participate in the Plan, any failure to provide or make payment due to utilization review, and a denial of an item or service which is determined to be experimental, investigational or not medically necessary.

ALCOHOLISM TREATMENT FACILITY

An alcoholism treatment facility is a facility that:

- a) Is approved by the Joint Commission on Accreditation of Healthcare Organizations or is certified by the Department of Health; and
- b) Has in effect plans for utilization and peer review; and
- c) Has in effect programs for detoxification or rehabilitation.

"Residential Alcoholism Treatment Facility" shall mean a facility as herein defined that operates 24 hours a day and seven days a week.

"Outpatient Alcoholism Treatment Facility" shall mean a facility as herein defined that provides services to ambulatory patients during designated hours and/or specified days.

ALTERNATE RECIPIENT

An Alternate Recipient is any child of an Eligible Employee or other Participant under the Plan who is recognized under a Medical Child Support Order (MCSO) as having a right to enrollment under the Plan with respect to that Eligible Employee or Participant.

ALTERNATIVE CARE MANAGEMENT SYSTEMS, INC. (ACMS)

ACMS is a health care management company that monitors the delivery of health care. ACMS works closely with local physicians in determining guidelines for patient care in accordance with acceptable medical and professional standards. ACMS has contracted with the Ohio Northern University Employee Benefit Plan to provide services to covered employees through the ACMS Patient Services Center.

The Patient Services Center is the operations center of ACMS, and is staffed by nurses and other support personnel. **Call the Patient Services Center at the following toll-free telephone number: 1-877-304-0761**

AMBULATORY CARE CENTER

An ambulatory care center is any public or private establishment with an organized medical staff of physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous physician services and registered professional nursing services whenever a patient is in the facility, and which does not provide services or other accommodations for patients to stay overnight.

ASSIGNMENT OF BENEFITS

An assignment of benefits is written authorization by the covered person for the Claims Administrator to pay benefits directly to the provider of service.

BUSINESS ASSOCIATE

A Business Associate is a person or organization that performs a function or activity on behalf of a Covered Entity, but is not part of the Covered Entity's workforce. A Business Associate can also be a Covered Entity in its own right.

CALENDAR YEAR

A calendar year is a period of 12 consecutive months beginning with January 1st and ending December 31st.

CLAIMS ADMINISTRATOR

A Claims Administrator is an entity that recommends or determines whether to pay claims to enrollees, Physicians, Hospitals or others on behalf of the group benefit plan. Employee Benefit Management Corp administers the claims as the Claims Administrator. Such claims information is available on EBMC's website at www.ebmconline.com.

COMMUNITY MENTAL HEALTH FACILITY

A community mental health facility is a facility that:

- a) Is approved by the Joint Commission on Accreditation of Healthcare Organizations or certified by the applicable State Department of Mental Health and Mental Retardation;
- b) Is approved by a regional health planning agency or is providing services under the applicable state statute; and
- c) Has in effect a plan for utilization review and for peer review.

COSMETIC SURGERY

Cosmetic surgery is surgical alteration for the improvement of the covered person's appearance, rather than improvement or restoration of bodily functions.

COVERED ENTITY

A Covered Entity is a health plan, healthcare clearinghouse or healthcare provider that transmits any health information in electronic form in connection with a HIPAA transaction, as defined in 45 C.F.R. § 160.103.

COVERED PERSON

A Covered Person is an eligible employee, who completes an Enrollment Form, his eligible dependents if the eligible employee elects dependent coverage and makes any required contribution, and any former covered employees or dependents whose coverage is continued by Plan provisions including but not limited to COBRA Continuation Coverage.

CREDITABLE COVERAGE

“Creditable Coverage” means those periods of coverage required to be included as such under Section 701(c) of ERISA and shall exclude those periods of coverage permitted to be excluded under Section 701(c) of ERISA, the purpose of which is to give credit for prior healthcare coverage under:

- A Group Health Plan
- A governmental or church health plan
- An individual health insurance plan
- Medicare Part A and B
- Medicaid
- A military-sponsored healthcare plan
- A program of the Indian Health Service or of a tribal organization
- A state health benefits risk pool
- The Federal Employees Health Benefits Program
- A public health plan as defined in regulations

CUSTODIAL CARE

Custodial care means any type of service including room and board and other institutional services which are designed essentially to assist the covered person, whether disabled or not, in the activities of daily living. Such services include assistance in walking or getting in and out of bed, bathing, dressing, feeding, preparation of special diets or supervision over medication that can normally be self-administered.

DAY TREATMENT PROGRAM/PARTIAL HOSPITALIZATION

A day treatment program is any outpatient treatment program accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association which is recommended by the attending physician for treatment of mental illness, nervous disorders, alcoholism or drug dependency and which takes place at least five (5) days per week for a minimum of six (6) hours per day. Such program must be under the direct supervision of a licensed psychologist or psychiatrist and may include both individual and group therapy, as well as family counseling by certified counselors if medically necessary, but shall not include any diversional therapy, marital counseling or court-ordered care.

EFFECTIVE DATE

The original effective date of the Plan was December 1, 1982; this revision is effective January 1, 2007. Benefits payable prior to this revision are governed solely by the terms of the Plan in effect when the covered expenses were incurred.

ELECTIVE ADMISSION

An Elective Admission is a Hospital Inpatient admission for a healthcare condition that is not life-threatening and for which there is flexibility in making Hospital arrangements. **The ACMS Patient Services Center should be notified at least seven days prior to an Elective Admission.**

ELECTIVE SURGERY

Elective Surgery is any non-emergency surgical procedure that may be scheduled at the convenience of the patient without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

ELECTRONIC PROTECTED HEALTH INFORMATION

"Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means Protected Health Information that is transmitted or maintained in any electronic media.

EMERGENCY ADMISSION

An emergency or urgent admission is an inpatient admission that occurs because of an immediate life-threatening situation. The ACMS Patient Services Center **must** be notified within **48 hours or two business days** following admission.

ENROLLMENT DATE

The enrollment date is the covered person's first day of coverage, or, if there is a waiting period, the first day of the waiting period.

ERISA

"ERISA" refers to the Employee Retirement Income Security Act of 1974 and has the meaning set forth in Pub. L. No. 93-406, as amended. It generally provides protections for Participants enrolled in health benefit plans and imposes various qualification standards, fiduciary responsibilities and enforcement procedures on welfare benefit plans.

EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN

Medical, surgical, psychiatric, substance abuse, or other health care technologies, treatment, diagnostic procedures, drug therapies other than Off-Label Drug Use, or devices, (collectively called treatment) will be considered experimental or investigational by the Plan if:

1. The treatment is governed by the United States Food and Drug Administration (“FDA”) and the FDA has not approved the treatment for the particular condition at the time the treatment is provided; or
2. The treatment is the subject of ongoing Phase I, II, or III clinical trials as defined by the National Institute of Health, National Cancer Institute, or the FDA; or
3. There is documentation in published US peer-reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine the safety, toxicity, or efficacy of the treatment.

FAMILY

“Family” means the enrolled employee and his dependents who meet the definition of an eligible dependent and are enrolled in the Plan.

FREE-STANDING SURGICAL OR EMERGENCY CARE FACILITY

A free-standing surgical or emergency care facility is a facility which is constituted, licensed and operated in accordance with the laws of legally authorized agencies responsible for medical institutions and which:

- a) Has emergency facilities and/or permanent operating rooms and at least one (1) recovery room and all necessary equipment for use before, during, and after surgery;
- b) Is supervised by an organized medical staff, including registered nurses (R.N.) available for care in an operating or recovery room;
- c) Has a contract with at least one (1) nearby hospital for immediate acceptance of patients who require hospital care following care in the free-standing surgical or emergency care facility; and
- d) Is other than a private office or clinic of one (1) or more doctors.

GROUP HEALTH PLAN

The term group health plan means an employee welfare benefit plan (as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974) to the extent that the plan provides medical care (as defined in paragraph (2) and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the Plan) directly or through insurance, reimbursement, or otherwise.

HIPAA

“HIPAA” refers to the Health Insurance Portability and Accountability Act of 1996 and has the meaning set forth in Pub. L. No. 104-191, as amended. It generally has two sections: Title I – which allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationship, and Title II – which mandates the adoption of standards for protecting the privacy and security of individually identifiable health information.

HOME HEALTH CARE AGENCY

A home health care agency is a public or private agency or organization, or a subdivision thereof that:

- a) Is primarily engaged in providing skilled nursing and other therapeutic services;
- b) Has policies established by associated professional personnel, including one or more physicians and one or more registered nurses (R.N.) to govern the services provided under the supervision of such physician or nurse;
- c) Maintains clinical records on all patients; and
- d) In cases where the applicable state or local law provides for the licensing of agencies or organizations of this nature, the latter are licensed or approved by the state or local laws as meeting the standards established for such licensing.

In no event, will the term "home health care agency" include one that is engaged primarily in the care and treatment of mental illness or provides primarily custodial care.

HOME HEALTH CARE AIDE

A home health care aide is an individual who provides medical or therapeutic care and who reports to and is under the direct supervision of a home health care agency.

HOME HEALTH CARE PLAN

A home health care plan is a plan for home care and treatment established and approved in writing by a physician who certifies that the individual would require confinement in lieu of the care and treatment specified in the Plan.

HOSPICE

A hospice is a facility which is engaged primarily in providing hospice services to terminally ill persons and which meets all the requirements set forth below:

- a) It has obtained any required state or government certificate of need approval;
- b) It is under the supervision of a duly qualified physician;
- c) It provides 24 hour a day, seven day a week service;
- d) It has a full-time administrator;
- e) It has a nurse coordinator who is a registered nurse (R.N.) with four years of full-time clinical experience, at least two of which involved caring for terminally ill patients;
- f) It has a social-service coordinator licensed in the jurisdiction where located;
- g) It maintains written records of services on all patients;
- h) It is established and operated in accordance with the applicable laws in the jurisdiction where located, is licensed and approved by the regulatory authority having responsibility for licensing under the law; and
- i) Its employees are bonded and it provides malpractice and malplacement insurance.

HOSPICE CARE

Hospice care is a plan for inpatient or outpatient treatment of a terminally ill patient with a life expectancy of six months or less as certified by a legally qualified physician.

HOSPICE CARE, PERIOD OF

A Period of Hospice Care is a period of time during which a Covered Person is in a Hospice Care program. Successive Periods of Hospice Care will be considered related and to have occurred in one period of care unless separated by at least three consecutive months.

HOSPITAL

A hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which meets all the requirements set forth below:

- a) It maintains permanent and full-time facilities for bed care of resident patients;
- b) It maintains, on the premises, diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified physicians;
- c) It continuously provides, on the premises, 24 hour a day nursing service by or under the supervision of registered graduate nurses; and
- d) It is operated continuously with organized facilities for operative surgery on the premises and is operating lawfully as a hospital in the jurisdiction where located. However, the requirements of facilities for surgery shall not apply to a qualified psychiatric institution or to an acute rehabilitation hospital.

The term "hospital" may also include a free-standing surgical or emergency care facility but does not include a hotel, rest home, nursing home, convalescent home, or facility for custodial care of the mentally ill or of the aged.

ILLNESS

An illness is a mental or physical disease or infirmity. For the purpose of coverage under this Plan, pregnancy and pregnancy related medical conditions, sterilization, and circumcision will be treated the same as an illness.

INJURY

An injury is a non-occupational accident that causes trauma to the body through unexpected external means.

INPATIENT

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

INTENSIVE OUTPATIENT TREATMENT PROGRAM

An intensive outpatient treatment program is any outpatient treatment program accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association and licensed or certified by the state where located, which is recommended by the attending physician for treatment of mental illness, nervous disorders, alcoholism or drug dependency and which takes place at least three (3) but not more than five (5) evenings per week for a minimum of three (3) hours per evening. Such program must be under the direct supervision of a licensed psychologist or psychiatrist and may include both individual and group therapy, as well as family counseling by certified counselors if medically necessary, but shall not include any diversional therapy, marital counseling or court-ordered care.

LIFETIME

Lifetime means, with regard to the Overall Lifetime Maximum Benefit, all periods of time during which the person is continuously covered under this Plan.

MATERNITY MANAGEMENT

Maternity management includes pre-natal care, risk assessment, and recommendations for life-style modifications. ACMS notification is encouraged as soon as possible after pregnancy has been confirmed to begin maternity management.

MEDICAL CHILD SUPPORT ORDER

A medical child support order (MCSO) is any court order, judgment, decree, or order (including a court's approval of a domestic relations settlement agreement) that:

- a) Provides for child support related to health benefits with respect to the child of a group health plan participant, or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- b) Enforces a state medical child support law enacted under Sec. 1908 of the Social Security Act with respect to a group health plan.

MORBID OBESITY

“Morbid Obesity” is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age, and mobility as the Covered Person; also, a Physician-verified Body Mass Index (BMI) of 40 or more, which is roughly equivalent to 100 pounds or more over ideal body weight, a weight level that is life risking.

NATIONAL MEDICAL SUPPORT NOTICE

A national medical support notice (NMSN) is a notice completed under an order issued by a court or by a state child support agency, including a qualified domestic relations order (QDRO), and is acceptable under ERISA in lieu of a Qualified Medical Child Support Order for adding a child under the Plan for medical and/or other coverage and which contains one or more of the following:

- a) The name of the issuing agency;
- b) The name and mailing address of an employee who is a participant in the Plan or eligible for participation under the Plan, who is a non-custodial parent obligated by a State court or administrative order to provide medical child support for one or more children named in the Notice;
- c) The name and mailing address of one or more alternate recipient(s); and
- d) The family group health care coverage required by the order is identified and available.

The employer must transfer Part B of the notice to the Plan Administrator within twenty business days, and the Plan Administrator must complete and return the notice to the issuing agency within twenty business days of receipt of the NMSN. Notification will be sent to the custodial and/or non-custodial parent whose coverage is the basis of the NMSN and from whom any necessary employee contributions will be withheld as determined under Part A of the notice.

NECESSARY MEDICAL SERVICES

Necessary medical services, procedures, or levels of care are those health services, supplies or drug therapies which are determined by the Plan to be medically necessary to meet the health needs of a covered person according to the benefits available in this Summary Plan Description.

Determination of necessary medical services is made on a case-by-case basis and considers several factors including, but not limited to, the standards of the medical community. The fact that a physician has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment of a particular injury or illness does not mean that it is medically necessary. In addition, the service must, in the Plan's judgment be:

- a) Consistent with the diagnosis of and prescribed course of treatment for the covered person's injury or illness;
- b) Necessary to treat the covered person's injury or illness;
- c) Required for reasons other than the convenience of the covered person or his physician, or not required for custodial, comfort or maintenance reasons; and
- d) Rendered at the frequency that is accepted by the medical community and in accordance with the Plan's guidelines.

NETWORK

A Network is a group of health care providers with whom the Ohio Northern University has contracted to provide medical care at negotiated rates to PPO plan participants.

NON-EMERGENCY ADMISSION

A non-emergency admission is an inpatient hospital admission, including a maternity admission, for a health care condition that is not life threatening and for which there is flexibility in making hospital arrangements. The ACMS Patient Services Center **must** be notified **at least seven days prior** to a non-emergency admission.

NON-EMERGENCY SURGERY

Non-emergency surgery is any surgical procedure that may be scheduled at the convenience of the patient without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

NOTICE OF PRIVACY PRACTICES

"Notice of Privacy Practices" has the meaning as set forth in 45 C.F.R. § 164.520, as amended, and is a document that outlines how a Covered Entity will use and disclose Protected Health Information and certain privacy and security rights under HIPAA

OCCUPATIONAL THERAPY

Occupational therapy means treatment that is rendered for reasons other than restoration of bodily function and the prevention of disability. Such treatment is usually rendered by the use of work-related skills and leisure time tasks for the evaluation of an individual's behavior and/or abilities for self-care, work or play.

OFF-LABEL DRUG USE

Off-Label Drug Use means the use of a drug for a purpose other than for which it was approved by the FDA. Expenses in connection with Off-Label Drug Use may be considered for coverage when all of the following criteria have been satisfied:

- The drug is not otherwise excluded under the Plan; and
- The drug has been approved by the FDA; and
- It can be demonstrated to the satisfaction of the Plan that the Off-Label Drug Use is appropriate and generally accepted for the condition being treated; and
- If the drug is used for the treatment of cancer, the American Medical Association Drug Evaluation, The American Hospital Formulary Service Drug Information, or the Compendia-Based Drug Bulletin recognize it as an appropriate treatment for that

OUTPATIENT

An Outpatient is a patient who receives healthcare services without being admitted to a Hospital or other facility for an overnight stay, his confinement is not an Inpatient, and the duration of his stay at the facility is less than 24 hours.

PERIOD OF CONFINEMENT

Successive periods of confinement will be considered one continuous confinement unless:

- a) The covered person has completely recovered from the injury or illness causing the earlier confinement;
- b) The employee has returned to work for at least one full day;
- c) The employee or dependent has not been confined for a period of at least 90 days; or
- d) The later confinement is for a totally unrelated condition.

PHYSICAL THERAPY

Physical therapy means treatment rendered to restore a certain degree of bodily function or prevent disability following illness, injury or loss of a body part. Physical therapy shall not include any occupational therapy.

PHYSICIAN

A physician is a person duly licensed under the governing authority to perform the services rendered for benefits covered under the Plan. Should such person be other than a Medical Doctor (M.D.), Doctor of Osteopathy (D.O.), or Doctor of Dental Surgery (D.D.S.), and the licensing requirements of the applicable jurisdiction require that such person be recognized as a provider to the extent that he is performing services within the scope of his license, such services will be recognized under the Plan.

PLAN

The Plan means the benefits and provisions for payment of benefits as set forth in the Ohio Northern University Employee Benefit Plan adopted by the Trustees.

POST-SERVICE CLAIM

A post-service claim is any claim that is not a pre-service claim. A post-service claim includes a claim that contains re-priced claims amounts, if applicable.

PRE-EXISTING CONDITION

A Pre-Existing Condition is any illness or injury for which a covered person has received any medical care or services during the three months immediately preceding his effective date of coverage under this Plan.

PRE-SERVICE CLAIM

A pre-service claim is any claim that relates to treatment that must be pre-certified or pre-approved under the terms of the Plan.

PRIVACY OFFICER

A Privacy Officer is the person responsible for developing and implementing the Company's policies and procedures under HIPAA's privacy and security rules.

PROTECTED HEALTH INFORMATION (PHI)

Protected Health Information (PHI) is individually identifiable health information transmitted or maintained in any form or medium, which is held by a Covered Entity or its Business Associate.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A qualified medical child support order (QMCSO) is an MCSO that specifies:

- a) The name and the last known mailing address of the eligible employee to whom the MCSO relates;
- b) The name and address of each child of the eligible employee ("alternate recipient") covered by the MCSO;
- c) A reasonable description of the type of coverage to be provided by the group health plan or the manner in which coverage will be determined;
- d) The period for which coverage must be provided; and
- e) Each group health plan to which the order applies.

In addition, the MCSO is "qualified" only if it does not require the group health plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent required by law.

RESIDENTIAL TREATMENT

Mental health/chemical dependency treatment in a facility or part of a facility operated for the primary purpose of providing residential mental health/chemical dependency care. The facility must be licensed by the state and JCAHO-approved for the treatment of a specific population. The treatment is 24 hours a day, seven days a week. It is direct, sub-acute mental health or chemical dependency treatment provided by licensed professionals in a multidisciplinary team. The providers of care are available 24 hours a day and are directly supervised by a licensed Physician.

SECOND SURGICAL OPINION

A second surgical opinion is an opinion of a board-certified surgical specialist based on his examination of the patient regarding the advisability of a non-emergency surgical procedure, surgical or otherwise, after another licensed surgeon has proposed to perform such procedure, but prior to the actual performance of the procedure.

SECURITY INCIDENT

“Security Incident” has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with systems operations in an information system.

SKILLED NURSING FACILITY

A skilled nursing facility is an institution or distinct part of an institution which:

- a) Is licensed pursuant to the law or approved by the appropriate authority;
- b) Provides twenty-four (24) hour nursing care for sick and injured patients on an inpatient basis;
- c) Has nursing care and service policies developed with the advice of and subject to review by professional personnel;
- d) Has a physician, registered nurse or other medical staff responsible for the execution of such policies;
- e) Requires every patient to be under the care of a physician and makes a physician available to furnish medical care in case of emergency;
- f) Maintains clinical records on all patients, has appropriate methods for dispensing drugs and medicines, and has at least one registered nurse employed on a full-time basis; and
- g) Provides for a group of physicians to periodically review medical necessity for admissions, continuation of confinements, duration of stay and adequacy of care.

The term "skilled nursing facility" shall not include an institution that is primarily for custodial care.

TOTALLY DISABLED

Totally Disabled shall mean that the covered person is under the regular care of a physician and is unable to perform any and every duty of his occupation and is not employed for wage or profit. If the covered person is not employed, "totally disabled" shall mean that he is unable to perform any of the normal activities of a person of like age and sex in good health.

TRUST

A Trust is a financial account established under the IRS code has been established to administer and otherwise conduct the affairs of the Ohio Northern University Employee Benefit Plan.

TRUSTEES

Trustees are three (3) individuals appointed by the Company to administer the Plan and Trust.

UNIVERSITY

The University is Ohio Northern University and any subsidiary or affiliate that has elected to participate in the Trust.

URGENT CARE CLAIM

An urgent admission is any claim for treatment that, if delayed, could seriously jeopardize the life or health of the patient, would limit the ability of the claimant to regain maximum function, or would subject the patient to severe pain that could not be adequately managed without the treatment that is the subject of the claim.

USUAL, CUSTOMARY AND REASONABLE (UCR) ALLOWANCE

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

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

WAITING PERIOD

With respect to a group health plan and an individual who is a potential participant under the plan, a waiting period is the period that must pass for an individual before he is eligible to enroll for coverage under the terms of the Plan. For a late enrollee or a special enrollee, however, any period before such late or special enrollment is not a waiting period.

WELL-CHILD CARE

Well-child care means a periodic review of a child's physical and emotional status performed by a physician or by a health care professional under the supervision of a physician. A periodic review is a review performed in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, development assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

PROCEDURES FOR CLAIMING BENEFITS UNDER THE PLAN

FILING FOR HOSPITAL/PHYSICIAN/ OTHER MEDICAL EXPENSES

All Out-of-Network claims submitted within the timely filing period should be submitted directly to the Claims Administrator. Network providers will submit their expenses directly to the Network. The Covered Person's health plan identification card indicates to providers and Covered Persons how to file a claim.

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

Complete and current information must be provided for:

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

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

DECISION ON SUBMITTED CLAIMS/PRE-AUTHORIZED SERVICES

Claims for benefits are defined as *Pre-Service Claims* or *Post-Service Claims*. Response time may vary according to the type of claim. Pre-Service Claims may be considered "urgent" or "concurrent." An Adverse Benefit Determination includes any decision to deny, reduce, terminate or refuse payment and includes eligibility denials and utilization review decisions. Upon written request, the Plan must explain any internal rules, guidelines or protocols, as well as disclose names of medical professionals who were consulted in the review process.

Pre-Service Claim: A Pre-Service Claim requires the Covered Person to pre-certify, notify or receive approval prior to receiving treatment. The Utilization Review Manager must give notice of the decision at least 15 days after the request for services, with one 15-day extension permitted. An extension is permitted only for reasons beyond control of the Plan and requires the Covered Person be given written notification before the first 15-day period ends.

Note: *The Plan requires notification to ACMS prior to elective Inpatient Hospital admissions and within [48] hours after receiving emergency Inpatient Hospital care. A Hospital or other healthcare professional may make the required call. ACMS may be contacted at 1-877-304-0761 (toll-free) Monday through Friday from 8 a.m. to 5 p.m. Eastern Standard Time. An answering system will take messages if ACMS is closed, which fulfills the notification requirement. Notifying ACMS does not guarantee benefit payment, as all Plan requirements and limitations will apply.*

Urgent Claim: An urgent claim is a Pre-Service Claim where the Covered Person's health or life is jeopardized without treatment or which would subject the patient to severe pain if treatment were delayed, as certified by a Physician. The Utilization Review Manager must respond to an urgent claim no later than 72 hours following receipt of the claim or, if additional information is required, request it within 24 hours and allow 48 hours for the Covered Person to respond. The Plan must then notify the claimant of the decision within 48 hours of receiving the additional information. No extensions are permitted.

Concurrent Claim: A concurrent claim is a Pre-Service Claim that requires approval over a course of treatment, such as physical therapy. If the care is urgent, the Plan must respond to the Covered Person within 24 hours. When approved, if services are to be rendered over an extended period of time, the Covered Person shall be entitled to a review prior to reduction or termination of benefits.

Post-Service Claim: A Post-Service Claim is any claim that is not a Pre-Service Claim. Timely claim filing begins when the Claims Administrator receives a claim with re-priced information from any participating Network, if applicable. The Plan must give notice of approval within 30 days after a Post-Service Claim is received. A Post-Service Claim also allows a 15-day extension for reasons beyond Plan control if proper notice is given prior to the end of the first 30-day period.

ADVERSE BENEFIT DETERMINATIONS AND APPEAL PROCEDURES

If a benefit is denied, in whole or in part, it is considered an Adverse Benefit Determination, as defined. When an Adverse Benefit Determination is made, the claimant will receive written or electronic notification of the following:

- 1) The specific reason(s) for the Adverse Benefit Determination
- 2) Reference to relevant Plan provisions used in making the determination
- 3) A description of additional information necessary for the claimant to perfect the claim and an explanation of why the additional information is necessary
- 4) A description of the Plan's appeal procedures applicable to the claim, including any applicable time limits
- 5) The claimant's right to bring a civil action under ERISA 502(a) following exhaustion of an appeal of an Adverse Benefit Determination
- 6) If the Adverse Benefit Determination reflected was based upon an internal rule, guideline or protocol, a copy of the rule, guideline or protocol will be provided free of charge upon written request. In addition, if the determination was based on a limitation or exclusion that the treatment was experimental or not medically necessary, an explanation of the scientific or clinical judgment relied upon will be sent free of charge upon written request.

If the Covered Person is dissatisfied with a benefit determination, he has 180 days following receipt of an Adverse Benefit Determination to submit a written appeal to the Plan Sponsor. If an appeal relates to an Urgent Care Claim, the Covered Person will be notified of the benefit determination on review as soon as possible, but not later than 72 hours after receipt of the appeal request. If an appeal relates to a non-urgent Pre-Service Claim, the Covered Person will be notified of the benefit determination on review not later than 30 days after receipt of the appeal request. If the appeal relates to a Post-Service Claim, the Covered Person will be notified of the benefit determination on review not later than 60 days after receipt of the appeal request. If a medical professional was consulted for the initial denial, then an independent reviewer must be used for the appeal. The “Definitions” section contains definitions for *Adverse Benefit Determination*, *Urgent Care Claim*, *Pre-Service Claim* and *Post-Service Claim*.

As part of the appeal process, a full and fair review of each claim will be provided on an unbiased basis. Any individual involved in the initial determination may not participate in an appeal of the initial determination. Documents and other information relating to the claim may be submitted. Upon written request (and free of charge), reasonable access to the Plan’s Documents and information relevant to the appealed claim will also be provided

A Covered Person may also submit a written appeal of his notice regarding Creditable Coverage applied to reduce any Pre-Existing Conditions Limitation in the Plan. The Claims Administrator will review this report and a written report will be sent to the Plan Administrator. The Plan Administrator will render a decision within 60 days of the appeal with specific reasons for the conclusions reached.

The Plan Administrator’s decision on the appeal will be final, binding and conclusive and will be afforded maximum deference permitted by law. All appeal procedures specified in the Plan must be exhausted before any legal action is filed. No legal action can be filed more than two years after the decision on appeal.

All days mentioned in the previous section refer to “calendar days.” All claims for benefits must be submitted within [one year from the incurred date of service to be eligible for benefits under this Plan.

GENERAL INFORMATION
(Required Under the Terms of the Employee Retirement
Income Security Act of 1974 – ERISA)

NAME OF THE PLAN

Ohio Northern University Employee Benefit Plan

PLAN NUMBER

501

END OF THE PLAN YEAR

December 31st

PLAN SPONSOR

Ohio Northern University Employee Benefit Plan
525 S. Main Street
Ada, Ohio 45810
(419) 772-2000

EMPLOYER IDENTIFICATION NUMBER

34-1376062

TYPE OF PLAN AND ADMINISTRATION

This is a benefit plan providing reimbursement for certain medical expenses as well as a prescription drug card plan. This Plan is administered through a Trust established by the Plan Sponsor. Benefits are not provided by insurance.

PLAN ADMINISTRATOR/AGENT FOR SERVICE OF LEGAL PROCESS

Vice President for Financial Affairs
c/o Ohio Northern University
525 S. Main Street
Ada, Ohio 45810
(419) 772-2020

METHOD OF PROVIDING BENEFITS & FUNDING MEDIUM

The Plan Sponsor and the covered employees share in the cost of coverage for employees and dependents. All additional costs are borne by the employer. The benefits are funded through the Ohio Northern University Employee Benefit Trust.

Covered persons do not receive any health plan benefits from an insurance company as all health benefits are funded by employer and employee contributions. Insurance policies purchased by the Plan Sponsor may reimburse the Plan for certain large claims but do not provide coverage directly to individuals in the Plan.

EXAMINATION OF CLAIMANT

The Plan Administrator, at the Plan's expense, shall have the right and opportunity to have examined the person whose injury or illness is the basis of the claim when and as often as may reasonably be required during the time a claim is pending under the Plan. Benefits under this Plan will be paid only if the Plan Administrator in his discretion decides that the covered person is entitled to them.

PARTICIPANT ENTITLEMENTS

As a participant in the Ohio Northern University Employee Benefit Plan, a covered person is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About This Plan and Benefits:

Each covered person has the right to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all

documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Covered persons may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Covered persons may also receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage:

The right to continue health care coverage applies to the employee, spouse or dependents if there is a loss of coverage under the Plan as result of a qualifying event. The employee or his dependents may have to pay for such coverage. This summary plan description and the documents governing the Plan should be reviewed for the rules governing COBRA Continuation Coverage rights.

Reduction or elimination of exclusionary periods of coverage will apply to pre-existing conditions under this group health Plan, if the covered person has creditable coverage from another plan. A certificate of creditable coverage should be provided, free of charge, from the covered person's group health Plan or health insurance issuer. A Certificate of Coverage should be issued:

- when he loses coverage under the Plan;
- when he becomes entitled to elect COBRA continuation coverage;
- when his COBRA continuation coverage ceases, if he requests it before losing coverage; or
- if he requests it, up to 24 months after losing coverage.

Without evidence of creditable coverage, the covered person may be subject to a pre-existing conditions limitation for twelve (12) months (18 months for late enrollees) after his reenrollment date in this coverage.

Prudent Actions by Plan Fiduciaries:

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate this Plan, called "fiduciaries" of the Plan, have the duty to do so prudently and in the interest of all Plan participants and beneficiaries. No one, including a covered employee's employer, a union, or any other person, may fire a covered employee or otherwise discriminate against him in any way to prevent him from obtaining a welfare benefit or exercising his rights under ERISA.

Enforce Covered Persons' Rights:

If a covered person's claim for a welfare benefit is denied or ignored, in whole or in part, he has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps to be taken to enforce the above rights. For instance, if a covered person requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay him up to \$110 a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If a covered person has a claim for benefits that is denied or ignored, in whole or in part, he may file suit in a state or Federal court. In addition, if a covered person disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, he may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if a covered person is discriminated against for asserting his rights, he may seek assistance from the U.S. Department of Labor, or he may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the covered person is successful, the court may order the person he has sued to pay these costs and fees. If he loses, the court may order him to pay these costs and fees, for example, if it finds his claim is frivolous.

No legal action for recovery of benefits allegedly due under any Company Sponsored benefit plan may be commenced by or on behalf of an employee or former employee against the Plan, the Plan Administrator, the Trustee, or successor of the same unless it is filed within one year after the date of the final determination noted in the appeals procedure of the relevant benefit Plan Document.

Assistance with Questions:

If a covered person has any questions about this Plan, he should contact the Plan Administrator. If he has any questions about this statement or about his rights under ERISA, or if he needs assistance in obtaining documents from the Plan Administrator, he should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

Covered persons may also obtain certain publications about their rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

HIPAA COMPLIANCE AND SECURITY STANDARDS

The requirements of § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations, 45 Code of Federal Regulations (C.F.R.)

Parts 160 through 164, established the extent to which the Plan Sponsor will receive, use and/or disclose Protected Health Information (PHI).

PLAN SPONSOR'S CERTIFICATION OF COMPLIANCE

Neither the Plan nor any health insurance issuer or Business Associate servicing the Plan will disclose Plan Participants' PHI to the Plan Sponsor unless the Plan Sponsor certifies that the Plan Documents have been amended to incorporate this section and agrees to abide by it.

PURPOSE OF DISCLOSURE TO PLAN SPONSOR

- 1) The Plan and any health insurance issuer or Business Associate servicing the Plan will disclose Plan Participants' PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing Regulations (45 C.F.R. Parts 160–64). Any disclosure to and use by the Plan Sponsor of Plan Participants' PHI will be subject to and consistent with the provisions of this section.
- 2) Neither the Plan nor any health insurance issuer or Business Associate servicing the Plan will disclose Plan Participants' PHI to the Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to the Plan Participants.
- 3) Neither the Plan nor any health insurance issuer or Business Associate servicing the Plan will disclose Plan Participants' PHI to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

RESTRICTIONS ON PLAN SPONSOR'S USE AND DISCLOSURE OF PHI

- 1) The Plan Sponsor will neither use nor further disclose Plan Participants' PHI, except as permitted or required by the Plan Document, as amended, or required by law.
- 2) The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Plan Participants' PHI agrees to the restrictions and conditions of the Plan Document, including this section, with respect to Plan Participants' PHI.
- 3) The Plan Sponsor will neither use nor disclose Plan Participants' PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- 4) The Plan Sponsor will report to the Plan any use or disclosure of Plan Participants' PHI that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.
- 5) The Plan Sponsor will make PHI available to the Plan Participant who is the subject of the information in accordance with 45 C.F.R. § 164.524.
- 6) The Plan Sponsor will make Plan Participants' PHI available for amendment, and will on notice amend Plan Participants' PHI, in accordance with 45 C.F.R. § 164.526.
- 7) The Plan Sponsor will track disclosures it may make of Plan Participants' PHI so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.

- 8) The Plan Sponsor will make its internal practices, books and records, relating to its use and disclosure of Plan Participants' PHI, available to the Plan and to the U.S. Department of Health and Human Services (HHS) to determine compliance with 45 C.F.R. Parts 160–64.
- 9) The Plan Sponsor will, if feasible, return or destroy all Plan Participants' PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Participant who is the subject of the PHI, when the Plan Participants' PHI is no longer needed for the Plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Plan Participants' PHI, the Plan Sponsor will limit the use or disclosure of any Plan Participant's PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

ADEQUATE SEPARATION BETWEEN THE PLAN SPONSOR AND THE PLAN

- 1) The employees, classes of employees or other workforce members designated by the Privacy Officer may be given access to Plan Participants' PHI received from the Plan or a health insurance issuer or Business Associate servicing the Plan.
- 2) The employees, classes of employees or other workforce members designated by the Privacy Officer may receive Plan Participants' PHI relating to payment under, healthcare operations of or other matters pertaining to the Plan in the ordinary course of business.
- 3) The employees, classes of employees or other workforce members designated by the Privacy Officer will have access to Plan Participants' PHI only to perform the Plan administration functions that the Plan Sponsor provides for the Plan.
- 4) The employees, classes of employees or other workforce members designated by the Privacy Officer will be subject to disciplinary action and sanctions, including, but not limited to, termination of employment or affiliation with the Plan Sponsor, for use or disclosure of Plan Participants' PHI in breach or violation of or non-compliance with the provisions of this section to the Plan Document. The Plan Sponsor will promptly report such breach, violation or non-compliance to the Plan, as required by this section, and will cooperate with the Plan to correct the breach, violation or non-compliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or non-compliance, and to mitigate any deleterious effect of the breach, violation or non-compliance on any Participant, the privacy of whose PHI may have been compromised by the breach, violation or non-compliance.

HIPAA SECURITY STANDARDS

Where Electronic Protected Health Information will be created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

- 1) The Plan Sponsor shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan.

- 2) The Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures.
- 3) The Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information, agrees to implement reasonable and appropriate security measures to protect such information.
- 4) The Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - a) The Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification or destruction of the Plan's Electronic Protected Health Information; and
 - b) The Plan Sponsor shall report to the Plan any other Security Incident upon the Plan's request.

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